**Annex A**

# Overview of consultation responses and proposed changes

## Introduction

This paper focuses on the responses to the general questions that were posed at the beginning of the online consultation survey and highlights a number of proposals to amend the Scheme that PSG has made in response to this feedback. The paper also identifies a number of wider issues that the consultation process brought to light and outlines the PSG's proposals to address these.

## Analysis of responses to general questions

***Q6/Q7: Having read about the changes to the Scheme are you: more likely to stay in the Scheme, less likely to stay in the Scheme, or neither more nor less likely to stay in the Scheme?***

1. This question was only shown to practices that indicated they were already in the Scheme. 19 individuals answered this question of whom 10 were neither more nor less likely to leave, 5 were more likely to leave and 4 were less likely to leave.

2. When asked to explain their reasons, 4 individuals highlighted concerns in relation to the amount of paperwork required and the Scheme appearing onerous for small practices.

***Q8: Having read about the changed to the Scheme is your practice: more likely to join the Scheme, less likely to join the Scheme, or neither more nor less likely to join the Scheme?***

3. This question was only shown to practices that indicated they were not in the Scheme. Only 7 individuals answered with 3 more likely to join and no one was less likely to join.

***Q9/Q10: Thinking generally about the Awards, on a scale of one to five, how clear and understandable are they to the profession? (where 1 is not at all clear, and 5 is very clear)***

4. 70 individuals responded to this question with 66% indicating that they considered the Awards to be clear and understandable or very clear and understandable to the profession.

5. When asked to provide a reason for their answer a number of respondents reiterated that the Awards and terminology were clear and understandable. Conversely, some respondents noted that the complexity of the system could lead to further confusion. One respondent noted that 'Good' could be deemed as 'Adequate'.

6. In response to the feedback the RCVS intends to create clear explanations as to what it means to be 'Good' or 'Outstanding'.

***Q11/Q12:...and how clear and understandable are the Awards to the public? (where 1 is not at all clear, and 5 is very clear)***

7. Regrettably 57% of respondents indicated that the Awards would not be clear to the public. It is important to note that we are starting from a low point regarding the public understanding of the Scheme. Moreover, the consultation does not provide a good testing ground for the clarity of the Awards to the public as no one who responded indicated that they were doing so as a member of the public. Nevertheless, it is critically important that Scheme is understandable to the public and that strenuous efforts are made to communicate the meaning of the Scheme and the Awards.

8. When asked to give a reason for their response, concern was expressed that the titles of the Awards would be difficult for the public to understand, and that there could be confusion between the base Accreditations (Core, GP and Veterinary Hospital) and the Awards.

9. In response to the feedback to questions 9-12 PSG noted the need to develop tools to help practices to market their membership of the Scheme and Awards more effectively. It was agreed that before launch PSG should hold a meeting dedicated to developing a more strategic approach to marketing and which would make the best use of the limited resources at the Scheme's disposal.

***Q13/14: Are the titles of the Awards appropriate?***

10. Despite concerns regarding the public understanding of the Scheme almost 64% of respondents thought that the proposed titles were appropriate.

11. When asked for suggestions for more appropriate Award titles, one respondent proposed that that 'Team' should be removed from the Award in 'Team and Professional Responsibility', whilst another suggested that the Awards should be accompanied by symbols.

12. PSG considered the removal of 'Team' from the Award, however, it noted that much of the Module focused on the practice team and their development, and to remove the term could be misleading. Moreover, 'Professional Responsibility' alone could be confused with the requirements of the Code. The Group noted that 'Practice Team' might be clearer descriptor and supported further consideration being given to the use of this term in the title.

***Q15/16 Are the Awards configured from the correct Modules?***

13. The response to this question was positive; 56% of respondents considered the Awards were configured correctly and only 14% believed that that we incorrectly configured.

14. When asked how the Awards might be better configured two notable themes that emerged were that the Emergency and Critical Care Award should comprise more than the single Module in Emergency and Critical Care (ECC), and that the Award in Client Service might be too easy to achieve as it also only required the completion of a single Module.

15. PSG expressed concerns in relation to the ECC Award and strongly supported changing the structure of the Awards. PSG proposed that in addition to the ECC Module, practices should also be required to undertake the Modules in 'In-Patients', 'Nursing' and 'Pain Management'. Following the meeting the representative of BAVECC also proposed that practices should be required to complete the Module in 'Anaesthesia'.

16. In relation to the Award in 'Client Service', PSG considered that further testing would be required to ascertain the difficulty of achieving the Award and whether any adjustments would be required. It was noted that whilst client service and clear communication with clients appeared straightforward they were still major sources of complaints to the College.

***Q17/18: Are the Awards pitched at an appropriate level?***

17. Again this question received a positive response; 59% of respondents considered the Awards were pitched at an appropriate level and 20% identified concerns.

***Q19/20: Do you support the proposal that practices can only outsource OOH to practices at their own accreditation level or higher?***

18. 65% of respondents supported the proposal, whilst 23% opposed it.

19. Concerns were highlighted as to whether Veterinary Hospitals could outsource to Emergency Service Clinics (ESCs) and how small practice in rural areas might comply with the requirements.

20. In response to the feedback PSG agreed that practices should be given five years to comply with this requirement. This would mirror the time Veterinary Hospitals would be allowed to comply with the requirement to provide OOH cover from their own premises. It was also agreed that further clarification should be given that it would acceptable for Veterinary Hospitals to outsource their OOH to ESCs.

***Q21/22: Do you support the proposal that, within five years Veterinary Hospitals must provide out-of-hours cover from their own premises?***

21. 62% of respondents supported the proposal and 22% were opposed to it.

22. Analysis of the comments suggests that further communication is required to clarify that Veterinary Hospitals could outsource their OOH cover so long as it was provided on their premises.

***Q23/24: Do you support the proposal for the introduction of an 'Equine GP – Ambulatory' Accreditation level?***

23. Teh consultation proposed that under new Scheme there should be a new accreditation level: Equine GP – Ambulatory. This accreditation would recognise that there were Equine practices that provided a GP level service albeit that they did not stabling facilities or premises where horses are treated. Practices wishing to achieve this level of accreditation would need to meet all the Equine GP requirements, with the exception of those within the 'In-patients' Modules.

24. Only two respondents opposed the proposal.

***Q25: We would welcome any feedback in relation to the new IT system***

25. The comments in response to the IT system were very positive, with the usual caveats that the system must be user friendly and deliver the promised functionality.

***Q26 Taking into account the additional benefits of the revised Scheme, do you think the proposed price increase represents good value for money?***

26. 44% of respondents considered the Scheme represented good value for money and only 26% opposed the statement. 29% were under decided and comments suggested their opinion would be determined by the extent to which the Scheme could differentiate practices and was understandable to the public.

27. One respondent, reflected views that had previously been fed back to the College, that larger practices or higher accreditation levels should be charged a higher price.

***Q28: If you have any general comments on the proposed revised Scheme, please add them below:***

28. The final question before the Module specific questions sought general feedback upon the proposals. The responses to this questions informed the items on the PSG agenda and formed the basis for a number of proposals to amend the Scheme outlined in the following section.

## Wider changes

**Ensuring the consistency of points for CPD, Certificate holders and Advanced Practitioners**

29. A number of respondents highlights inconsistencies in the way that the points were allocated for specific CPD, those who had completed a module of the CertAVP, old style Certificate holders or Advanced Practitioners. PSG agreed that this issue needed to be addressed and supported the principle that whatever points allocation was adopted the lack of access to an Advanced Practitioner or old Style Certificate holder should not prevent a practice from achieve an 'Outstanding' rating within a particular Module.

30. Following the meeting it was proposed that the following weighting be applied: Module specific CPD – 10 points; at least one MRCVS has a completed a module of the CertAVP- 30 points, at least one MRCVS has a post-graduate qualification relevant to the PSS Module in question – 50 points.

**Visiting Specialists**

31. The consultation highlighted confusion as to whether practices with visiting Specialist or Certificate holders were to be awarded points. PSG agreed that where a practice had a contractual arrangement with a Specialist or Certificate holder, and where evidence could be provided that such an individual disseminated their knowledge and expertise to the practice team then points would be Awarded.

**Removal of Premises Award**

32. PSG considered the Award Points section of the 'Premises' Module in light of the consultation feedback. It was agreed that this section focused too heavily on equipment and facilities, and not outcome or behaviours. With the exception of two clauses that would be moved to 'Infection Control' and 'Outpatients' respectively, it was agreed that the Award Points clauses for this module would be removed.

**Head torches**

33. PSG considered whether surgical head torches would be an adequate alternative to uninterruptable surgical lighting for Veterinary Hospitals and Emergency Service Clinics. The Group was in agreement that given advances in technology such head torches would be acceptable, but work would be required to ensure that detailed information was given to practices as to the minimum acceptable specification for head torches.

# Annex B – Updated Small Animal Modules

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## Introduction

This document outlines all of the Practice Standards Scheme (PSS) modules and requirements for Small Animal accreditation and Awards.

It is important to note that whilst this document may appear complex, under the new Scheme the bespoke IT system will lead practices through accreditation in a step-by-step process and will only show the requirements that are relevant to the accreditation level and Awards the practice seeks to achieve.

## Accreditation Levels

Small Animal practice premises can apply for be accredited as:

- Core Standards
- General Practice (GP)
- Emergency Service Clinic (ESC)
- Veterinary Hospital

### Core Standards

Core standards are relevant to all veterinary practices and reflect mainly legal requirements which must be met in running a veterinary practice, together with guidance as set out in the *RCVS Code of Professional Conduct*.

Every practice premises within the Scheme must meet Core Standards for all species treated.

To achieve Core Standards practices must meet the Core requirements in all relevant modules. Thus if a practice did not undertake any surgery at the premises then it would be exempt from the requirements of this module.

### General Practice

General Practice accreditation reflects the requirements of a primary care practice which also aims to facilitate the achievement of high standards of clinical care, and encompasses many of the facilities required for veterinary nurse training standards.

General Practices must meet the Core and GP requirements in all of the modules.

### Emergency Service Clinic

Emergency Service Clinic accreditation reflects the requirements of a designated out-of-hours provider.

Emergency Service Clinics must meet the Core and GP requirements in all the modules and the ESC requirements in the Emergency and Critical Care Module.

## Veterinary Hospital

Veterinary Hospital accreditation reflects the requirements of a General Practice allied with additional facilities and protocols for the investigation and treatment of more complex cases.

Veterinary Hospitals must meet the Core, GP and Veterinary Hospital requirements in all of the modules. If, however, a Veterinary Hospital can demonstrate that it undertakes no dentistry, because for example it only undertakes orthopaedic work, then it may be exempted from the requirements of the Dentistry Module.

## Small Animal Awards

In addition to accreditation under the Practice Standards Scheme, Small Animal practice premises are eligible to apply to be inspected for additional Awards in:

- Team and Professional Responsibility
- Client Service
- Patient Consultation Service
- Diagnostic Service
- In-patient Service
- Emergency and Critical Care Service

Practice premises will be designated as ‘Good’ or ‘Outstanding’ within the Awards they select and will be free to promote themselves as such. This follows a similar format to that used by Ofsted in the inspection of schools and should therefore be easily recognised and understood by the public.

Within each of the Modules there are ‘Award Points’ which go above and beyond Module requirements and focus upon behaviours and outcomes. Every clause within the ‘Awards Points’ section is given a weighting in terms of the points it is allocated. In order to be designated as ‘Good’ in a Module a practice premises will need to achieve 60% of the available points. A practice premises which achieves 80% or more will be designated as ‘Outstanding’.

The Modules fit together to form the Awards. Practice premises that wish to achieve an Award must be at ‘Good’ or ‘Outstanding’ in every Module in the Award. In order to be designated as ‘Outstanding’ within an Award a practice premises must be ‘Outstanding’ in all the Modules in the particular Award.

The tables below indicate how the Awards are formed from the Modules and the 'Awards Points' that are available. Some Modules, such as 'Nursing' contribute to more than one Award:

| Award 1: Team and Professional Responsibility | | | |
|---|---|---|---|
| **Required Modules:** | **Award Points Available:** | **Good:** | **Outstanding:** |
| Clinical Governance | 270 | 160 | 220 |
| Infection Control | 280 | 170 | 220 |
| Medical Records | 210 | 130 | 170 |
| Medicines | 370 | 220 | 300 |
| Practice Team | 570 | 340 | 460 |

| Award 2: Client Service | | | |
|---|---|---|---|
| **Required Modules:** | **Award Points Available:** | **Good:** | **Outstanding:** |
| Client Experience | 550 | 330 | 440 |

| Award 3: Patient Consultation Service | | | |
|---|---|---|---|
| **Required Modules:** | **Award Points Available:** | **Good:** | **Outstanding:** |
| Infection Control | 280 | 170 | 220 |
| Medicines | 370 | 220 | 300 |
| Nursing | 340 | 200 | 272 |
| Out-of-Hours | 150 | 90 | 120 |
| Out-patients (First Opinion) | 400 | 240 | 320 |
| Pain Management | 250 | 150 | 200 |

| Award 4: Diagnostic Service | | | |
|---|---|---|---|
| **Required Modules:** | **Award Points Available:** | **Good:** | **Outstanding:** |
| Diagnostic Imaging | 430 | 260 | 340 |
| Laboratory and Clinical Pathology | 280 | 170 | 220 |

| Award 5: In-patient Service | | | |
|---|---|---|---|
| **Required Modules:** | **Award Points Available:** | **Good:** | **Outstanding:** |
| Anaesthesia | 660 | 400 | 530 |
| Dentistry | 320 | 200 | 260 |
| Infection Control | 280 | 170 | 220 |
| In-patients | 320 | 200 | 260 |
| Nursing | 340 | 200 | 270 |
| Out-of-Hours | 150 | 90 | 120 |
| Pain Management | 250 | 150 | 200 |
| Surgery | 770 | 460 | 620 |

| Award 6: Emergency and Critical Care Service | | | |
|---|---|---|---|
| **Required Modules:** | **Award Points Available:** | **Good:** | **Outstanding:** |
| Emergency and Critical Care | 660 | 400 | 530 |
| In-patients | 320 | 200 | 260 |
| Nursing | 340 | 200 | 270 |
| Pain Management | 250 | 150 | 200 |

The Awards will be available to all practice premises whether they are accredited to Core Standards, General Practice, Emergency Service Clinic or Veterinary Hospital.

For a practice premises accredited to Core Standards some of the Awards may not be achievable due to the constraints of the premises or the work undertaken, however we would expect they would be able to attain Awards in 'Team and Professional Responsibility' and 'Client Service'. Where a Core Standards practice premises would like to apply for an Award it would also need to comply with the 'General Practice' requirements within the applicable Modules.

Practice premises wishing to achieve the Award in Emergency and Critical Care Service must also meet the Emergency Service Clinic (ESC) requirements within the Emergency and Critical Care Module.

# Modules

## Module 1: Anaesthesia

### CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. The practice must carry out monitoring of anaesthetic pollutants in operating areas and maintain written records of this.<br>Written evidence of measurement of personal exposure to anaesthetic monitoring is required. Monitoring must be carried out on an annual basis, or if the nature of the anaesthetic equipment and circuitry is changed.<br>Assessors will check that the readings recorded fall within the current Workplace Exposure Limits for the agent(s) used. | The current workplace limits are:<br>10ppm Halothane<br>50ppm Isoflurane<br>60ppm Sevoflurane<br>100ppm Nitrous oxide<br>All these values are subject to review and are calculated on an eight-hour Time Weighted Average (TWA) basis. |
| 2. The practice must provide facilities for the scavenging of anaesthetic gases.<br><br>Scavenging must comply with current health and safety laws. | Facilities for scavenging include any device or ducting system for the removal of waste gases from the operating area:<br>• Passive scavenging – by duct to the open air;<br>• Charcoal absorbers – e.g. Aldosorb;<br>• Active scavenging – via a pump and air break device.<br><br>If a sophisticated active scavenging system is in operation, it must be serviced annually. An inspection certificate must be available and is an acceptable alternative to personal dosimetry. |
| 3. Anaesthetic equipment must be subject to professional maintenance according to the manufacturers' recommendations. | Regular service records must be produced for all anaesthetic equipment. |
| 4. A veterinary surgeon must administer general anaesthesia if the induction dose is either incremental or to effect. | |

# Module 1: Anaesthesia

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. Anaesthetic equipment must be checked before use on a daily basis. | See BSAVA Guide to Practice Management |
| 2. There must be a source of oxygen and emergency oxygen flush with reducing valve, rotameter and vaporiser. | |
| 3. Equipment for the administration of oxygen and the safe maintenance of anaesthesia and resuscitation must be appropriate for the species treated. | |
| 4. Temperature-compensated vaporisers must be used | |
| 5. Anaesthetic circuits suitable for the range of patients routinely treated must be provided. | Circuits must include a circuit suitable for small patients, such as a T-piece; a circuit suitable for medium sized patients; such as a Lack or a Bain; and a circuit suitable for a giant breed of dog; such as a circle unit, or a high flow rate mechanism for a non-rebreathing unit. |
| 6. A range of endotracheal tubes must be available. | |
| 7. At least one monitoring device must be available e.g. oesophageal stethoscope, pulse oximeter, capnograph, ECG. | |
| 8. Anaesthetic charts must be filled in for each patient (except in emergency or very short procedures, e.g. cat castrate).These charts must form part of the clinical records. | The charts must include:<br>- Date<br>- Personnel involved<br>- Induction agent<br>- Maintenance agent<br>- Duration of anaesthetic<br>- Surgical procedure<br>- Any anaesthetic complications<br>- Vital signs<br>- Other medication administered |

| | |
|---|---|
| | |
| 9. A trained team member, other than the surgeon, must be present to monitor the patient throughout the general anaesthetic. | Evidence of suitable training must be provided if the team member is not a Registered Veterinary Nurse. In-house training is acceptable, but must be evidenced to the Assessor. The Assessor will wish to speak to those put forward as having competency in anaesthetic monitoring. |
| 10. A clock or watch showing seconds must be visible to any team member monitoring an animal under anaesthesia or sedation. | |
| 11. Equipment must be available for the maintenance of body temperature during anaesthesia and recovery. | |
| 12. There must be suitable means of resuscitation. A resuscitation pack must always be maintained and be readily available for instant use, and checked to ensure the contents are in date. | A concise chart of emergency drug doses must be kept with the emergency resuscitation box. |

## Module 1: Anaesthesia

### VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. A practice team member is dedicated solely to monitoring the condition of each anaesthetised patient until fully recovered at all times including out of hours. | The Assessor will ask to see patient charts and team member rotas, and will speak to team members. |
| 2. Additional training and qualifications. | At least one team member (MRCVS or RVN) should have undertaken CPD in anaesthesia in last two years. |
| 3. There is a suitable number of monitoring devices required for the normal workload and at least one multi-parameter monitoring device is available. | This would normally be expected to include pulse oximetry, capnography, continuous ECG, body temperature and blood pressure. |
| 4. A range of induction and maintenance agents must be stocked to permit anaesthesia of all patients treated, including high risk patients. | |
| 5. Records of vital signs and agents employed must be retained. | |
| 6. There is proper ventilation during patient recovery to limit human exposure to exhaled anaesthetic gases. | |

## Module 1: Anaesthesia

### AWARD POINTS

### This Module contributes towards the Award in 'In-patient Service'.

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. General anaesthesia CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | . | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in anaesthesia and there is evidence of dissemination to the rest of the team. | | | 30 |
| 3. At least one MRCVS has a post-graduate qualification in anaesthesia and there is evidence of dissemination to the rest of the team. | | This includes AP status or an old style Certificate | 50 |
| 4. There are masks available in a suitable range of sizes, which are regularly cleaned and disinfected. | Systematic approach to maintaining cleaning and disinfection standards. | Team members will be asked to explain the process. Cleaning/disinfection records | 20 |
| 5. Endotracheal tubes and breathing systems must be cleaned and stored appropriately. | Systematic approach to maintaining cleaning and disinfection standards. | | 20 |
| 6. The practice has a protocol for the safe re-filling of anaesthetic vaporisers (e.g. a key-filling system). | | This will help reduce team members' exposure to inhalation agents. | 20 |
| 7. There is a designated area for induction separate from the theatre. | | | 20 |

| | | | |
|---|---|---|---|
| 8. The practice uses a checklist to identify the patient, procedure and current medication prior to premedication and induction. | | Team members will be asked to explain the process and provide example checklist.<br><br>See AVA Checklist for further information: http://www.ava.eu.com/recommendations/AVA-AnaestheticSafetyChecklist-FINAL-EU-WEB.pdf | 30 |
| 9. A patient assessment including a risk assessment is performed by a veterinary surgeon prior to the administration of any premedication, sedation or anaesthetic and recorded. | | See AVA Checklist for further information: http://www.ava.eu.com/recommendations/AVA-AnaestheticSafetyChecklist-FINAL-EU-WEB.pdf<br>https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system | 30 |
| 10. Patients have intravenous catheters in place during general anaesthetic and/ or sedation for at least ASA categories 2-5. | | See AVA Checklist for further information: http://www.ava.eu.com/recommendations/AVA-AnaestheticSafetyChecklist-FINAL-EU-WEB.pdf | 30 |
| 11. The use of intravenous fluid therapy during anaesthesia for appropriate cases can be demonstrated. | | | 30 |
| 12. Patients are intubated or use a supraglottic airway device is used to provide inhalational anaesthesia. | | There may be exceptional circumstances where the size, anatomy or species of the patient precludes this. | 30 |
| 13. A practice team member is dedicated solely to monitoring the condition of each anaesthetised patient until fully recovered. | | This does not have to be the same person all the way through but the hand over must be appropriate. | 30 |

| | | | |
|---|---|---|---|
| 14. All anaesthetics are monitored by a veterinary surgeon, RVN or SVN under supervision. | | | 30 |
| 15. Training has been undertaken and facilities are available for the following monitoring: | What is required should be based on a risk assessment and will depend on the number and nature of operations performed-practices should ensure that monitoring is adequate for the work undertaken.<br>Evidence of suitable monitoring could be completed anaesthetic forms, observations on the day and speaking with team members. | | |
| | | i. respiratory rate | 20 |
| | | ii. blood oxygen saturation | 20 |
| | | iii. Blood pressure | 20 |
| | | iv. cardiac rate and rhythm | 20 |
| | | v. end tidal $CO_2$ | 30 |
| 16. Body temperature is monitored at appropriate intervals and steps taken to maintain normal body temperature. | | | 30 |
| 17. There has been adequate training of team members in the interpretation of data from and troubleshooting of monitoring equipment. | | | 30 |
| 18. There is a means of assisting ventilation either manual or mechanical available which is used as needed. | | The practice must be able to demonstrate that team members have been adequately trained in IPPV. | 30 |
| 19. A suitable number of team members are trained in CPCR of veterinary patients. | | | 20 |

| | | | |
|---|---|---|---|
| 20. There is an appropriately ventilated designated staffed area for recovery of patients. | | To reduce the occupational exposure to inhalational agents. | 10 |
| 21. Appropriate communication is held with the owner, prior to anaesthesia, explaining the potential risks and complications of the procedure. | | This may be evidenced by an entry on the client record or a signed consent form including these details. | 30 |
| 22. Anaesthetic procedures are subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **660** |
| | | **OUTSTANDING:** | **530** |
| | | **GOOD:** | **400** |

# Module 2: Clinical Governance

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. Veterinary surgeons must ensure that clinical governance forms part of their professional activities. | Clinical governance is a framework to enable the practice to deliver good quality care by reflecting on clinical cases, analysing and continually improving professional practice as a result, for the benefit of the animal patient and the client/owner.<br><br>Clinical effectiveness measures how well a particular procedure achieves the desired outcome. For practices to be clinically effective they need access to the best available evidence in order to discuss and draw up protocols and monitor how effective they are by clinical audit and significant event reviews.<br><br>Practical suggestions of how the practice can fulfil this requirement can be found in Chapter 6 of the supporting guidance to the *RCVS Code of Professional Conduct:*<br><br>http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/clinical-governance/<br><br>There is a useful practical guide on BSAVA website:<br>www.bsava.com<br><br>Information on this developing area of practice is also available through other veterinary organisations e.g. BVA, BEVA, SPVS, BCVA etc.<br><br>Evidence-Based Veterinary Medicine is a key focus of RCVS Knowledge. Further information and resources are available at:<br>https://knowledge.rcvs.org.uk/evidence-based-veterinary-medicine/ |
| 2. Veterinary surgeons must refer cases as appropriate. | The assessors will expect to see records of recent referrals or of case discussions where referral was recommended. |

# Module 2: Clinical Governance

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. The practice must have a system in place for monitoring and discussing clinical cases, analysing and continually improving professional practice as a result. | Written evidence of regular clinical meetings, journal clubs or clinical protocols and guidelines. Evidence of changes made as a result of the analysis. This could be recorded on the practice management system e.g. under client clinical governance. |

# Module 2: Clinical Governance

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. Regular morbidity and mortality meetings must be held to discuss the outcome of clinical cases, there are records of meetings and changes in procedures as a consequence | Open, honest discussions with clear actions, no barriers to feedback.<br><br>Discussions should be ongoing or at least monthly as a minimum and would ideally be face-to-face.<br><br>Evidence of changes made as a result of such meetings. |

**Comment [t1]:** Add requirement for auditing clinical procedures as currently indicated in guidance and number 9 in Awards

# Module 2: Clinical Governance

## AWARD POINTS

**This Module contributes towards the Award in 'Team and Professional Responsibility'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. Clinical governance CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in clinical governance. | | | 30 |
| 3. The practice has regular clinical meetings to which all clinical team members can input items for discussion. | Open, honest discussions with clear actions, no barriers to feedback. | Meetings should be monthly as a minimum and do not necessarily need to be face-to-face. | 20 |
| 4. Following a significant events (e.g. unexpected medical or surgical complication, anaesthetic death, accident or serious complaint), a 'no-blame' meeting is held as soon as possible to consider what, if anything, could have been done to avoid it. | Open, honest discussions with clear actions, no barriers to feedback. | The meeting is recorded and any changes in procedure as a result are communicated to all team members. | 30 |
| 5. Clinical protocols / guidelines are drawn up and reviewed following team discussion considering the evidence base. | Reviews of best practice. | Evidence of reviews of procedures and changes made as a result of review. | 20 |
| 6. Copies of clinical protocols/guidelines are available for new team members and locum induction. | Consistent information is provided to all new team members. | Evidence of induction records and training. | 20 |
| 7. There is a system for updating | | | 20 |

| | | | |
|---|---|---|---|
| team members on the use of all new equipment, procedures and new medicines used in the practice. | | | |
| 8. | | | |
| 9. | | | |
| 10. The practice runs regular journal clubs. | | This forms part of the review of best practice. | 20 |
| 11. There are protocols for referral that are regularly reviewed and known to all the practice team. | | Evidence of annual review.<br>Referral reports are shared with the team | 10 |
| 12. Clinical procedures carried out in the practice are audited and any changes implemented as a result. | | There is evidence that some commonly used procedures are audited and that any changes required are implemented.<br>This forms part of the regular review of best practice. | 30 |
| 13. Regular morbidity and mortality discussions are held to discuss the outcome of clinical cases; there are records of discussions and changes in procedures as a consequence. | Open, honest discussions with clear actions, no barriers to feedback. | There are records of discussions and changes in procedures as a consequence.<br><br>Discussions should be ongoing or at least monthly and would ideally be face-to-face.<br><br>Evidence of changes made as a result of such meetings. | 20 |
| 14. The practice is contributing data towards professional benchmarking or clinical data collection, or data for future potential publication | | This could include contributing data towards undergraduate projects orclinical data to organised multicentre studies for potential publication (e.g. VetCompass or SAVSNET) | 40 |
| 15. . | | | |
| | | **TOTAL POINTS AVAILABLE:** | **270** |
| | | **OUTSTANDING:** | **220** |
| | | **GOOD:** | **160** |

# Module 3: Client Experience

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. The practice must have an effective means of communication with its clients. | The practices should provide clients, particularly those new to the practice, with comprehensive written information on the nature and scope of their services, including:<br>a. The provision, initial cost and location of the out-of-hours emergency service;<br>b. information on the care of in-patients;<br>c. The practice's complaints handling policy<br>d. Full terms and conditions of business, to include for example:<br>- Surgery opening times<br>- Normal operating times<br>- Fee or charging structures<br>- Procedures for second opinions and referrals<br>- Use of client data<br>- Access to and ownership of records<br><br>Evidence could include client information leaflets, emails to clients and reminders. This information might be displayed on the website, provided to new clients and / or displayed in the surgery. |
| 2. The practice must have a means of recording and considering client complaints. | |
| 3. There is an effective system for referring all patients. | Referral communications are personal and directed from veterinary surgeon to veterinary surgeon. Relevant clinical team members understand the process of referral and can describe how a referral is made. |

| | |
|---|---|
| 4. Veterinary surgeons must respond promptly, fully and courteously to clients' complaints and criticisms. | All team members should be aware of the practice's complaints procedure and know what to do in the event of a complaint or criticism. |
| 5. Options are discussed regarding cremation, destination of ashes etc. | |
| 6. Charges are discussed with clients. | The practice must be able to demonstrate how fee estimates are generated, and procedures for updating and informing clients of ongoing costs. |

# Module 3: Client Experience

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. There must be sufficient telephone capacity and human resources to meet the workload of the practice. | It could be that the practice carries out a regular audit of time taken to answer calls. |
| 2. Team members should be effective at prioritisation of emergency cases. | The practice team who are responsible for answering phones should be aware of cases that require immediate emergency attention and how to communicate and liaise with veterinary surgeon to provide appropriate attendance.<br><br>Examples of acute trauma that may require urgent attention include fractures, wounds causing massive blood loss etc that require urgent attention. |
| 3. Clients are aware of identity of team members responsible for the care of their animals and any changes in personnel day-to-day | Pictures on notice boards, name badges, websites, newsletters. |
| 4. Insurance claims are handled efficiently and in a timely manner. | |
| 5. There must be a written policy to deal with clients' complaints or criticisms and the practice must keep a record of complaints received and the responses made. | This should in line with guidance provided by the VDS or similar organisation. |
| 6. There is an efficient system for regular and timely invoicing. | Statements should be provided at least monthly and sent in a timely fashion. |

## Module 3: Client Experience

### VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. The practice must have a means of encouraging feedback from clients and acting upon the results of feedback. | A consistent and systematic approach to gathering feedback and evidence of analysis and actions taken. |

# Module 3: Client Experience

## AWARD POINTS

**This Module contributes towards the Award in 'Client Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. There is an appointment system for named veterinary surgeons. | | | 10 |
| 2. The practice provides guidance on parking facilities and access. | | | 10 |
| 3. Clients' preferred clinician is noted on records, if applicable. | | | 10 |
| 4. The practice has an online presence which is updated with latest information on opening times, services and team members. | | | 20 |
| 5. A range of media is used to communicate and interact with clients. | | This might include social media, newsletters etc. | 20 |
| 6. The time taken to answer the telephone is monitored. | | | 20 |
| 7. There are current and relevant notice boards in the public areas of the practice. | | This can include electronic notice boards. Details of current topical items, education. | 20 |
| 8. The practice provides reminders, for example for appointments and routine vaccinations, by: | | i. Telephone<br>ii. Text<br>iii. Email | 10<br>10<br>10 |

| | | | |
|---|---|---|---|
| 9. The practice has a means of monitoring client perceptions and feedback | A consistent and systematic approach to gathering feedback and evidence that analysis is done to determine any required action | i) The practice has a recognised systematic system for gathering feedback in place.<br>ii) There is evidence that the practice acts upon such feedback. | 10<br>30 |
| 10. Use of RCVS Pre-PSS Inspection Client Questionnaire. | | Note: The RCVS is developing a survey for practices to use which will be ready when the Scheme in launched in November 2015. | 40 |
| 11. A member of the team has undertaken training in bereavement counselling in the last four years and provided internal training to the team. | | This might include an external course, webinar, online resources and documented self-study.<br><br>Evidence through team members training records. | 20 |
| 12. There is client information available on coping with the loss of their pets and sources of support. | | This could include leaflets, websites.<br>See: www.ourspecialfriends.com or www.thepetlossvet.com/<br><br>Suggestion to include emotional support for clients and team members, pre post euthanasia care. | 10 |
| 13. A member of the team has undertaken training in the last four years in communication and handling difficult situations and provided internal training to the team. | | This might include an external course, webinar, online resources and documented self-study. | 20 |
| 14. | | | |
| 15. All relevant staff understand and are able to clearly communicate the practice's financial terms and conditions and insurance protocols plus any alternative payment mechanisms that may be available including possible charitable eligibility. | | Written information for clients is advisable. | 10 |
| 16. Team members are trained in offering appropriate treatment options, considering animal welfare, financial considerations and client expectations. | | This might be demonstrated by client feedback. | 40 |

| | | | |
|---|---|---|---|
| There is a process in place to ensure that referrals are carried out to a consistent standard. | | The protocol must ensure the transfer or records and clinical information are accurate and consistent. | 10 |
| 17. There is a system for updating the clients on fees on a frequent basis and for alerting the client as soon as practicable when fees reach or exceed the estimate or agreed fee interval. | | Ideally for hospitalised animals updates would be daily. Written evidence is required, for example client feedback forms or notes on client records. | 10 |
| 18. Payment options for all pets (including insured animals) are clearly communicated to clients. | | Client literature. | 10 |
| 19. Practices should have measures in place to direct clients to appropriate sources of information to help them choose an appropriate insurance policy for their animal. | | Only team members who have received Appointed Persons Training should give advice about specific policies. | 10 |
| 20. Practice tours and client awareness events are encouraged and available. | | Practices tours might be virtual. | 10 |
| 21. Team members have received training on customer service. | | This does not have to be veterinary specific training. | 30 |
| 22. The practice is qualified in Investors in People or Investors in Customers. | | | 30 |
| 23. A method is in place to monitor the client understanding of the consultation. | | e.g. Consultation exit feedback. | 10 |
| 24. There is an annual consideration of appointment schedules, including need for early pick-ups or drop-offs. | | This enables an assessment to be made regarding demand for early/late/weekend appointments. | 10 |
| 25. Team members understand PSS and communicate what accreditation means to clients. | | Evidence is required that team members know their practice accreditation level and any Awards achieved, what the scheme means and why the practice participates. | 40 |
| 26. There is a system in place for the delivery of repeat dispensed medicines. | | This may be an SOP for posting medicines. | 10 |

**Comment [AR2]:** Review in light of whether covered adequately by the Code.

| | | | |
|---|---|---|---|
| 27. There should be a culture of reviewing and learning from positive and negative feedback and complaints, with follow up to change procedures and systems where necessary. | It should be evident in discussion that complaints are seen as a positive way to engage with clients. Practices that focus on reducing or eliminating complaints do not understand the process. | Evidence of a record of the feedback and where appropriate investigation and action as a result.<br><br>The assessor will speak to team members to understand better the attitude towards clients. | 40 |
| 28. The practice is transparent and makes clients aware of any commission or financial incentives related to treatments provided. | | | 10 |
| | | **TOTAL POINTS AVAILABLE:** | **550** |
| | | **OUTSTANDING:** | **440** |
| | | **GOOD:** | **330** |

# Module 4: Dentistry

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. Instruments and equipment must be appropriately maintained. | Internal maintenance records, service records.<br>Includes cleaning, disinfection, sterilisation and sharpening as appropriate e.g. instruments used for surgical procedures. |
| 2. Evidence of training team members in the proper use and maintenance of equipment must be available. | Team member training, and or induction records.<br>Includes protocols for cleaning / disinfection / sterilisation |
| 3. Appropriate Personal Protective Equipment (PPE) must be available and used. | Aprons, face masks, goggles and disposable gloves. |
| 4. A selection of diagnostic / treatment equipment appropriate for the range of species to be treated must be present. | A selection of hand scalers, curettes, periodontal probes, elevators and/or luxators must be available, suitable for the range of species to be treated. |

# Module 4: Dentistry

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. Appropriate equipment will be available to undertake routine oral surgical procedures in the species treated, including extraction. | Appropriate instruments for cats and dogs should include elevators and or luxators, gags, hand instruments, powered dental unit, handpieces and burs. High speed air driven dental hand pieces are recommended, however an electrically driven hand piece may be used. Suitable cooling must be used when sectioning teeth.<br><br>Appropriate instruments for rabbit dentistry should include suitable gags, hand instruments, handpieces and burs. Rabbit incisor teeth should be mechanically trimmed and not clipped. |
| 2. Appropriate equipment will be available to undertake routine oral hygiene procedures in the species treated. | This includes mechanically scaling and polishing teeth |
| 3. Detailed dental records must be maintained and recorded on the patient history. | Records should include diagnosis and therapy, and the use of dental charts is recommended. |
| 4. Measures must be employed to reduce contamination of other areas, especially the sterile operating theatre. | Measures should be taken to minimise aerosol contamination. |

# Module 4: Dentistry

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. Dentistry must never be performed in surgical theatres. | Specific measures to prevent contamination beyond the immediate dental area must be taken.<br><br>These might include use of suction tips close to the operating head of scalers and dental hand pieces, an extraction fan close to the operating site or ideally a dedicated dental procedure room with negative pressure ventilation.<br><br>This will be assessed through observation and talking to team members. |
| 2. The use of sterilised dental packs for each procedure is required. | This will be assessed through observation and talking to team members. |
| 3. Suitable facilities to obtain dental radiographs must be available and the practice must demonstrate that effective dental radiography is conducted regularly. | This will require either digital facilities or the use of dental oral films. |

# Module 4: Dentistry

## AWARD POINTS

**This Module contributes towards the Award in 'In-patient Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| | | | |
| 1. Dental CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | . | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in dentistry | | | 30 |
| 3. At least one MRCVS has a post-graduate qualification in dentistry | | This includes AP status or an old style Certificate. | 50 |
| | | | |
| 4. | | | |
| 5. There is a dedicated dental procedures area with appropriate ventilation. | | This area may be used for other contaminated procedures.<br><br>Air extraction from contaminated areas should not contaminate clean areas. | 20 |
| 6. The practice produces diagnostic quality dental x-rays. | | This covers the species normally treated by the practice. | 40 |
| 7. Dental charts are regularly used and accessible. | | Charts will be used in the majority of dental procedures. | 30 |
| 8. Appropriate lighting suitable for illuminating the oral cavity is available. | | For example head torch. | 10 |
| 9. Closed sterile packed instruments are available. | | | 20 |
| 10. Magnification is available and used regularly. | | For example loupes/endoscopes are used when required | 10 |
| 11. Local anaesthesia procedures are used. | | | 20 |

| | | | |
|---|---|---|---|
| 12. There is a contaminated procedures protocol. | | Any dental procedure is a source of contamination so consideration should be given to where and when dental procedures are carried out and to operator safety.<br><br>Use of oral antiseptics should be routine. | 20 |
| 13. There is appropriate waste fluid management. | | There must be provision for drainage of fluids from the mouth during dental procedures. | 10 |
| 14. Provision of educational resources on preventative oral health care is provided for clients routinely and always after dental procedures. | | Website, posters, verbal instructions, nurse clinics, client meetings, tooth brushing, appropriate chews, dental diets. Warnings regarding inappropriate and dangerous activities and products such as playing with sticks/stones/tennis balls, chewing hard bones/antlers. | 20 |
| 15. There is written evidence of practice dental ethics policy. | | This should include a policy for the referral of complex dental cases and cosmetic / elective treatments. | 10 |
| 16. Dental procedures are subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **320** |
| | | **OUTSTANDING:** | **260** |
| | | **GOOD:** | **200** |

# Module 5: Diagnostic Imaging

## CORE STANDARDS

**If the Practice does not have an X-Ray Machine, only requirement 1 is applicable.**

**If the practice has an x-ray machine, practices must meet requirements 2-17.**

| Requirements | Guidance notes |
|---|---|
| 1. Core practices must be able to demonstrate what system/procedure/protocol is in place if a patient requires an x-ray and offer this facility if it is not available within the practice. | Practice protocols / team members can explain. |
| 2. The practice must notify the Health and Safety Executive (HSE) of their use of ionising radiations. | Veterinary use of ionising radiations requires prior notification to the HSE at least 28 days before commencing such work for the first time. Where any subsequent changes are made to the work with ionising radiations, which would affect the particulars given in the notification, the changes must be notified to the HSE immediately. In the absence of a copy of the letter sent by the practice to HSE (and for practices in business for a number of years and without any formal documents) the practice should send a fax or email (irrnot@hse.gov.uk) to the HSE and retain a copy of the notification for their records. There is no specific form for notifying HSE but notification must be in writing to the local HSE office and the assessor will require to see a copy. Notification should include:<br>• Name and address of Radiation Employer;<br>• Address of premises where the work is carried out;<br>• Nature of the business of the employer;<br>• Category of the source of the ionising radiations;<br>• Whether or not any source is to be used at premises other than the address of the work premises;<br>• Dates of notification and commencement of the work activity. |
| 3. The practice must appoint a radiation protection adviser (RPA) who possesses appropriate knowledge and experience relevant to veterinary practice. | The assessor will ask to see an agreement with an RPA, including the scope of the activities upon which advice is required. RPAs previously appointed under IRR85 must be reappointed in writing. |

| | |
|---|---|
| | The assessor will ask to see a copy of the last RPA report, together with evidence that any recommendations have been complied with. The precise frequency of visits by an RPA will be discussed and agreed between the RPA and the practice.<br><br>Material changes in e.g. equipment or workload must be notified to the RPA, who will decide if a visit is required. Practices should note that a Certificate of Competency issued to an RPA does not automatically denote experience of veterinary practice and suitable enquiries should be made.<br><br>A list of the RPA 2000 Certificate holders is available from http://www.rpa2000.org.uk/list-of-certificate-holders/ |
| 4. The practice must appoint a Radiation Protection Supervisor (RPS) in writing. | The assessor will ask to see a written appointment of one or more suitable RPSs.<br><br>The RPS must command sufficient authority to supervise the work so that it is performed in accordance with the local rules and have an adequate understanding of the requirement of the Ionising Radiation Regulations. They must also know what to do in an emergency.<br>The assessor will expect to speak to the RPS during the visit. |
| 5. A suitable and sufficient assessment of the risks of ionising radiation must be made for the purpose of identifying the measures to restrict exposures to employees and other persons. | The risk assessment must be sufficient to demonstrate that:<br>• All hazards with a potential to cause a radiation accident have been identified;<br>• The nature and magnitude of the risks have been evaluated.<br>Where the risk assessment shows the existence of a risk of a reasonably foreseeable radiation accident, the radiation employer shall take all reasonable steps to:<br>• Prevent any such accident<br>• Limit the consequences of any such accident<br>• Provide employees with such instruction and training as is necessary to restrict their exposure. |
| 6. Written local rules must be approved by the RPA and clearly displayed to all team members. | Local rules must be displayed in or near each x-ray room and MUST contain:<br>• Name of RPS;<br>• Controlled area – when and where it exists<br>• Dose investigation level<br>• Contingency plan |

| | |
|---|---|
| | • Written arrangements<br>• Name, address and telephone number of RPA<br>• Duties of RPS<br>• How entry to controlled area is restricted<br>• Arrangements for maintenance of equipment<br>• Dosimetry arrangements;<br>• Use, storage and inspection of Personal Protective Equipment (PPE).<br><br>Clinical Team Members involved with radiography must sign to indicate that they have read and understood the local rules.<br>Separate local rules must be agreed with the RPA in respect of any separate dental x-ray equipment. |
| 7. A controlled area must be designated in accordance with advice from the RPA. It must also be adequately described in the local rules, physically demarcated where practical and provided with suitable and sufficient signs and warnings, all in accordance with the RPA's advice. | Within practice premises a specified room or rooms must be designated for radiography. It is desirable but not essential that the room is used solely for radiography.<br>It is recommended that appropriate warnings are provided at the entrances to controlled areas. |
| 8. A copy of Guidance Notes for the Safe Use of Ionising Radiations in Veterinary Practice (IRR 1999) must be available to all members of the practice. | These guidance notes do not seek to give detailed and comprehensive advice on all aspects of the use of ionising radiations in the veterinary profession and the practice must have consulted an RPA. |
| 9. Evidence must be provided of diagnostic quality imaging by or on behalf of the practice for the range of species treated. | The Assessor will wish to see a range of diagnostic images and/or reports as appropriate, e.g. radiographs, ultrasound images, endoscopic images etc. covering appropriate regions of the body. |

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|---|---|
| 10. Sufficient personal protective equipment must be provided and examined at regular intervals. | All protective clothing must be thoroughly examined on an annual basis and a record kept. Regular inspection of safety equipment must be recorded.<br><br>When necessary, the practice must provide at least one protective apron with a lead equivalence throughout of not less than 0.25mm, and, if animals are ever held, must provide hand and forearm protectors with a lead equivalence of not less than 0.5mm, sufficient for all personnel involved.<br>When not in use, aprons should be stored and transported appropriately to avoid damage.<br>The assessor will check team members understanding of appropriate use.<br><br>Personal protective equipment may not be required where a practice confirms that:<br>• Animals are never held; and<br>• There are no circumstances where Team Members enter the controlled area when the x-ray machine is switched on; and<br>• The isolation switch for the machine is located out with the controlled area; and<br>• The practice provides written confirmation from their RPA that the situation is<br>acceptable<br><br>The risk assessment should be reviewed at least annually. |
| 11. The x-ray machine must be serviced according to manufacturer's requirements and there must be written evidence of a satisfactory report. | The inspector will ask to see the x-ray machine's service records. |
| 12. The x-ray machine must have a functional collimator. | The x-ray beam must be collimated so as to leave a margin of unexposed film on all edges of the radiograph. |

| | |
|---|---|
| 13. There must be suitable radiographic processing facilities (conventional or digital) used and maintained in accordance with the manufacturer's instructions to avoid wasted exposures. | Good processing techniques are essential to avoid unnecessary exposures. |
| 14. For wet processing of film the processing area must be ventilated and chemicals handled and disposed of according to current legislation and best practice guidelines. | In particular, the development time, temperature and replenishment must be in accordance with the manufacturer's instructions.<br>All x-ray chemicals must be stored safely and disposed of in an appropriate manner.<br><br>See BVA Good Practice to Handling Veterinary Waste for further information: http://www.bva.co.uk/uploadedFiles/BVA_Good_practice_guide_to_handling_veterinary_waste_in_England_and_Wales.pdf<br><br>Advice of relevant local water authorities must be obtained and recorded unless all material is disposed of by a registered contractor. Silver traps may be used in accordance with guidance/approval from the relevant local water authority. |
| 15. There must be sufficient provision for the non-human restraint of patients during radiography. Sufficient means of mechanical and chemical restraint must be provided for the range of species treated. | No animal should be held unless there are clinical reasons why they cannot be restrained by other means.<br>Positioning aids such as sand bags, cradles, wedges and ties must be suitable for the range of species routinely treated. Suitable drugs and equipment for anaesthesia or sedation must be available. |

| | |
|---|---|
| 16. There must be a system of personal dose monitoring for all persons entering the controlled area as agreed with the appointed RPA. Records must be maintained of the doses received for at least two years. | The arrangements for personal dose monitoring must be made in consultation with the RPA. Any personal dose meters should normally be worn on the trunk. They must not be left inside a controlled area when not being worn and must be stored away from sources of ionising radiations and extremes of temperature. They must only be worn by the person to whom they are issued. |
| 17. A record of all x-ray exposures, which contains a chronological record of the patient details, date, region radiographed, exposure factors and personnel involved, and the quality of the resultant radiograph; must be available/easily retrievable. | The record must provide a permanent record of all x-ray exposures and records and identify the persons involved.<br>Digital systems should also have a recording of exposures – not just to ensure the settings work but to record the personnel involved. If digital systems have a section for reporting the quality of images, this can be recorded there. Suitable back-up must be provided for any electronic records.<br><br>An exposures guide should also be available. A chart or specific list of commonly used exposures is more accessible than an x-ray logbook and helps to reduce the number of incorrect exposures.<br><br>Team members may be asked to retrieve an example exposure.<br><br>Team members should be proficient in recognising film faults. |

# Module 5: Diagnostic Imaging

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. There must be x-ray facilities suitable for the range of species routinely treated. | For an individual premises (branch or main practice) to be accredited as a General Practice there must be x-ray facilities actually available on site in those premises. |
| 2. A suitable range of cassettes, screens and grids must be available. | A range of grids suitable for species routinely treated should be available. This should include a grid and cassette of at least 30cm x 40cm. The underlying principle is that x-rays of a large dog's chest may be taken in one picture to avoid errors in two frames.<br><br>Grids are required for digital systems. |
| 3. Original diagnostic images should be retained for an appropriate period. | Images may be hard copy or in digital format.<br>Before disposal of images, consideration should be given to their potential future value. (Ideally these should be retained for at least the life of the patient). Consult your indemnity insurer for advice on retention period. |
| 4. Diagnostic images must have a means of patient identification | Labels or digital tags are acceptable. |
| 5. The practice must provide or have arranged access to ultrasound diagnostic services suitable for the species treated. | |

## Module 5: Diagnostic Imaging

### VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. Screen film combinations or digital systems to minimise radiographic exposure while providing the necessary level of detail must be used. | Screens must be kept clean. |
| 2. Measuring callipers, or other suitable devices, must be available to determine accurately the depth of the part being radiographed. | |
| 3. The hospital must be able to perform a range of contrast examinations and a suitable range of contrast material must be available. | Evidence of these must be provided. |
| 4. The sole use of self-adhesive labels for the identification of radiographs is not acceptable. Radiographs should be permanently identified at the time of the exposure. | |
| 5. An ultrasound system capable of providing diagnostic quality images of the range of species treated is provided. | Evidence must be provided of training and CPD for team members in the use of the equipment. Reference material must be available. |
| 6. ECG equipment producing a recordable trace suitable for taking measurements is provided. | Evidence must be provided of training and CPD for team members in the use of the equipment. Reference material must be available. |
| 7. ECG recordings are suitably filed and stored. | Team members can demonstrate suitable filing and storage of recordings. |
| 8. Endoscopes are provided to allow diagnostic investigation of the upper and lower digestive tract and upper airway/trachea of appropriate species. | Evidence must be provided of training and CPD for team members in the use of the equipment. Reference material must be available. |
| 9. A pair of endoscopy biopsy forceps is available, compatible with the equipment available. | |
| 10. Equipment for the measurement of intraocular pressure must be available. | Evidence of training and its use provided. |

## Module 5: Diagnostic Imaging

### AWARD POINTS

**This modules contributes towards the Award in 'Diagnostic Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. General diagnostic imaging CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | . | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP veterinary diagnostic imaging and there is evidence of dissemination to the rest of the team. | | | 30 |
| 3. At least one MRCVS has a post-graduate qualification related to veterinary diagnostic imaging and there is evidence of dissemination to the rest of the team. | | This includes AP status or an old style Certificate | 50 |
| 4. Diagnostic images are easily searchable by patient name and date. | | | 20 |
| 5. Facilities are available for transmission and distribution of copies of diagnostic images to other practices and owners. | | Email, CD's, memory sticks etc. With images in Dicom and more easily accessed formats. | 10 |
| 6. A range of images are available for reference. | | Images of normal patients or with common conditions. | 20 |
| 7. Training aids - CPD reference material is available. | | Text books, electronic resources. | 10 |
| 8. | | | |
| 9. | | | |

| | | | |
|---|---|---|---|
| 10. Evidence is provided of training team members in the use and routine maintenance of all imaging equipment available within the practice. | | Team members training records<br><br>Reference material must be available and team members will be interviewed by the assessor. | 10 |
| 11. Training has been undertaken and facilities are available for the following advanced diagnostic studies: | | | |
| | | i. Pneumocystogram/double contrast cystogram, | 10 |
| | | ii. Barium studies | 10 |
| | | iii. Excretory urography | 10 |
| | | iv. Diagnostic endoscopy (flexible) | 30 |
| | | v. Diagnostic endoscopy (rigid) - | 20 |
| | | vi. ECG (interpretation in-house or by telemetric interpretation service) | 20 |
| | | vii. Diagnostic ultrasound | 50 |
| | | viii. Diagnostic ultrasound - with Doppler (echocardiography) | 20 |
| | | ix. Slit lamp | 10 |
| | | | |
| | | x. Tonometry (glaucoma) | 20 |
| | | xi. Myelography | 10 |
| 12. Documented audit of image quality either in house or external | | Assessment of image quality and diagnostic value, performed for each modality used in practice. | 20 |
| 13. | | | 20 |

**Comment [AR3]:** Move ultrasound out of this section and new add ultrasound section

Training and facilties for the following ultrasounds studies
Abdonomical organs
Reproductive
Cardic
Other thorasic
Opthamalogical

Ultrasounds recording and reporting.

Outstanding should not be possible without gaining these points

| | | | |
|---|---|---|---|
| 14. | | | 20 |
| | | **TOTAL POINTS AVAILABLE** | **430** |
| | | **OUTSTANDING** | **340** |
| | | **GOOD** | **260** |

# Module 6: Emergency and Critical Care (ECC)

**There are no Core, General Practice or Veterinary Hospital requirements in this Module.**

## Emergency Service Clinic (ESC)

Comment [AR4]: This section will be tweaked to ensure that it refers to what happens when the clinic is open and not out of hours

| Requirements | Guidance notes |
|---|---|
| 1. A full-time veterinary surgeon must be employed at each premises who shall have overall responsibility for all emergency and critical care and professional matters within the clinic. | |
| 2. All clinical team members must be provided with guidance notes on emergency practice policies before commencement of work. There must be formal evidence of induction of team members at the outset of their employment. | Assessors will ask to see team members' induction records |
| 3. | |
| 4. A protocol must be in place for the referral of appropriate cases e.g. spinal injuries, head injuries and multiple system trauma. | |
| 5. When covering for another practice, a written agreement must be entered into with the client practices which includes a written policy on surgical complications of their cases and daily reporting of clinical records back to the client's practice. | |
| 6. There must be an animal ambulance service or agreement with a local animal transport company for the transportation of animals. | |
| 7. A full-time RVN must be employed at each premises, whose primary role is the responsibility for the nursing and clinical care of the clinic's patients and who shall be directly involved in such care. | |

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| 8. At least one on-duty veterinary surgeon, directly responsible for the care of in-patients and any new admissions or out-of-hours appointments is on the clinic's premises at all times during all of the hours of operation of the clinic. | Evidence will be provided through team rotas.<br>This does not preclude a veterinary surgeon attending off-site in the rare circumstances that this may be necessary. |
| 9. In addition to the veterinary surgeon, at least one other on-duty member of team whose role is the active involvement in nursing and medical care of patients must be on the premises during all the hours of operation of the clinic. | Evidence will be provided through team rotas. |
| 10. Any on-duty team members on a 'rest break' must at all times be readily available for active duty during the hours of operation of the clinic. | Evidence will be provided through team rotas. |
| 11. There must be a written policy on answering the telephone including how to answer call-outs, transports concerns and fee estimates. | |
| 12. The practice has a system in place for monitoring and discussing the clinical outcomes of ECC cases and acting upon the results. | It is expected that outcomes will be actively followed up with daytime practices/clients. |
| 13. Lighting suitable for the accurate illumination of surgical sites on the patient must be provided in theatre. | This lighting must continue to function in the event of a loss of power. An operating lamp must be supplied by an uninterruptible power supply or a generator sufficient to complete a surgical procedure.<br><br>Surgical head torches are acceptable. |
| 14. Suitable facilities for neonatal care are provided. | Should include heat, oxygen provision, glucose provision and airway suction. |
| 15. The practice must provide separate accommodation for the isolation of infectious and zoonotic cases or have a written policy for dealing with such cases that is known to all team members. | The premises has the ability to isolate an infectious animal from all other patients.<br><br>i. Isolation facilities must have:<br>ii. Hand washing facilities;<br>iii. Separate air space;<br>iv. Ventilation that produces a negative air pressure in the facility to reduce the risk of cross infection;<br>v. Separate drains to avoid cross infection.<br><br>Isolation facilities can mean either a special area to which access is limited |

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| | or a separate ward. It is recommended that there is a written policy, which details the procedure for the isolation and care of cases including barrier nursing requirements. The written policy must be available to relevant team members who must be fully conversant with its contents. |
| 16. There must be an ability to provide close control of fluid replacement. | This could be by an infusion pump or syringe driver suitable for infusion of high volumes rapidly and low volumes slowly. |
| 17. Facilities are available for the intensive care of critically ill patients. | These must include intravenous fluid therapy, blood transfusion, oxygen therapy and maintenance of body temperature. |
| 18. Multi-parameter monitoring suitable number of monitoring equipment required for the workload of the premises. | This would normally be expected to include pulse oximetry, capnography, continuous ECG, body temperature and blood pressure. |
| 19. A practice team member is dedicated solely to monitoring the condition of each anaesthetised patient until fully recovered at all times. | |
| 20. The following equipment must be available on site together with evidence of training or CPD for the team in its use and maintenance - x-ray, ECG, ultrasound machine, endoscopes. | There must be a suitable quantity and range of endoscopes for the range of species routinely treated. |
| 21. The premises must have a biochemistry analyser onsite. | 24-hour availability. |
| 22. The premises must have an electrolyte analyser onsite. | 24-hour availability. |
| 23. The premises must have haematology analyser onsite. | 24-hour availability. |

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| 24. The following equipment must be provided on the premises:<br>i. Binocular microscope with mechanical stage, electric light source and oil immersion facility;<br>ii. Centrifuge suitable for PCV, blood separation and urine sedimentation;<br>iii. Urinary refractometer. | |

# Module 6: Emergency and Critical Care (ECC)

## AWARD POINTS

**This Module contributes towards the Award in 'Emergency and Critical Care'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. Emergency critical care CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in Emergency critical care and there is evidence of dissemination to the rest of the team | | | 30 |
| 3. At least one MRCVS has a post-graduate qualification in Emergency critical care and there is evidence of dissemination to the rest of the team. | | This includes AP status or an old style Certificate | 50 |
| 4. | | | |
| 5. Members of the ECC team demonstrate that at least 30% of CPD is specifically relevant to ECC work. | | | 50 |
| 6. In addition to the veterinary surgeon, at least one RVN whose role is the active involvement in nursing and medical care of patients is on the premises during all the hours of operation of the clinic. | | Evidence will be provided through team members rotas. | 40 |
| 7. The practice has the ability to measure: | The practice shows evidence of appropriate use of these measures. | | |
| | | i. Acid-base | 10 |

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| | | ii. | Blood gases venous | 10 |
| | | iii. | Blood pressure | 10 |
| | | iv. | Lactate | 10 |
| | | v. | Coagulation which must include BMBT | 10 |
| | | vi. | Intraocular pressure | 10 |
| 8. The practice has the ability to perform: | | | | |
| | | i. | Assisted feeding: naso-gastric or naso-oesophageal tubes | 10 |
| | | ii. | Assisted feeding: oesophagostomy tubes and peg tubes | 10 |
| | | iii. | Assisted feeding: microenteral | 10 |
| | | iv. | Blood transfusion cross-matching | 10 |
| | | v. | CSF sampling | 10 |
| | | vi. | Central venous catheterisation | 10 |
| | | vii. | Arterial blood gas analysis | 10 |
| | | viii. | CRIs | 10 |
| | | ix. | Peritoneal dialysis | 10 |
| | | x. | Intraosseous access | 10 |
| | | xi. | IPPV | 10 |
| | | xii. | Electrocautery | 10 |
| | | xiii. | Epidural pain management | 10 |
| | | xiv. | Pericardiocentesis | 10 |
| | | xv. | Thoracocentesis | 10 |
| | | xvi. | Chest drain placement | 10 |
| | | xvii. | Tracheotomy / tracheostomy | 10 |
| | | xviii. | Tube cystotomy | 10 |

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| | | xix. Ultrasonography | 30 |
| 9. The practice can supply supplementary oxygen by means of: | | | |
| | | i. Oxygen cage | 10 |
| | | ii. Nasal catheter | 10 |
| | | iii. Transtracheal catheter | 10 |
| | | iv. Oxygen hood | 10 |
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| 10. The practice has the following drugs in stock :<br>Activated Charcoal<br>Apomorphine<br>European Viper Venom Antiserum<br>Fresh Frozen Plasma<br>Methocarbamol<br>Acetylcysteine<br>Vitamin K1<br>Intralipid | It is recognised that there may be supply or geographical reasons for some items not being required or temporarily unavailable. | | 40 |
| 11. Oxyglobin is available. | | | 10 |
| 12. The practice has a protocol in place for accessing advice from a service providing veterinary specific advice on the management of poisons. | | | 30 |
| 13. Team members have been trained in CPR on animals. | | | 30 |
| 14. Team members have been trained in the use of FAST and T-FAST Scans. | | | 30 |
| 15. Individuals have access to a range of suitable resources, including the internet, in relation to emergency and critical care. | | This could include access to journals or databases. | 10 |
| 16. ECC procedures are subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **660** |
| | | **OUTSTANDING:** | **530** |
| | | **GOOD:** | **400** |

# Module 7: Infection Control

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. The practice must have a biosecurity policy | The practice biosecurity policy should include requirements for personal hygiene, cleanliness of premises and equipment. Cleanliness and disinfection of personal protective equipment and clothing and cleanliness of vehicles. This applies to all species and practices.<br><br>See Bella Moss Foundation in Guidance notes<br>http://www.thebellamossfoundation.com/ |
| 2. The practice must have disinfection and / or sterilisation facilities suitable for the work undertaken. There must be adequate facilities for sterilisation, and a recognised method of sterilisation must be employed. The practice must provide an autoclave, vacuum or non-vacuum or other recognised sterilisation system, for the effective sterilisation of instruments and equipment. | |
| 3. For autoclaves and dental compressors greater than 250 bar litres, a separate Written Scheme of Examination and Certificate of Inspection are required. | A Written Scheme of Examination must be titled as such, and must specify how and when the autoclave(s) must be inspected. Practices must also have a Certificate of Inspection under the regulations. It will be titled Certificate of Inspection under the Pressure Systems Safety Regulations (2000).<br><br>Only pressure vessels over 250 bar litres are covered by the Pressure Systems Safety Regulations (2000). All autoclaves would come into this category and each would require both a written Scheme of Examination and Certificate of Inspection. Dental machines are unlikely to work at such high pressure and so are usually exempt from the provisions.<br><br>NB a service is not necessarily an inspection under the regulations, and a note of the last service is not a written Scheme of Examination. A Written Scheme may be obtainable from the manufacturers. |
| 4. Each clinical area and all consulting rooms must have facilities for | Team members should be trained in safe disposal. Needles should not be |

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| | safe disposal or sharps, hazardous and non-hazardous waste. | recapped and should be placed directly into the sharps container.<br><br>See BVA Good Practice Guide to Handling Waste for further information:<br><br>http://www.bva.co.uk/uploadedFiles/BVA_Good_practice_guide_to_handling_veterinary_waste_in_England_and_Wales.pdf |
| 5. | The practice must provide designated accommodation for the isolation of infectious and zoonotic cases or have a written policy for dealing with such cases that is known to all members of team members. | Where truly separate and self-contained isolation facilities are not available, there must be a detailed Standard Operating Procedure (SOP) setting out how infectious cases are to be dealt with or referred elsewhere. Sending patients home is insufficient. The inspector will expect to see a SOP, which details the procedure for isolation and care of infectious cases. Either separate isolation facilities must be provided along with the SOP, or, if such facilities are not available, there must be a detailed SOP for isolation of infectious cases, including barrier nursing requirements.<br>Team Members must be trained to implement the SOP, which must include:<br>• Details of waste disposal;<br>• Protective clothing to be worn;<br>• Disinfection of all utensils/equipment and accommodation;<br>• Designated persons to be responsible;<br>• Reference to COSHH and Health and Safety information pertaining to the risks of dangerous pathogens and zoonoses;<br>• Clear information regarding the demarcation of the isolation area. |
| 6. | Procedures must be in place to minimise cross-infection in clinical areas. Cleaning and disinfection materials must be readily available and used in all areas of the practice. | Risk based disinfection of all clinical areas must be done between patients. This can include floor, equipment and hand touch areas such as doors, door handles and keyboards. |
| 7. | Hand washing facilities must be available for all team members. | |

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| 8. A hand washing sink should be available in or immediately adjacent to the consulting room. | |
| 9. Washing and disinfectant facilities must be provided for team members in the kennels and cattery. | The expectation is that each ward area will have its own sink located in the ward.<br><br>Where this is impossible, and the nearest sink is located in an adjacent room, then consideration must be given as to whether the room in which the sink is located is in a 'clean' or a 'dirty' environment. As 'dirty' procedures are done in the ward area, it would generally be unsuitable for the sink or access to it to be via a clean environment.<br><br>Additionally, consideration must be given to the touching of the door handles; it would not be acceptable for team members to use their hands to open a door to access a sink in the adjacent room.<br><br>Hand sanitisers alone are not suitable.<br><br>It is expected that team members will wash their hands between each patient. |
| 10. Appropriate PPE must be readily available and used. | Dedicated clean clothing should be used in clinical areas and changed regularly. Gloves and aprons must be readily available and used where appropriate. Sterile gloves and gowns for surgical cases must be available and used where appropriate. |
| 11. Vehicles used for the practice must be clean and well maintained. There must be clear segregation of clean and contaminated items and protective clothing and safe storage and transport of waste materials including sharps. | |
| 12. Cleaning and disinfection materials must be readily available and used. | Risk based disinfection of consulting and all related surfaces must be done between patients. This should include floor, equipment and keyboards. |
| 13. | |



## Module 7: Infection Control

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. Written cleaning protocols for all vehicles and clinical areas of the practice are required and must be regularly audited and recorded. | The frequency of cleaning will vary according to the clinical area and caseload. |

# Module 7: Infection Control

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. The practice must provide separate accommodation for the isolation of infectious and zoonotic cases or animals receiving chemotherapy, and have a written policy for dealing with such cases that is known to all team members. | A hospital must have the ability to isolate an infectious animal from all other patients.<br><br>Isolation facilities must have:<br>- Hand washing facilities<br>- Separate air space<br>- Ventilation that produces a negative air pressure in the facility to reduce the risk of cross infection.<br>- Separate drains to avoid cross infection.<br><br>Isolation facilities can mean either a special area to which access is limited or a separate ward. It is recommended that there is a written policy, which details the procedure for the isolation and care of cases including barrier nursing requirements. The written policy must be available to relevant team members who must be fully conversant with its contents. |
| 2. Vacuum autoclaves are compulsory for wrapped packs/drapes. | |

# Module 7: Infection Control

## AWARD POINTS

**This Module contributes towards the Awards in 'Team and Professional Responsibility', 'In-Patient Service' and 'Patient Consultation Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. The practice has a designated individual responsible for infection control who monitors compliance with infection control policies. | | Ideally this would be a veterinary surgeon or RVN. | 30 |
| 2. The surfaces and furnishings of the waiting room are impervious and easily disinfected. | | | 10 |
| 3. Hand washing or sanitising facilities are available to clients in the waiting and consulting rooms. | | | 10 |
| 4. The practice has written protocols in place for infection control, which are known to all team members and evidence can be produce that these are being used. | Team members show awareness of policy and procedure and any areas of practice that would increase infection risks. | | |
| | | i. Cleansing and disinfection of hand touch areas, including computer keyboards, mice, light switches, door handles etc. | 10 |
| | | ii. Laundry, clothing and drapes. | 10 |
| | | iii. Management of Bedding. | 10 |
| | | iv. Management of utensils e.g. litter trays, feed bowls and water bowls/bottles. | 10 |

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| | | v. Use of disinfectants. | 10 |
| | | vi. Preparation for surgery | 10 |
| lean and appropriate clothing is worn for the clinical task being undertaken. | | | 20 |
| 5. Every ward area has its own dedicated sink with hot and cold running water. | | | 20 |
| 6. The practice has a dedicated isolation facility. | | Isolation facilities must have:<br>- Hand washing facilities<br>- Separate air space<br>- Ventilation that produces a negative air pressure in the facility to reduce the risk of cross infection.<br>- Separate drains to avoid cross infection. | 30 |
| 7. The practice has protocols in place for the identification and management of cases of infection involving multi-resistant bacteria. | | | 30 |
| 8. The practice has procedures in place to educate the team and clients about responsible use of antimicrobials, antimicrobial resistance and zoonoses, and the implications for animal and human health. | | http://www.thebellamossfoundation.com/<br><br>https://www.bsava.com/Portals/4/knowledgevault/resources/files/Protect_Poster.pdf<br><br>http://www.bva.co.uk/News-campaigns-and-policy/Policy/Medicines/Antimicrobials/<br><br>The assessor will talk to team members to ascertain their awareness and understanding. | 20 |

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| **9.** All areas of the practice including clinical, non-clinical, residential and storage areas are maintained and cleaned to the same high standard. | | This ensures the presentation of the practice is of a uniformly high standard. | 30 |
| 10. Infection control measures in the practice are subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **280** |
| | | **OUTSTANDING:** | **220** |
| | | **GOOD:** | **170** |

## Module 8: In-patients

### CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. The practice must have a written policy for the overnight care of in-patients detailing who is responsible, frequency of checks etc. | |
| 2. The owners must be informed of the level of overnight supervision during an overnight stay. | Needs clarifying - clients must be made aware if someone is on the premises overnight or if not how often checks are made – i.e. last thing at night/first thing in the morning. |
| 3. Any in-patient facilities must be of a suitable size, securable, sturdy, escape-proof, without potentially injurious faults and easily cleanable. | The practice must have at least one kennel suitable for a large breed of dog or have a plan in place for this facility if the need arises. |
| 4. The practice must provide facilities and an adequate nursing team for the care of any in-patients. | Te practice must demonstrate that provisions are made to ensure animal welfare. where there are animals onsite but no team members present. |
| 5. A suitable range of bedding, feed stuffs and clean fresh water must be available. | |
| 6. Feeding equipment must be disposable or regularly disinfected. | |
| 7. Dirt trays, absorbent litter and adequate cage space are required for feline in-patients. | |
| 8. Sanitary facilities for ambulatory canine in-patients must be provided. | These may be outside and precautions must be taken to prevent the escape of animals. |
| 9. There must be suitable provision for the storage and preparation of food. | |

# Module 8: In-patients

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. All hospitalised animals (other than short/routine surgical procedures admitted as day cases) must have in –patient sheets recording basic husbandry parameters, with timed and initialled entries:<br>- Temperature<br>- Pulse<br>- Respiration<br>- Treatments<br>- Food and Water intake<br>- Urine and Faeces output<br>- Clinical signs | |
| 2. There must be a positive means of identifying the patient while on the premises. | This may involve tagging the patient and/or well-identified accommodation. |
| 3. Equipment that will be in contact with the patients must be chosen to minimise the risk of cross-contamination or exacerbation of any clinical condition. | |
| 4. Facilities to maintain body temperature must be available and can be demonstrated to be used safely. | |
| 5. Facilities to provide supplementary oxygen must be available in the in-patient area. | |
| 6. Intravenous fluids and an appropriate means of administration must be available. | |
| 7. A range of diets must be available to meet the needs of in-patients and stored appropriately. | |
| 8. There must be the ability for hospitalisation of the full range of species routinely admitted. | |
| 9. There must be a range of accommodation of a suitable size for the number and species routinely treated. | The inspector will ask to see the daily surgery log and appointment list to correlate with in-patient facilities available.<br><br>Collapsible kennels are acceptable for emergency day hospitalisation. |

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| 10. There must be adequate heating, lighting and ventilation of the inpatient area. | |

# Module 8: In-patients

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. There must be a minimum of 6 kennels or cages for the hospitalisation of patients.<br><br>- Towels, blankets or acrylic bedding materials must be provided.<br>- The kennels or cages, and their fittings, must be made of non-permeable materials so as to be easily cleaned and disinfected.<br>- Where dogs are treated there must be at least one large kennel suitable for a giant breed of dog together with a good range of smaller kennels and cages.<br>- At least 1 cage must be of the walk in type.<br>- There must be no overcrowding.<br>- Newspaper alone is not considered a suitable materials for overnight stay patients | |
| 2. A person directly responsible for the nursing care of in-patients must be within the curtilage of the site at all times. | There must be residential accommodation or other arrangements so that a veterinary surgeon, veterinary nurse or an adequately trained member of lay team members is present on the premises 24 hours a day, every day of the year. |
| 3. The practice must have the ability to provide 24-hour inpatient care including intensive care. | This is expected 24/7. If the case exceeds the ability of the current team members to provide care provisions should be made to refer cases.<br><br>Team rotas will provide evidence. |
| 4. There must be the ability to cater for the full range of species routinely treated and species segregation where appropriate. In particular, consideration must be given to separation of prey and predator species. | |
| 5. Team members should have access to appropriately trained and experienced team members to provide advice and back-up 24/7. | This is to ensure that inexperienced team members are not left to deal with complex cases especially out-of-hours.<br><br>Out-of-hours on call rotas may provide evidence. |
| 6. There must be a minimum of daily examination of all in-patients by a veterinary surgeon, which should be recorded on the hospital records. | |

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| 7. Facilities for neonatal care must be provided. | |
| 8. There must be access to appropriate imaging 24/7. | |
| 9. There must be access to laboratory facilities 24/7. | Biochemisty / haematology. |
| 10. The practice must have the ability to undertake blood transfusions. | |
| 11. The practice must have at least one infusion pump and one syringe driver. | |
| 12. There must be enhanced facilities for maintaining body temperature. | e.g Bair hugger / incubator. |
| 13. There must be enhanced facilities for providing oxygen | e.g oxygen tent (including a humidifier). |

# Module 8: In-patients

## AWARD POINTS

**This Module contributes towards the Award in 'In-patient Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. A veterinary surgeon examines all in-patients at least twice daily and update records accordingly. | | Patient records. | 20 |
| 2. The veterinary surgeons and veterinary nurses in charge of a case undertake suitable handover. | Sharing of essential information between parties involved in patient care. | Personnel in charge of an animal should be recorded on the patient record. | 20 |
| 3. All patients have a structured admission and discharge procedure with a member of the team appropriately trained to discuss the case with the client. | | In most cases this should be supported with written discharge instructions. | 10 |
| 4. There are procedures in place to update clients on the progress of their animal and to ensure that informed consent is maintained | | This should include updating on costs.<br><br>The inspector will wish to be satisfied that all post-op cases are being monitored until discharged from the premises. | 20 |
| 5. There are facilities to separate cats and dogs and predator and prey species. | | This is could be achieved by the sub-division of wards. | 10 |
| 6. There are facilities for bathing and grooming appropriate to species treated. | | This should include either a tub table or a separate facility. | 10 |
| 7. Nutritional assessments are carried out for all in-patients, and feeding plans implemented and recorded and regularly re-assessed. | | This could be incorporated into the nursing care plan e.g. WSAVA toolkit which can be found at http://www.wsava.org/sites/default/files/JSAP%20WSAVA%20Global%20Nutritional%20Assessment%20Guidelines%202011_0.pdf | 20 |

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| 8. Provision is made for clients to visit in-patients as appropriate to the condition of the animal. | | This may need to be restricted to allow for practice working and should take into account the safety of the client and the animal and minimise the risk of disease transmission. | 10 |
| 9. The practice has appropriate equipment to accurately deliver fluids at the appropriate rate for the species treated. | | This should include infusion pumps and/or syringe drivers | 10 |
| 10. The practice can demonstrate a plan for delivery of intravenous fluids which is reviewed at regular intervals. | | This will include type of fluid, rate of delivery and total of delivery. | 10 |
| 11. There is a protocol in place defining intravenous catheter maintenance. | | This should include instructions on aseptic placement, daily maintenance and replacement schedule. | 10 |
| 12. The practice has the ability to undertake canine blood transfusions. | | The team members should demonstrate they are trained to prepare, carry out and monitor patients undergoing transfusions. Consideration should be given to ethical sourcing of blood, blood typing and storage of blood and blood products. | 10 |
| 13. When animals are hospitalised overnight there is a clear protocol for regular appropriate checks and evidence that these are carried out. | | The inspector will ask to review patient records. | 20 |
| 14. When animals are kept overnight there is a member of the team responsible for the care of the animals on the premises at all times. | | Team members may take rest periods as long as they remain on the premises. | 20 |
| 15. The member of the team on the premises and responsible for the overnight care of the animals is a veterinary surgeon or RVN. | | Team members may take rest periods as long as they remain on the premises | 40 |

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| 16. When animals are kept overnight there is a veterinary surgeon or RVN responsible for the care of the animals on the premises and awake at all times when there is a patient under their care. | | Team members may take rest periods as long as they remain on the premises | 60 |
| 17. At least one cage is of the walk-in type. | | | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **320** |
| | | **OUTSTANDING:** | **260** |
| | | **GOOD:** | **190** |

## Module 9: Laboratory and Clinical Pathology

### CORE STANDARDS

**If the practice does not have an in-house laboratory only requirements 1-15 apply.**

| Requirements | Guidance notes |
|---|---|
| 1. Where pathological samples are sent to external organisations, a suitable range of containers, envelopes and forms must be available. | |
| 2. The practice identifies specimens with:<br><br>- Patient ID<br>- Date of collection<br>- Tests required<br>- Method of collection if applicable | |
| 3. There must be an SOP for the post and packaging of pathological samples which complies with current packaging regulations. | A copy of current postal and other carrier's requirements should be available. |
| 4. There must be adequate facilities for storage of specimens and reagents, including refrigeration, and disposal of waste materials. | It is acceptable for laboratory samples which are already securely packaged and in a separate closed box to be stored in the same fridge where vaccines and other medications are kept. |
| 5. PPE is available and used. | |
| 6. The results of all laboratory tests must be stored so as to permit easy retrieval. Data must be stored safely in an easily retrievable form. | Team members may be asked to retrieve data. |
| 7. The practice has reference materials applicable to the tests carried out. | |
| 8. Adequate post-mortem facilities must be available or other arrangements made.<br><br>Post-mortem examinations on site must be performed in an area | When conducting post-mortem examinations full consideration must be given to the health and safety issues. Adequate risk assessment and protocols need to be undertaken and consideration must be given to the provision of suitable protective clothing to guard against zoonoses and |

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| not concurrently used for clinical work. This may be achieved by performing the examination after clinical work has ceased Or an external laboratory may provide facilities, in which case, adequate licensed arrangements must be in place for the transport of carcases or diagnostic quality examination to be performed. | spread of infection.<br>When conducting post-mortem examinations full consideration must be given to the health and safety issues associated with primates, birds and reptiles. |
| 9. When making arrangements for a post-mortem examination the practice must ensure that clients are made aware of the level of procedure being undertaken. | The practice must ensure that clients are aware whether or not an autopsy it will involve a full pathological examination with detailed autopsy and tissue sampling, as well as the costs involved and whether post mortem is carried out by same practice group or otherwise. |
| | |
| 10. The practice has a system in place to ensure suspected, notifiable diseases are reported to the appropriate authority. | |
| 11. Where potential zoonotic agent is suspected protocols for control of spread are followed. | Adequate risk assessment and protocols need to be undertaken and consideration must be given to the use of active filtered air extraction and the provision of suitable additional adequate protective clothing, and the use of glove boxes or similar, to guard against zoonoses.<br><br>Team members and clients, statutory authorities are informed. |
| 12. The practice has designated resources e.g. books, manuals etc that identify external laboratory tests available to the practice team. | |
| 13. The laboratory procedures must be performed in a clean and tidy designated area used specifically for that purpose. | The designated area does not have to be a separate room and may, for example, be part of the dispensary or the preparation area. However, the designated area/bench must be clearly used only for laboratory purposes. |
| 14. Only trained personnel perform laboratory tests. | Evidence must be provided of training or CPD for Team Members in use of all equipment. A list of persons trained in handling laboratory specimens and in the risk of laboratory work must be kept.<br><br>The practice must have a system in place to know where to send the samples for suitable testing. |
| 15. The laboratory has: | The designated area does not have to be a separate room and may, for example, be part of the dispensary or the preparation area. However, the |

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|---|---|
| - adequate space for performance of tests<br>- adequate space for storage of reagents<br>- surfaces which permit efficient handling of specimens<br>- adequate space for equipment<br>- countertops and sinks of suitable construction<br>- adequate heating and lighting<br>- adequate electrical circuits and outlets<br>- adequate facilities for hand washing. | designated area/bench must be clearly used only for laboratory purposes and must be made of impervious material.<br><br>There must be a sink in the laboratory area or a sink accessible to team members without touching door handles. There must be an SOP in place for accessing hand washing facilities in an adjacent room if none is available in the laboratory. |
| 16. In house laboratory has a log or similar tracking mechanism to ensure results are received, reviewed by veterinary surgeon and conveyed to client. | The log should include:<br><br>- Patient ID<br>- Date of sample collection<br>- Time of sample collection<br>- Tests ordered<br>- ID of practice team member requesting test<br>- Date results received<br>- Date of client notification<br>- ID of practice team member informing client<br><br>Test requests should be tracked so that arrival or non-arrival or results can be flagged and followed up as appropriate. |
| 17. Equipment is used and maintained according to manufacturer's instructions and this is recorded. | |
| 18. There must be suitable arrangements for quality control of automated practice laboratory tests. | Periodic controls as per the manufacturer's instructions to test the machine is running correctly and is calibrated correctly, the results documented and acted upon where necessary. |
| 19. Reagents are stored according to manufacturer's instructions. | |
| 20. The practice disposes of test kits and reagents upon expiration in the correct manner. | |
| 21. Reference range values are available for each species commonly dealt with by practice. | |

# Module 9: Laboratory and Clinical Pathology

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. The practice has an in-house laboratory | |
| 2. Instrumentation for tests performed on the premises include:<br><br>- Method of measuring PCV<br>- Binocular microscope (with a range of objective lenses and light source)<br>- Centrifuge<br>- Refractometer<br>- Glucometer or chemistry analyser capable of measuring blood glucose<br>- Cytology stains<br>- Method to measure TP | Evidence will be required that some of the following tests are being performed in house:<br><br>- cytology (e.g.. Urine, skin scrape, ear, vagina, semen, FNA)<br>- Worm egg counts<br>- Urine specific gravity<br>- Serum specific gravity (TP)<br>- PCV<br>- Blood glucose<br>- Urine dip stick tests<br>- FeLV / FIV / T4 / Pancreatitis tests |
| 3. In addition to internal quality control of automated laboratory tests, external quality assurance by reference of internal samples to external labs or internal analysis of external samples must be routinely undertaken and the results documented and acted on where necessary. | EQA is the analysis of samples by reference to an external laboratory performed either by comparing samples run internally with the same paired sample run externally or by internal analysis of control reagent received from the laboratory through a QA scheme. The frequency of testing should be related to the number of tests undertaken. It is expected that this will be at least quarterly. |

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| 4. The practice has a log or similar tracking mechanism to for samples sent to outside laboratories to ensure results are received, reviewed by a veterinary surgeon and conveyed to client and archived. | The log should include:<br><br>- Patient ID<br>- Date of sample collection<br>- ID of outside laboratory<br>- Tests ordered<br>- ID of practice team member requesting test<br>- Date results received<br>- Date of client notification<br>- ID of practice team member informing client<br><br>Test requests should be tracked so that arrival or non-arrival or results can be flagged and followed up as appropriate. |

## Module 9: Laboratory and Clinical Pathology

### VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. There must be a nominated person in overall charge of the laboratory facilities. | |
| 2. The hospital must have a biochemistry analyser onsite. | 24-hour availability. |
| 3. The hospital must have an electrolyte analyser onsite. | 24-hour availability. |
| 4. The hospital must have haematology analyser onsite. | 24-hour availability. |
| 5. The following equipment must be provided on the premises:<br>• Binocular microscope with mechanical stage, electric light source and oil immersion facility<br>•Centrifuge suitable for PCV, blood separation and urine sedimentation<br>•Urinary refractometer | |
| 6. If bacteriology is undertaken on site, adequately qualified team members must be available. | The accurate interpretation of bacteriology plates requires team members qualified to HNC in Applied Biology or equivalent standard. |
| 7. Facilities must be available for bone marrow aspiration. | |

## Module 9: Laboratory and Clinical Pathology

### AWARD POINTS

**This Module contributes towards the Award in Diagnostic Service.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| | | | |
| 1. Veterinary pathology CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | . | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in Veterinary pathology and there is evidence of dissemination to the rest of the team | | | 30 |
| 3. Histopathology and cytology is performed by pathologists with relevant veterinary qualifications. | | Pathologist with expertise in tissues/species being examined. | 10 |
| 4. There is a nominated person in overall charge of the laboratory facilities. | | | 30 |
| 5. A biochemistry analyser is available and used appropriately to inform clinical decision making. | | Appropriate use includes training of team members in use, cleaning and maintenance. | 30 |
| 6. An electrolyte analyser is available and used appropriately to inform clinical decision making. | | Appropriate use includes training of team members in use, cleaning and maintenance. | 30 |
| 7. A haematology analyser is available and used appropriately to inform clinical decision making. | | Appropriate use includes training of team members in use, cleaning and maintenance. | 20 |

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| 8. The practice must demonstrate that they look at blood smears and use them to inform clinical decisions. | | | 30 |
| 9. A blood gas analyser is available and used appropriately to inform clinical decision making. | | Appropriate use includes training of team members in use, cleaning and maintenance. | 20 |
| 10. | | | |
| 11. The practice performs microscopy on relevant clinical samples eg. Ears, urine sediment | | | |
| 12. The practice performs fine needle aspiration biopsies and/or impression smears. | | Consideration should be given to referral to a pathologist as appropriate. | 10 |
| 13. The practice monitors culture and sensitivity / MIC results to follow local patterns in bacterial resistance and informs treatment regimes. | Treatment procedures are informed by results | The assessor will look for evidence of changes to treatment regimes following a review of test data.<br><br>See Infection Control Module | 10 |
| 14. The practice should carry out a regular laboratory sample technique audit. | | This should include records artefacts e.g. lipaemia, haemolysis in order to identify potentially rectifiable problems. | 10 |
| 15. | | | |
| 16. | | | |
| 17. In the case of the unexpected death of a patient an independent post mortem is offered. | An honest and open approach. | An independent post mortem would be performed by a person not normally employed with the practice.<br><br>In cases potentially involving litigation a thorough post mortem is required and will be sent to a recognised pathologist | 20 |
| 18. Practice team members training in laboratory procedures is updated annually and documented. | | This could be in-house training.<br><br>Evidence provided through training records. | 20 |

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| | | **TOTAL POINT AVAILABLE:** | **280** |
| | | **OUTSTANDING:** | **220** |
| | | **GOOD:** | **170** |

# Module 10: Medicines

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. The dispensary must be operated in accordance with the guidelines laid out in the current Veterinary Medicines Regulations. | BVA Good Practice Guide on Veterinary Medicines or BSAVA Guide to the use of Veterinary Medicines, may provide further information. |
| 2. A record of premises and other places where medicines are stored or kept must be available. | A means of recording the transfer of VMP's to other premises, store or vehicle should be implemented to ensure trace ability and enable stock reconciliation. |
| 3. All medicinal products must be stored in a clean and tidy location in accordance with manufacturers' recommendations and appropriate records kept. | All VMPs should be stored on appropriate and secure shelving; in such a way as to be protected from adverse effects of light, temperature extremes and moisture.<br><br>It is acceptable for small quantities of drugs to be in consulting rooms for use during consultation. These should be kept to a minimum and should be in drawers/cupboards.<br><br>POM-Vs should be placed out of sight in closed cupboards (not glass-fronted) or drawers, but there is no requirement for cupboards to be locked. |
| 4. The advertising of POM-V and POM-VPS products may only be aimed at appropriate persons, which do not include the general public. This includes adverts on websites, brochures and those displayed in retail areas to which the general public have access. | |
| 5. Accurate records of POM-V and POM-VPS medicines received and supplied must be kept. | See VMD guidance note 14 for further guidance on record keeping: https://www.gov.uk/government/publications/record-keeping-requirements-for-veterinary-medicines-vmgn-14 |
| 6. Monitoring and recording of environmental temperatures wherever medicines are stored must be undertaken (including consulting rooms, prep rooms, refrigerators and vehicles). | There must be proper monitoring and recording of maximum and minimum temperatures in the refrigerator and dispensary, and where temperatures have been recorded out with the appropriate ranges, there must be evidence of an action plan to remedy such deviations, and to deal with affected medicines. Consideration should be given to the use of alarms to indicate when temperatures stray out of set parameters. |

**Comment [t5]:** May need further clarification to bring into compliance with VMRs.

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| | Data loggers and maximum / minimum thermometers will provide constant monitoring. However, for those without an alarm to warn of temperature deviations, and for maximum / minimum thermometers, checks are required to be made daily and the inspector will ask to see written records, produced on a weekly basis, showing the results for the week. If maximum and minimum temperature recordings are being taken wherever medicines are stored it is not necessary to take additional recordings of ambient temperatures.<br><br>Ideally temperature sensitive medicines should only be taken out on vehicles on a "by use" basis, but whether being stored or transported, measures should be taken to ensure that products remain within the temperature range specified on their SPC, e.g. by use of a cool box or refrigerated unit. The suitability of such measures should be demonstrated. |
| 7. If it is stipulated that a medicine be used within a specific time period, it must be labelled with the opening date or use by date, once broached. | Medicines should be checked on a regular basis to ensure they are within the specific time period. |
| 8. Records of medicines administered to food-producing animals must include batch numbers. | In the case of a product for a non-food-producing animal, this need only be recorded either on the date of receipt of the batch or the date a veterinary medicinal product from the batch is first supplied. |
| 9. Premises should have Veterinary Medicinal Product (VMP) storage areas clearly separated from food / drink for human consumption and toilet and washing areas. | |
| 10. POM-Vs, POM-VPSs and NFA-VPSs should be stored in areas that are not accessible to the public / pets. | |
| 11. Medicines must not be available for self-service except those with a category AVM-GSL. | |
| 12. An adequate supply of medicines and materials used in the treatment of patients must be readily available. | |
| 13. There must be an efficient stock control system to ensure a | Procedures should be in place to quarantine, and ultimately dispose of, out |

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| continuous supply of all medicines and removal of out-of-date medicines in accordance with the current legislation. | of date medicines and leaking, broken or unwanted containers and to deal with spillages and leakages.<br><br>See VMD guidance note 14 for further guidance on record keeping: |
| 14. At least once a year a detailed audit should be carried out and incoming and outgoing medicines reconciled with medicines held in stock and any discrepancies recorded. | A practice must be able to demonstrate to the inspector the ability to carry out a detailed audit as clarified by the VMD; in addition, the inspector will ask to see a full audit and reconciliation of all Schedule 2 controlled drugs i.e. the register. |
| 15. Medicines should be disposed of in accordance with the current legislation. | Stock of Schedule 2 Controlled Drugs must be destroyed in the presence of an authorised witness and the resulting destroyed products and containers appropriately disposed of.<br><br>Authorised witnesses include:<br><br>- An inspector appointed under regulation 33 of the Veterinary Medicines Regulations.<br><br>- A veterinary surgeon independent of a practice where the destruction takes place. This would include those who have no, personal, professional or financial interest in the veterinary practice where the drug is being destroyed. Temporary staff and family members are specifically excluded.<br><br>- A person authorised to witness the destruction of Controlled Drugs und the MDR 2001 or the MDR (NI) 2002 such as a Police Controlled Drugs Liaison Officer.<br><br>- A list of Police Controlled Drugs Liaison Officers can be found at: http://www.apcdlo.org.uk/contact.html<br><br>- A record must be made of the date of destruction and the quantity |

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| | destroyed, which the witness must sign. It is also good practice to record the name of the Controlled Drugs, form, strength and quantity.<br><br>- A separate record should be kept of client returned Schedule 2 Controlled Drugs and they should not be re-entered in the Controlled Drugs Register. They do not need to be destroyed in the presence of an authorised witness, but it is considered good practice to do so.<br><br>Any special handling or disposal requirements, such as for cytotoxic medicines, must be observed. |
| 16. If Controlled Drugs are kept, these must be stored and recorded according to current legislation. Schedule 2 Controlled Drugs and certain Schedule 3 Drugs must be kept in a secure, lockable and immovable receptacle that can only be opened by a veterinary surgeon or a person authorised by him or her. Controlled drugs are regulated by the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001 as amended. These regulations classify such drugs into 5 schedules, numbered in decreasing order of severity of control.<br><br>**Schedule 1**: Includes LSD, cannabis, and other hallucinogenic drugs, which are not used medicinally. Possession and supply are prohibited except in accordance with Home Office Authority.<br><br>**Schedule 2**: Includes etorphine, fentanyl, morphine, papaveretum, pethidine, methadone, diamorphine (heroin), cocaine and amphetamine. Record all purchases and each individual supply (within 24 hours). Registers must be kept for two calendar years after the last entry. Drugs must be kept under safe custody (locked secure cabinet), except quinalbarbitone. Drugs may not be destroyed except in the presence of a person authorised by the Secretary of State. Failure to comply with this Act can lead to prosecution.<br><br>**Schedule 3**: Includes tramadol, buprenorphine, pentazocine, the barbiturates (e.g. pentobaritone and phenobarbitone but not | A register of such drugs obtained, supplied and used must be kept in accordance with the Misuse of Drugs Act 1971 (and the Misuse of Drugs Regulations 2001, as amended).<br>The inspector will ask to see the Controlled Drugs cabinet and registers (a register should be kept for each controlled drug) and prescriptions against which supplies of Controlled Drugs of Schedule 2 and 3 have been made, to confirm in particular:<br>• That appropriate records are kept;<br>• That any out-of-date Controlled Drugs have been destroyed by an authorised person.<br><br>• For supplies of Controlled Drugs of Schedules 2 and 3, against other veterinary surgeon's prescriptions;<br>* The prescriptions have been retained at least two years;<br>* The date on which the supply was made is marked on the retained prescriptions;<br>* The supply of Controlled Drugs was made within 28 days of the appropriate date on the prescription (also for supplies of Controlled Drugs of Schedule 4);<br>* The name of the person who collected the controlled drugs is recorded in the Controlled Drugs Register (for Controlled drugs of Schedule 2 only).<br><br>An example of a Controlled Drugs register which details the information |

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| quinalbarbitone - now Schedule 2) and others. Subject to certain exemptions, Schedule 3 drugs must be kept under safe custody (locked secured cabinet), buprenorphine, diethylpropion and temazepam must be kept under safe custody (locked secure cabinet); it is advisable that all Schedule 3 drugs are locked away. Retention of invoices for five years is necessary.<br><br>**Schedule 4**: Includes most of the benzodiazepines (temazepam is now in Schedule 3) and androgenic and anabolic steroids (e.g. clenbuterol).<br><br>**Schedule 5**: Includes preparations (such as several codeine products) which, because of their strength, are exempt from virtually all Controlled Drug requirements other than the retention of invoices for five years. | that needs to be recorded can be found at<br><br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367071/ExampleCDregister.pdf<br><br>It is expected that running totals will be kept and checks against stock carried out at least weekly.<br><br>It is considered good practice to have a written SOP setting out who is authorised to access the Controlled Drugs cabinet and for what purposes. The SOP may also cover ordering (requisition), receipt, supply, disposal of CD and the regular changing of codes if a keypad safe is used.<br><br>Where Controlled Drugs which are subject to special storage conditions are transported in a vehicle, they must be kept securely within a locked receptacle in the vehicle and the vehicle must be locked when not attended. See VMD Guidance Note 20 for further guidance.<br><br>https://www.gov.uk/government/publications/controlled-drugs-and-the-misuse-of-drugs-regulations-vmgn-20 |
| 17. Ketamine may be the subject of misuse and, therefore, must be stored in the controlled drugs cabinet and its use and witnessed destruction recorded in an informal register. | The requirements for entries for the informal ketamine register are the same as for the Register (though the entries need not be signed). It is expected that running totals will be kept and checks against stock carried out at least weekly. |
| 18. The practice must carry out a full audit and reconciliation of all Schedule 2 controlled drugs and Ketamine. There must be SOPs for storage and recording of Controlled drugs. | It is expected that running totals will be kept and checks against stock carried out at least weekly<br>The SOPs should include details of:<br>-who has access to controlled drugs,<br>- who is responsible for checking stock against the register<br>- who to alert in the event of a discrepancy |

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| 19. Medicines must be prescribed and supplied according to current legislation. | • A veterinary surgeon who prescribes a POM-V medicine must first carry out a clinical assessment of the animal and the animal must be under his or her care. Code of Conduct Supporting Guidance 4.9:<br><br>http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/veterinary-medicines/<br><br>• A veterinary surgeon who prescribes a POM-V or POM-VPS medicine must be satisfied that the person who will use the product will do so safely, and intends to use it for the purpose for which it is authorised.<br><br>POM-V and POM-VPS medicines may be prescribed and supplied by a veterinary surgeon. Alternatively, medicines may be prescribed and a prescription written by a veterinary surgeon and the supply made by another veterinary surgeon (or a pharmacist) on the authority of that prescription.<br><br>There should be appropriate protocols, certificate records and/or clinical records for evidence of compliance with prescribing requirements. |
| 20. **PRESCRIBING WITHOUT SUPPLYING**<br>If a veterinary surgeon prescribes by written prescription (for supply by another veterinary surgeon or a pharmacist), in addition to the requirements for prescribing generally, he, or she must:<br>• Each time he or she prescribes the medicine advise on its safe administration and as necessary on any warnings or contra-indications on the label or package leaflet;<br>• Not prescribe more than the minimum amount required for the treatment(see exemptions in Schedule 3 paragraph 7 of the VMRs). | Use of the BVA prescription form is recommended. |
| 21. **PRESCRIBING WITH SUPPLY**<br>If a veterinary surgeon supplies a POM-V or POM-VPS medicine, in addition to the requirements for prescribing generally they must:<br>• Advise on its safe administration and, as necessary, on any warnings or contraindications on the label, package leaflet;<br>• Not supply more than the minimum amount required for the treatment (see exemptions in Schedule 3 paragraph 7 of the VMRs). | Note: A Suitably Qualified Person (SQP) under the Veterinary Medicines Regulations is under similar requirements for the prescription and supply of POM-VPS medicines. |

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| 22. **SUPPLY IN THE ABSENCE OF THE VETERINARY SURGEON**<br>Having prescribed a POM-V or POM-VPS medicines, if the veterinary surgeon is not<br>present when the medicine is handed over, they must:<br>• Authorise each transaction individually before the medicine is supplied;<br>• Be satisfied that the person handing it over is competent so to do. | A veterinary surgeon could meet the requirement to authorise each transaction by:<br>• Handing over a medicine personally following a consultation, or instructing a fellow team member to supply the medicine;<br>• Making a note on a client's records that repeat prescriptions could be supplied to the client;<br>• A team member taking a call from a client and putting a medicine aside for the veterinary surgeon to authorise before being supplied;<br>• In the case of a client unexpectedly coming into the practice, by a phone call to the veterinary surgeon to authorise the supply. |
| 23. **SUPPLY OF NFA-VPS MEDICINES BY A VETERINARY SURGEON OR SQP**<br>If a veterinary surgeon or SQP supplies an NFA-VPS they must:<br>• Be satisfied that the person who will use the medicine will do so safely, and intends to use it for the purpose for which it is authorised;<br>• Each time the medicine is supplied, advise on its safe administration and on any warnings or contra -indications on the label, package leaflet;<br>• Not supply more than the minimum amount required for the treatment (see exemptions in Schedule 3, paragraph 7 of the VMRs). | Re SQPs, the assessor will ask to see SOP for procedures for supplying POM-VPS/NFA-VPS. |
| 24. All containers and outer packs dispensed by the practice must be legibly and indelibly labelled with sufficient information. | **MEDICINES OTHER THAN POM-Vs**<br>All such medicines supplied by the practice must be labelled in accordance with the VMR. Generally, such medicines must be supplied in a container (with labelling) specified in the marketing authorisation for the medicine. It is advised that, in addition, such medicines are labelled with the name and address of the practice supplying the medicine.<br><br>**POM-Vs**<br>All POM-V medicines supplied by the practice must be labelled with the following information:<br>• The name and address of the animal owner;<br>• The name and address of the veterinary practice supplying the medicine;<br>• The date of supply;<br>• The words "keep out of the reach of children"; |

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| | • The words “for animal treatment only” unless the package or container is too small for it to be practicable to do so;<br>• The words “for external use only” for topical preparations;<br>• The name and quantity of the product, its strength and directions for use.<br><br>**MEDICINE SUPPLIED FOR USE UNDER THE CASCADE**<br>Medicines for supply under the Cascade, must include the following additional information:<br>• Identification of the animal or group of animals;<br>• Name of the veterinary surgeon who has prescribed the product e.g. veterinary surgeons initials or a code, provided that this can be traced back to an individual.<br>And, unless already specified on the manufacturer’s packaging:<br>• Any special precautions;<br>• The expiry date;<br>• Any necessary warnings for the user, target species, administration or disposal of the product. |
| 25. Veterinary medicinal products must be supplied in appropriate containers. | For loose tablets, gloves must be worn when dispensing.<br>Loose tablets and capsules must be dispensed in crush-proof and moisture-proof containers.<br>Sachets and manufacturers’ strip or blister pack medicines should be dispensed in paperboard cartons, wallets or paper envelopes.<br><br>A veterinary surgeon may break open any package containing a VMP. Where VMPs are supplied in a container other than that specified in the MA, the veterinary surgeon must ensure that the container is suitably labelled and must supply sufficient written information to enable the product to be used safely, e.g. a copy of the SPC or package leaflet can be provided, or appropriate information such as usage instructions, warnings and contra-indications can be included on the dispensing label. |
| 26. Practices must make clients aware that they can request a prescription. | Advise clients, by means of a large and prominently displayed sign or signs (in the<br>waiting room or other appropriate area), with reference to the following:<br>* “Prescriptions are available from this practice.<br>* “You may obtain Prescription Only Medicines, Category V, (POM-Vs) from your veterinary surgeon OR ask for a prescription and obtain these medicines from another veterinary surgeon or a pharmacy. |

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| | * “Your veterinary surgeon may prescribe POM-Vs only for animals under their care.”<br>* “A prescription may not be appropriate if your animal is an in-patient or immediate treatment is necessary.”<br>* “You will be informed, on request, of the price of any medicine that may be dispensed for your animal.”<br>* “The general policy of this practice is to re-assess an animal requiring repeat prescriptions every [xx] months, but this may vary with individual circumstances. The standard charge for a re-examination is £[xx].”<br>* “Further information on the prices of medicines is available on request.”<br><br>Provide new clients with a written version of the information set out in the sign or signs referred to above, which may be set out in a practice leaflet or client letter or terms of business document.<br><br>On a continuing basis, take reasonable steps to ensure that all clients are provided with a written version of the information set out in the sign or signs referred to above, which may be set out in a practice leaflet or client letter (Reasonable steps may include a combination of practice leaflets, client letters, and information on practice websites). |
| 27. Provide the price of any relevant veterinary medicinal product stocked or sold, to clients or other legitimate enquirers making reasonable requests. | If requested, inform clients of the price of any medicine to be prescribed or dispensed. Where possible and relevant, inform clients of the frequency and charges regarding further examinations of animals requiring repeat prescriptions.<br><br>Provide clients with an invoice that distinguishes the price of relevant veterinary medicinal products from other charges and, where practicable, provide clients with an invoice that distinguishes the price of individual relevant veterinary medicinal products. |
| 28. Medicines must be used in accordance with the legislation commonly referred to as “the Cascade”. | The assessor will wish to see evidence that Cascade medicines are clearly identified to owners who give informed consent for their use. Written forms for signature are expected.<br><br>Human generic preparations must not be used other than under Veterinary Medicines Guidance Note 13 (VMG13) which allows for the welfare of |

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| | animals to be a primary consideration in the choice of treatment.<br><br>https://www.gov.uk/government/publications/the-prescribing-cascade-for-veterinary-medicines-vmgn-13<br><br>The assessor will ask to see completed Cascade consent forms – not just that a stock of blank forms is held.<br><br>The VDS can supply a suitable template for these consent forms:<br><br>http://www.veterinarydefencesociety.co.uk/<br><br>If there is no suitable authorised veterinary medicinal product in the United Kingdom for a condition in a particular species, in order to avoid unacceptable suffering veterinary surgeons may exercise their clinical judgement according to the "Cascade", whereby they select in the following order:<br>• A veterinary medicinal product authorised in the United Kingdom for use with another animal species, or for another condition in the same species;<br>• If, and only if, there is no such product that is suitable, either:<br>* A medicinal product authorised in the United Kingdom for human use or<br>* A veterinary medicinal product not authorised in the United Kingdom but authorised in another European Member State for use with any animal species (in the case of a food-producing animal, it must be a food-producing species) (see Special Import Certificate VMD Guidance Note 7);<br>• If, and only if, there is no such product that is suitable, a veterinary medicinal product prepared extemporaneously by a pharmacist, a veterinary surgeon or a person holding a manufacturing authorisation authorising the manufacture of that type of product;<br>• If a veterinary surgeon considers that there is not a suitable veterinary medicinal product authorised in the UK or another EU Members state to treat a condition then it is possible to apply for a Special Treatment Certificate (STC) to import a suitable authorised product from outside the UK. A STC will not be issued if a suitable product is authorised and available in the UK or in another EU Member State. |

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| 29. Consent for products supplied under the Cascade is required | It is not acceptable to use an all embracing "general" lifelong consent for any and all off-label products that might be given to any animal.<br><br>Specific consent needs to be obtained for each unauthorised medicine used. But it is acceptable where there is a specific ongoing condition requiring unauthorised medicine for a lifelong consent form to be used for that particular medicine in that particular animal. Similarly in the case of exotics where there are no licensed products available, it is acceptable to use lifetime consent.<br><br>The inspector will ask to see completed off-label forms – not just that a stock of blank forms is held. |
| 30. A suspected adverse event or lack of efficacy to a veterinary medicine must be reported promptly to the VMD and/or manufacturer. | A protocol is required that recognises when the use of adverse event reporting is necessary.<br><br>This should be noted on the clinical records.<br><br>https://www.vmd.defra.gov.uk/adversereactionreporting/ |
| 31. No Wholesale dealing must take place of medicines unless the practice must holds an appropriate Wholesale Dealers Authorisation (WDA). | Emergency supply of medicines to another practice would be permitted. |
| 32. A practice must be able to demonstrate that when using antimicrobials or anthelmintics, it does so responsibly, and is accountable for the choices made in such use. | The development and spread of antimicrobial resistance is a global public health problem that is affected by use of these medicinal products in both humans and animals. Veterinary surgeons must be seen to ensure that when using antimicrobials they do so responsibly, and be accountable for the choices made in such use.<br>Resistance to anthelmintics in grazing animals is serious and on the increase; veterinary surgeons must use these products responsibly to minimise resistance development.<br><br>Further information is available from the following:<br>**BVA**<br>http://www.bva.co.uk/public/documents/BVA_Antimicrobials_Poster.PDF |

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| | http://www.bva.co.uk/activity_and_advice/Antimicrobials.aspx<br><br>**BSAVA** http://www.bsava.com/Advice/PROTECT/tabid/1665/Default.aspx<br><br>**BEVA** http://www.beva.org.uk/useful-info/Vets/Guidance/AMR |
| 33. For medicines requiring special handling e.g cytotoxic/cytostatic/hormones the practice has in place SOPs for the storage, dispensing, administration and disposal. | RCVS guidance for Chemotherapy drugs |

# Module 10: Medicines

## GENERAL PRACTICE

There are no General Practice requirements in this Module

# Module 10: Medicines

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. At least one member of Team Members must have attended an appropriate pharmacy course in the last 4 years. | For example BSAVA Dispensing course, University of Glasgow course.<br><br>Evidence will be provided through training records. |
| 2. All labels must be mechanically or machine produced, handwritten labels are not acceptable. | Handwritten labels for ambulatory practitioners or those on visits are considered acceptable for reasons of practicality- as the majority of details (i.e. veterinary practice address) are pre-printed onto labels the additional information can be added by hand. |

# Module 10: Medicines

## AWARD POINTS

**This Module contributes towards the Awards in 'Team and Professional Responsibility' and 'Patient Consultation Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. The practice has a designated person responsible for the running of the dispensary. | | This person would be expected to ensure that dispensary SOPs are available and the team is trained in their use. | 30 |
| 2. The practice has a designated person responsible for auditing Controlled Drugs by checking the register balance and the amount in stock at least weekly. | | This person must be a veterinary surgeon or RVN.<br><br>In the absence of the designated person an appropriate deputising system is in place. | 20 |
| 3. A team member has recently attended further training in dispensing and medicines legislation. | Team members that receive the training ensure that there is transfer of knowledge to other members of the practice team. | e.g BSAVA, Glasgow, it is expected that a current member of the team will have attended training in the last four years. | 50 |
| 4. The dispensary has a clearly demarcated work surface for the preparation of prescriptions and medications. | | | 10 |
| 5. There is a clear storage system for medications awaiting collection by clients that ensures they are held under the appropriate conditions. | | This applies to systems inside the clinic and to out-of-hours medicine collection arrangements.<br><br>There should be a system in place to audit those medicines not collected. | 10 |
| 6. For animals sent home on cytotoxic and hormone medications leaflets, training and suitable PPE are provided to animal owners/carers. | | | 10 |
| 7. The practice employs an Suitably | | An SQP as defined by AMTRA. | 10 |

| | | | |
|---|---|---|---|
| Qualified Person (SQP). | | | |
| 8. The practice has ready access to appropriate and current reference materials relevant to the use of medicinal products. | | e.g. BVA guide, BSAVA formulary, BEVA formulary app and VMD guidance notes. | 10 |
| 9. The practice uses a written quality management system for dispensing medicines. The practice utilises SOPs for: | The Assessor will look for evidence that the SOPs are used and their use is monitored. | This should include systems in place to prevent errors. | |
| | | i. Handling veterinary medicines | 10 |
| | | ii. Stock and date control | 10 |
| | | iii. Placing orders | 10 |
| | | iv. Unpacking drug orders | 10 |
| | | v. Labelling medicines | 10 |
| | | vi. Temperature and environmental monitoring protocols | 10 |
| | | vii. Disposal of out of date and returned medicines | 10 |
| | | viii. Dispensing medicines | 10 |
| 10. The practice has a system in place for updating all members of the practice team on new products or changes in the SPCs for current products. | | For example, new product notice board or monthly updates at practice meetings, NOAH updates. | 20 |
| 11. | | | |
| 12. The PMS identifies unauthorised human POM products used under the Cascade and prompts the user to label correctly and use appropriate consent forms. | | | 20 |
| 13. The PMS automatically labels unauthorised human POM products used under the Cascade correctly | | | 10 |

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| and automatically produces a consent form. | | | |
| 14. The practice routinely provides written information to the client about side-effects or complications relating to unauthorised products whenever they are prescribed. | | For example the BSAVA Patient Information Leaflets. | 10 |
| 15. The practice provides suitable training to clients if they are to administer injectable medicines themselves. | | This will include the disposal of sharps and used syringes. | |
| 16. The practice has a protocol for antimicrobial use in common conditions encountered. | | These should have been drawn up following clinical team discussion and considering the evidence base. This will encourage clinical discussion and consistency but should not interfere with clinical freedom.<br><br>The inspector will require an example of a written protocol. | 30 |
| 17. The practice has a protocol for endo and ecto parasiticide use. | | These should have been drawn up following clinical team discussion and considering the evidence base. This will encourage clinical discussion and consistency but should not interfere with clinical freedom.<br><br>The inspector will require an example of a written protocol. | 30 |
| 18. Dispensing procedures are subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **370** |
| | | **OUTSTANDING:** | **300** |
| | | **GOOD:** | **220** |

# Module 11: Medical Records

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. The practice must maintain an efficient system of documenting and filing clinical records and comply with the Data Protection Act. | The Data Protection Act 1998 (as amended) sets out eight enforceable principles of good practice with which all organisations processing personal data, even if exempt from notification, must comply. These require data to be:<br>• fairly and lawfully processed<br>• processed for limited purposes<br>• adequate, relevant and not excessive<br>• accurate<br>• not kept longer than necessary<br>• processed in accordance with individual's rights<br>• kept secure<br>• not transferred to other countries without adequate protection.<br><br>Practices may be exempt from notification if they are processing data only for the following purposes of their own business:<br>• accounts and records<br>• staff administration<br>• contacting own clients.<br><br>Evidence of registration under the provisions of the Data Protection Act (if appropriate) should be provided.<br><br>Different organisations (e.g. Veterinary Defence Society / Veterinary Medicines Directorate / HM Revenue and Customs) will have different requirements for the length of time records should be kept. Practices should check directly with these organisations for up-to-date information. |
| 2. Where appropriate, records must be maintained for each animal or group. There must be adequate back-up for computerised records. | |

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|---|---|
| 3. Records must be maintained so that any veterinary surgeon coming into the practice may, by reading the records, be able to proceed with the continuity of care of the patient. | |
| 4. Before any diagnostic or surgical procedure is performed on an animal, informed consent must be sought. | Informed consent, which is an essential part of any contract, can only be given by a client who has had the opportunity to consider a range of reasonable treatment options, with associated fee estimates, and had the significance and main risks explained to them e.g. record of verbal discussion or consent forms.<br><br>It is recognised that in an emergency it may be necessary to perform procedures without prior consent. |
| 5. Likely charges must be discussed with clients and updated as necessary. | Discussion should take place with the client covering a range of treatment options and prognoses, and the likely charges (including ancillary or associated charges, such as those for medicines/anaesthetics and likely post-operative care) so as to ensure that the client is in a position to give informed consent. The practice must be able to provide written estimates on request. The practice should be able to demonstrate procedures in place to update and inform clients of ongoing costs. This is particularly important when ongoing costs are about to exceed the previously agreed estimate. |
| 6. Itemised invoices must be available at the request of the client. | Itemised invoices may be produced by computer or manually and must include a breakdown of services, drugs and consumables, VAT and any surcharges. |
| 7. At the request of a client or veterinary surgeon, copies of any relevant clinical and client records and similar documents including results of imaging, must be provided within a reasonable period | Veterinary surgeons must keep clear, accurate and detailed clinical and client records.<br><br>Team members must be aware of the requirements of relevant Data Protection legislation. |
| 8. Any alterations or corrections to clinical records whether written or electronic are clearly recorded in an audit trail. | If clinical records are altered after initial entry, the changes must be logged (date and time, and by whom). |
| 9. Veterinary surgeons are aware of their professional obligations in relation to their communications with each other and when sharing or taking over care of a patient. | When an animal is initially presented, a veterinary surgeon should ask whether the animal is already receiving veterinary attention or treatment and, if so, when it was last seen; then, contact the original veterinary surgeon for a case history. It should be made clear to the client that this |

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| | is necessary in the interests of the patient. If the client refuses to provide information, the case should be declined.<br>Where different veterinary surgeons are treating the same animal, or group of animals, each should keep the other informed of any relevant clinical information, so as to avoid any danger that might arise from conflicting advice, or adverse reactions arising from unsuitable combinations of medicines.<br><br>Even where two veterinary surgeons are treating different groups of animals owned by the same client, it is still advisable for each to keep the other informed of any problem that might affect their work.<br><br>See Chapter 5 in the supporting guidance for *The RCVS Code of Professional Conduct* for further information: http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/communication-between-professional-colleagues/ |

# Module 11: Medical Records

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. Signed consent forms are usually required for all procedures when a patient is admitted to the care of a veterinary surgeon. This will include diagnostics, medical treatments, surgery and euthanasia. | "Admitted" means where an animal is in the care of the veterinary surgeon and is not in the presence of the owner.<br><br>Consent follows from discussions with the client.<br><br>This applies to animals seen at the owner's premises or at the practice.<br><br>If treatment changes during the course of investigation, telephone consent is allowed, but should be recorded in the clinical records. |
| 2. All hospitalised animals must have in-patient sheets recording basic husbandry parameters, with timed and initialled entries:<br>• Temperature<br>• Pulse<br>• Respiration<br>• Treatments<br>• Food and water intake<br>• Urine and faeces output<br>• Clinical signs<br>• Demeanour | This includes animals admitted as day patients. |
| 3. The practice system is capable of passing patient records between premises within the same practice group. | |
| 4. Complete records must contain the following information, where applicable:<br>• Owner identification<br>- name,<br>- address,<br>- contact telephone numbers.<br>• Patient identification: | It is prudent to include plans for future treatment or investigations, details of proposed follow-up care or advice, notes of telephone conversations, fee estimates or quotations, consents given or withheld and contact details. The practice should have the ability to separate clinical and financial records so that clinical records can be forwarded without financial information. |

| | |
|---|---|
| - Name;<br>- species;<br>- breed;<br>- colour;<br>- age;<br>- sex;<br>- microchip number or tattoo number and weight.<br>• Clinical information:<br>- Dates of all examinations, investigations, treatments;<br>- author of clinical records, history and details of clinical examination, investigations, provisional diagnosis and treatments;<br>- vaccinations - batch numbers;<br>- special considerations – abnormal drug reactions by patient or client;<br>- concurrent clinical conditions;<br>- repeat prescriptions – authorisation and review date.<br>• External communications:<br>– referrals and laboratory reports.<br>• Consent forms and estimates. | Clinical and client records should include details of examination, treatment administered, procedures undertaken, medication prescribed and/or supplied, the results of any diagnostic or laboratory tests (including, for example, radiograph, ultrasound or electrocardiogram images or scans), provisional or confirmed diagnoses, and advice given to the client. It is prudent to include plans for future treatment or investigations, details of proposed follow-up care or advice, notes of telephone conversations, fee estimates or quotations, consents given or withheld and contact details. Ideally, client financial information should be recorded separately from clinical records.<br><br>See Chapter 13 of the supporting guidance to the *RCVS Code of Professional Conduct for further information:* http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/clinical-and-client-records/ |

# Module 11: Medical Records

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. There must be facility for easy referral of patients from a branch surgery to the full facilities available at a hospital. The clinical records system must be accessible at branches of the Veterinary Hospital. | |
| 2. Records must include therapeutic and diagnostic plans. | |

# Module 11: Medical Records

## AWARD POINTS

**This Module contributes towards the Award in 'Team and Professional Responsibility'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. The practice uses a computerised practice management system. | | The computerised clinical records are accessible at all premises within the same practice group. | 50 |
| 2. Records include diagnostic and therapeutic plans. | | This should be in a form that is understandable to the whole practice team, ideally using standardised medical nomenclature. | 30 |
| 3. The clinical records system is set up in such a way as to allow data mining for the purposes of clinical governance, clinical audit, benchmarking, clinical research etc. | | The records system can search e.g. name of a procedure. | 20 |
| 4. The practice is working towards standardised medical nomenclature. | | This can either be based on a local nomenclature or other standard system e.g. VENOM or SNOMED. Evidence of training for all team members using the system. | 10 |
| 5. There is easy access from the patient medical record to associated clinical documentation - digitalised, scanned or paper. | | e.g. imaging records, laboratory reports, referral reports, insurance records, previous history (from other practices) and written discharge instructions for the owner and referring veterinary surgeon. | 30 |
| 6. The Practice utilises a protocol to update records regarding deceased patients including removal of patient's names from reminder lists. | Team members understand the rationale behind this. | | 30 |

| | | | |
|---|---|---|---|
| 7. The animal's weight is regularly updated to ensure accurate therapeutic dosing. | Team members understand the rationale behind this. | | 20 |
| 8. The animal's body condition score is regularly updated. | | | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **210** |
| | | **OUTSTANDING:** | **170** |
| | | **GOOD:** | **130** |

# Module 12: Nursing

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. Where veterinary nurses are carrying out work under Schedule 3 of the Veterinary Surgeons Act 1966, the inspector will require evidence of suitable training. | Student veterinary nurses must be under direct and continuous supervision by a qualified veterinary nurse or veterinary surgeon.<br><br>Training records confirm. |
| 2. Where lay team members are required to assist with clinical activities, the assessor will ask to see evidence of suitable training. | Evidence may be provided verbally, with the assessor speaking to a cross-section of team members.<br><br>Training records confirm. |
| 3. Any member of the team carrying out triage or first aid on an animal must have had appropriate training. | Evidence may be provided verbally, with the inspector speaking to a cross-section of team members.<br><br>Training records confirm. |

# Module 12: Nursing

## GENERAL PRACTICE

There are no General Practice requirements in this Module.

# Module 12: Nursing

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. At least one Registered VN is employed. | The RVN 's primary role is the responsibility for the nursing and clinical care of the clinic's patients.<br><br>Team members' schedules / rotas will provide evidence.<br><br>It is an intention for the future that Veterinary Hospitals have a RVN onsite for all normal opening hours. |
| 2. There must be a CPD plan for the nursing team. | CPD should be specific to job requirements of the nursing team. |
| 3. Nursing care is provided 24/7. | Schedules / rotas to provide evidence. |
| 4. All animals (non-routine) have a nursing plan. | This should include specific instructions for complex interventions e.g. managing chest drains, nursing post chemotherapy / radioactive isotopes.<br><br>A recognised nursing care plan (NCP) should be completed and regularly reviewed for each eligible patient. NCPs should be overseen by a qualified member of the practice. |

# Module 12: Nursing

## AWARD POINTS

**This Module contributes towards the Awards in 'Patient Consultation Service' and 'In-patient Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| **1.** A RVN is employed for all normal practice opening hours (or part time equivalents to FTE). | | The RVN's primary role is the responsibility for the nursing and clinical care of the clinic's patients. | 70 |
| 2. There should be sufficient appropriately trained team members to provide patient care to expected numbers of patients. | Team members can describe the appropriate level of care expected. | For team members without a recognised qualification (or on an approved course) the practice must demonstrate the training given. Training could be in-house or externally provided.<br><br>This includes inpatients and surgical patients. | 50 |
| 3. All animals undergoing any procedure should have a nursing care plan. | | A nursing care plan should be completed and regularly reviewed for each eligible patient. NCP's should be overseen by a qualified team member.<br><br>For routine procedures standardised plans are acceptable. | 50 |
| 4. All anaesthetics are monitored and maintained by a Veterinary Surgeon or Registered Veterinary Nurse, (or enrolled student under the continuous and direct supervision of a Veterinary Surgeon). | Observation and check anaesthetic records | This means that different people are undertaking the procedure and monitoring anaesthesia.<br><br>Short term exceptions for sickness etc. | 50 |
| 5. The nursing team is involved in the regular practice clinical meetings. | | All members of the nursing team should have the opportunity to input items for discussion. | 20 |
| 6. Clinical nursing procedures are subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |

| | | | |
|---|---|---|---|
| 7. Nurse clinics are provided for clients | | They are carried out by an RVN with appropriate training e.g. Nutrition, Pet Health Councillor.<br><br>Evidence may be provided through training records, client literature and team rotas. | 30 |
| 8. One or more RVN (s) has additional relevant qualifications. | | e.g. BSAVA Nurse Merit Award, Advanced Diploma , BVNA certificate, VTech etc<br><br>Training records. | 30 |
| 9. The practice has clinical clubs / meetings for the nurses. | | | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **340** |
| | | **OUTSTANDING:** | **270** |
| | | **GOOD:** | **200** |

## Module 13: Out-of-hours

### CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. Practices must take steps to provide 24-hour emergency cover for those species treated by the practice during normal working hours. | See Chapter 3 in the supporting guidance to *the RCVS Code of Professional Conduct* for further information:<br><br>http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/<br><br>Veterinary surgeons taking steps to provide emergency first aid and pain relief for animals should provide protocols for on-duty veterinary surgeons. |
| 2. Practices should facilitate the provision of first aid and pain relief to species not normally covered. | See Chapter 3 in the supporting guidance to *the RCVS Code of Professional Conduct* for further information:<br><br>http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/<br><br>Practices must demonstrate availability of information for species/cases outside of their competencies is available to on duty veterinary surgeons. |
| 3. Practices must make provision to attend cases away from the practice premises on the occasions when in the veterinary surgeon's professional judgement it is deemed necessary. | See Chapter 3 in the supporting guidance to *the RCVS Code of Professional Conduct* for further information:<br><br>http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/<br><br>Practices should be able to provide advice on animal ambulance and taxi services willing to transport animals outside normal working hours, any veterinary back-up, local contacts, and information on the provision of other |

| | |
|---|---|
| | 24-hour emergency services in the local area. |
| 4. It is acceptable for clients' initial contact to be with an automated or remote device such as an answering machine used to give a duty telephone number. | Where non veterinary surgeons answer the phone the practice must demonstrate the provisions for contacting the duty veterinary surgeon. |
| 5. Ideally informed consent and discussion of costs should precede treatment however in acute emergencies immediate first aid and pain relief should not be delayed. | Team members are aware of practice protocols in the case of acute emergencies |
| 6. When covering for another practice or providing out of hours services a written agreement must be entered into, including a protocol for handover of cases. | |
| 7. Practices should inform all clients of their out-of-hours (OOH) arrangements. | Clients should be provided with information, at initial registration, on the emergency service, including relevant telephone numbers, location details and the likely initial costs of a consultation.<br><br>Written duty rota or formal written arrangement with an alternative veterinary surgeon/practice and by what means the practice informs clients of the out-of-hours arrangements. Assessors may interview clients as to how they are informed of OOH arrangements. |
| 8. Proper safety precautions must be taken for team members on duty at night. An appropriate protocol for dealing with night-time callers must be in place. Suitable means must be available to enable team members to call for immediate assistance when necessary. | See Chapter 3 of the supporting guidance for *the RCVS Code of Professional Conduct* for further information.<br><br>http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/ |

# Module 13: Out-of-hours

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. If out-of-hours cover is provided by veterinary surgeons not normally working with that species then suitable training, CPD and backup must be demonstrated. | |
| 2. A suitably trained person is available to assist in the administration of a general anaesthetic. | The inspector will ask to see what arrangements are made for surgical emergencies to ascertain that a suitably trained person would be available to assist in the administration of a general anaesthetic. |
| 3. Practices can only outsource their OOH provision to practices that meet or exceed their own level. | This refers to the base categories of Core/GP/Veterinary Hospital |

# Module 13: Out-of-Hours

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. The practice must provide out-of-hours cover at the Hospital premises. | This must be in place by 2020.<br>This requirement can be met by an external OOH providers based at the hospital premises.<br><br>The assessor will wish to discuss plans or preparation for meeting this requirement. |

# Module 13: Out-of-hours

## AWARD POINTS

**This Module contributes towards the Awards in 'Patient Consultation Service' and 'In-patient Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. A protocol is a place to ensure that resources are available (e.g. weekend and overnight team members) to complete the patient's treatment, however long. | | This might entail referring / transferring the patient to another practice prior to treatment. | 30 |
| 2. The practice's OOH is covered by an ESC. | | This could be the practice itself. | 10 |
| 3. The practice's OOH is covered by a practice that is good or better at ECC. | | This could be the practice itself. | 20 |
| 4. The practice's OOH is covered by a practice that is outstanding at ECC. | | This could be the practice itself. | 30 |
| 5. Transfers between practices should be based on clinical need not convenience of either practice and should be kept to a minimum and organised by the practice. | | This might entail referring the patient to another practice prior to treatment. The practise of transferring patients to and from out-of-hours as routine is to be discouraged.<br><br>If animals are transferred an estimated of cost is provided and the owner's consent is sought.<br><br>See Supporting Guidance in the *Code of Professional Conduct*<br><br>Practices undertaking their own out-of-hours are eligible to receive these points. | 50 |

| | | | |
|---|---|---|---|
| | | | |
| 6. | | . | |
| 7. The practice undertakes OOH onsite or it has its own ambulance to move patients to and from it OOH site or external provider. | | This should be a designated vehicle with suitable cages for the safe transport of the animals routinely treated.<br><br>This requirement could be met through the use of external pet transport operator, with an animal ambulance, contracted to the practice. | 10 |
| | | **TOTAL POINTS AVAILABLE:** | **150** |
| | | **OUTSTANDING:** | **120** |
| | | **GOOD:** | **90** |

# Module 14: Out-patients (First Opinion)

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. Consulting areas whether mobile or static should have equipment appropriate for the range of species treated in that area. | Minimum of a stethoscope, thermometer, ophthalmoscope and aureoscope must be available for clinical examination. Items may be shared between consulting areas. |
| 2. Vehicles routinely used by the practice must be clean, tidy and well maintained and equipped sufficiently to enable basic procedures to be performed at the client's premises. | The inspector will view as many vehicles as practicable to be reasonably sure that this standard is met. It would be acceptable for a visit box to be moved between vehicles. |
| 3. Contaminated items, waste materials (including sharps) should be transported and disposed according to Regulations. | See Infection Control Module, Core Standards Requirement 1 regarding bio security policy and BVA Good Practice Guide to handling veterinary waste: http://www.bva.co.uk/uploadedFiles/BVA_Good_practice_guide_to_handling_veterinary_waste_in_England_and_Wales.pdf |
| 4. If mobile phones have to be used in vehicles, hands free must be available. | |
| 5. Equipment should be stowed so as not to risk accident or injury. | |
| 6. The practice must have a means of estimating or establishing the weight of species routinely treated. | Weight should be determined as accurately as possible e.g. scales or standard weight charts. |
| 7. Cleaning and disinfection materials must be readily available and used. | Risk based disinfection of consulting and all related surfaces must be done between patients. This should include floor, equipment and keyboards. |
| 8. Appropriate PPE must be readily available and used. | Dedicated clean clothing should be used for consulting and changed as required. Gloves and aprons must be readily available and used where appropriate. |

| | |
|---|---|
| 9. Team members must be adequately trained in animal handling. | Non slip lead, muzzles, crush cage, blanket, gloves, dog catcher.<br><br>Ability to call for assistance – personal or room alarm.<br><br>Evidence may be required in the form of team members induction / training records. |
| 10. A stretcher or trolley must be provided for the safe transportation of heavy animals. | |

# Module 14: Out-patients (First Opinion)

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. The ability to view x-rays / diagnostic images must be available in at least one consulting area | Could be an x-ray viewer or computer |
| 2. The practice must have access to a service providing veterinary specific advice on management of poisons. | It is not necessary to have a formal annual contract. An SOP to show how information is being accessed, for example, via websites on a 'pay-as-you-go' basis would be acceptable. |
| 3. Scales must be provided to allow accurate weighing of the full range of species routinely treated. | This enables accurate dosage of medications and treatment planning, |
| 4. At least one examination area must be able to be darkened. | |

# Module 14: Out-patients (First Opinion)

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. There must be a hand basin within each consulting area available for use by Team Members and clients. | |

## Module 14: Out-patients (First Opinion)

### AWARD POINTS

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | This could be in small animal medicine, veterinary cardiology, veterinary dermatology veterinary ophthalmology, | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in anaesthesia and there is evidence of dissemination to the rest of the team. | | This could be in small animal medicine, veterinary cardiology, veterinary dermatology veterinary ophthalmology, | 30 |
| 3. At least one MRCVS has a post-graduate qualification in anaesthesia and there is evidence of dissemination to the rest of the team. | | This includes AP status or an relevant old style Certificate | 50 |
| 4. A Written Diagnostic Protocol (WDP) is utilised for: | The Assessor will look for evidence that the WDPs are used and their use is monitored. | These should have been drawn up following clinical team discussion and considering the evidence base. This will encourage clinical discussion and consistency but should not interfere with clinical freedom.<br><br>The inspector will require one example of a written protocol for each category the practice wishes to attain points for. | |
| | | i. skin disease | 10 |
| | | ii. ears | 10 |
| | | iii. urogenital | 10 |
| | | iv. GI | 10 |

| | | | |
|---|---|---|---|
| | | v. cardiac | 10 |
| | | vi. respiratory | 10 |
| | | vii. ophthalmic | 10 |
| | | viii. exotic | 10 |
| | | ix. neurological | 10 |
| | | x. reproductive | 10 |
| | | xi. lameness | 10 |
| | | xii. endocrine | 10 |
| 5. | | | |
| 6. There is a hand basin within each consulting area available for use by team members and clients. | | | 20 |
| 7. A written vaccination policy is utilised in the practice. | | This must be reviewed at regular intervals and at least annually. | 10 |
| 8. Aa written parasite control policy is utilised in the practice. | | This must be reviewed at regular intervals and at least annually. | 10 |
| 9. Written Therapeutic Protocols (WTPs) for commonly encountered conditions and clinical scenarios are utilised for: | The Assessor will look for evidence that the WTPs are used and their use is monitored.<br><br>WTPs will encourage clinical discussion and consistency but should not interfere with clinical freedom. | These should have been drawn up following clinical team discussion and considering the evidence base. The assessor will require one example of a written protocol for each category the practice wishes to attain points for.<br><br>The assessor will look at case records and talk to team members. | |
| | | i. skin disease | 10 |
| | | ii. ears | 10 |
| | | iii. urogenital | 10 |
| | | iv. GI | 10 |
| | | v. cardiac | 10 |
| | | vi. respiratory | 10 |
| | | vii. ophthalmic | 10 |
| | | viii. exotic | 10 |
| | | ix. neurological | 10 |

| | | | |
|---|---|---|---|
| | | x. reproductive | 10 |
| | | xi. lameness | 10 |
| | | xii. endorcrine | 10 |
| **10.** The waiting area allows for the separation of dogs, cats and other predator/prey species, and nervous animals. | | | 30 |
| | | **TOTAL POINTS AVAILABLE:** | **400** |
| | | **OUTSTANDING:** | **320** |
| | | **GOOD:** | **240** |

# Module 15: Pain Management

## CORE STANDARDS

| Requirements | Guidance notes |
|---|---|
| 1. Pain is routinely assessed and appropriate analgesia provided. | See *RCVS Code of Professional Conduct* Guidance note 3 for further information. http://www.rcvs.org.uk/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/ |

# Module 15: Pain Management

## GENERAL PRACTICE

There are no General Practice requirement in this Module.

# Module 15: Pain Management

## VETERINARY HOSPITAL

There are no Veterinary Hospital requirement in this Module.

## Module 15: Pain Management

### AWARD POINTS

**This Module contributes towards the Awards in 'Patient Consultation Service' and 'In-patient Service'.**

| Requirements | Behaviours | Guidance notes | Points |
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| 1. The practice has a designated person for pain relief who implements training and monitors compliance with pain protocols. | | This person is expected to be a veterinary surgeon. | 30 |
| 2. A pain scoring sheet (e.g. Glasgow pain score) is available throughout the practice. | | Evidence that relevant personnel understand why the sheet is there and its use. | 10 |
| 3. Members of the clinical team have received specific training on recognising pain. | | Evidence of this training / how the practice assesses the impact of training / have they retained or changed pain control policy based on this assessment? | 20 |
| 4. Team members know how to access relevant reference materials on pain assessment and control. | | This could be reference texts or materials held in the practice or online resources. | 10 |
| 5. Pain assessment is performed and recorded using a standardised peer-reviewed system e.g. Glasgow pain score. | | Evidence that there has been thinking and planning behind acquiring the appropriate pain scale and this has been followed through with clear communication in the practice; training for relevant personnel; and an assessment of judging its impact and modifying its usage if necessary. | 40 |
| 6. Appropriate interventions against pain are provided for in- and out-patients in response to pain scores. | | Evidence should be provided through clinical records. Interventions will be in response to initial pain scores and changes in pain scores.<br><br>Interventions may include local and regional anaesthesia. | 40 |

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| 7. The practice utilises pre-emptive pain control. | | Evidence that all relevant personnel recognise the need of pre-emptive pain control and that this is a recorded step in each case. | 20 |
| 8. Pain is reassessed and recorded regularly throughout surgical procedures and recovery. | | Evidence that this reassessment has led to recorded decisions. | 20 |
| 9. Patients with chronic conditions, e.g. osteoarthritis, are reassessed regularly and treatment plans adjusted appropriately. | | Seek evidence of the reassessment and that the resulting decisions are recorded. | 10 |
| 10. The practice provides a holistic approach to pain relief. | | This could include overall management of the patient and the use of non-pharmaceutical pain relief (e.g. immobilisation, massage, physiotherapy). The practice should be able to demonstrate an appropriate protocol. | 10 |
| 11. Clients are given verbal and written information about recognising pain and the benefits of treating as well as potential adverse reactions. | | | 20 |
| 12. Pain management in the practice is subject to clinical audit. | | This could be outcome, process or significant event audits. | 20 |
| | | **TOTAL POINTS AVAILABLE:** | **250** |
| | | **OUTSTANDING:** | **200** |
| | | **GOOD:** | **150** |

# Module 16: Practice Team

## CORE STANDARDS

| Requirements | Guidance notes |
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| 1. All veterinary surgeons and veterinary nurses working in the practice must currently be registered with the RCVS. | This should include locums.<br><br>Pre submitted before inspection. |
| 2. All veterinary surgeons and RVNs employed by the practice have Professional Indemnity Insurance in place | |
| 3. The practice must have Employers' Liability Insurance. | The certificate must be displayed for all members of team members to see. |
| 4. The practice must have Public Liability Insurance. | |
| 5. Written statement of the main terms and conditions of employment or a contract containing the same information are provided to team members. | Within two months of commencement of employment. |
| 6. Team members are clear what their role responsibilities are. | Team members can describe what they are responsible for and what is expected of them.<br><br>It may be useful to support this with a recorded list of responsibilities. This should be reviewed annually. |
| 7. Clinical team members are supported with regular reviews to plan their professional development. | Team members can describe the plans that have been agreed for their development and how they discuss their progress.<br><br>We would expect this to occur as appropriate to the individual but at least annually. |
| 8. All professional team members must comply with the RCVS requirements for CPD. | Each team member must evidence their own CPD indicating topics covered and hours in an aggregate form.<br><br>New graduates are expected to complete PDP |
| 9. Where RVNs or SVNs are performing Schedule 3 procedures there should be evidence of training and assessment to ensure the individual is competent in that procedure. | There should be appropriate records of the assessment available |

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| 10. Team members understand the practice's responsibilities to their employees, potential employees, clients and external parties under the Equality Act 2010 and how it impacts their role in the practice. | Team members can explain how the policies are implemented. |
| 11. The practice must have clear requirements for a professional standard of behaviour, personal hygiene and appearance to be maintained by all members of the practice at all times. | Evidence of how this is communicated to team members.<br><br>A recorded policy may be useful. This policy is to help portray a professional image and comply with Health and Safety advice. |
| 12. The practice must have a completed up to date Health and Safety Law poster, which is displayed for all team members to see. | |
| 13. The practice must have a clear Health and Safety Policy which is known to and understood by all team members. This must be updated on a regular basis and updates communicated to team members. | All team members should be able to describe their and their employer's responsibilities with regard to working safely<br><br>The practice's policy should be set out in a document which is given to or displayed for all team members.<br><br>The practice must set out its policy for Health and Safety under the Health and Safety at Work Act 1974, employers are required to have a policy setting out how they ensure that risks to Health and Safety to employees, contractors and customers are kept as low as is reasonably practical. Where five or more people are employed (even if this is only temporarily) this policy must be set down in writing. Such a written policy must include:<br>• A statement of general policy;<br>• Delegated responsibilities for dealing with specific areas (e.g. equipment, substances, training, first aid, fire, reporting of accidents etc.);<br>• General instructions to team members arising out of the significant findings of the risk assessments.<br>Such a document must aim to be concise, pointing the reader to more detailed guidance where necessary.<br><br>The law applies when people are at work so will also apply to farm/equine practitioners working mainly from vehicles but also from home, and where locums are used. Employers have duties to ensure the health and safety of their employees and this includes situations where work is carried out at, or from, home. |

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| | Veterinary surgeons who are self-employed also have duties towards their own health and safety and that of third parties (e.g. their family/locum) therefore, health and safety requirements do apply in this situation.<br><br>Equipment used at home for work purposes also needs to comply with health and safety regulations and would be subject to maintenance and testing. |
| 14. There are designated persons with agreed responsibilities for Health and Safety. | People with delegated responsibilities for health and safety should be clearly identified within the practice, and their responsibilities should be agreed in writing<br><br>Fire officer, H&S rep/officer, first aiders, radiation protection supervisor (and RPA), area safety officers (if applicable).<br><br>The practice must have appointed, in writing, a Fire Officer, and drawn up a written list of the practice Fire Officer's duties. A Fire Risk Assessment must have been drawn up.<br><br>The inspector will ask to see a list of the practice Fire Officer's duties and the Fire Risk Assessment, including procedures for raising the alarm and evacuation. Where gas/oxygen cylinders are being transported in practice vehicles, a 2kg dry powder fire extinguisher is required in the vehicle. Evidence should be provided of suitable hazard training. |
| 15. Team members are consulted appropriately in all matters of health and safety activity. | People can describe how they have been consulted about their safety at work and can describe how they would raise any concerns they have day to day.<br><br>Consulting employees on health and safety matters is a legal requirement and is more than simply having health and safety documents on site for team members to refer to and is very important in creating and maintaining a safe and healthy working environment.<br><br>Any change which may substantially affect their health and safety at work, i.e. in procedures, equipment or ways of working, must be communicated to the team, highlighting any dangers.<br><br>Team meeting minutes evidence discussion around H&S policy. |

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| 16. The practice has carried out risk assessments in all areas of activity and has recorded the significant findings of these risk assessments | Safety officer(s) can describe how they carried out their risk assessments and how these have informed the practice's standard procedures.<br><br>If more than five people are employed, copies of the findings from the risk assessments should be available in the practice and regular review should be evidenced. Assessors will be verifying that the principles of risk assessment are understood and that risk has been addressed, they will not be examining individual risk assessments. Practices are referred to www.hse.gov.uk for detailed guidance.<br><br>Activities/work areas to be considered would include both physical and psychological health, for example:<br>• Cleanliness/tidiness;<br>• Disinfection;<br>• Handling and restraint of animals (including the use of on farm facilities);<br>• Manual handling and lifting of weights (with particular reference to aids for moving<br>• Heavy/paraplegic animals<br>• Slips/trips/falls;<br>• Veterinary medicines/pharmaceuticals;<br>• Anaesthetic gases;<br>• Injection procedures (risk of self-injection);<br>• Risk to pregnant workers;<br>• Risk of work related stress;<br>• Proper use of work equipment:<br>• Display screen equipment;<br>• Office electrical equipment;<br>• Portable electrical appliances<br>• Dental machine;<br>• Liquid nitrogen;<br>• Imaging equipment;<br>• Anaesthetic equipment;<br>• Laboratory equipment;<br>• Laboratory procedures;<br>• Dental procedures using mechanical scaling;<br>• Security of team members, including provisions for lone/night |

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| | working;<br>• Dealing with members of the public;<br>• Personal protective equipment;<br>• First aid, recording and reporting of accidents;<br>• Disposal of sharps, clinical, pharmaceutical, chemical and other waste (including safe handling of spillages/leakages, broken and unwanted containers);<br>• Infectious disease/biological agents;<br>• Zoonoses; (e.g. fungal - ringworm; bacterial - salmonella; viral - birdflu)<br>• Working at height;<br>• Water supplies/air-conditioning maintenance;<br>• Transport and storage and use of gas cylinders;<br>• Vehicles and driving for work<br>• employment of young persons (under 18 years of age)<br>• whether the practice premises does, or is liable to contain asbestos, any risk arising there from and action taken to manage risk, may be required (Control of Asbestos at Work Regulations 2002 and 2006).<br><br>Stored pressurised gas cylinders must be kept securely outside the building unless authorised by a fire officer. Stocks of explosives or inflammable agents must be stored in locked metal cupboards.<br><br>Best practice is to store cylinders of oxygenand flammable gases outside in the open air, which allows vapours to be dispersed effectively. Storage outside should be secure. If storage has to be located within a building, an adequate level of ventilation should be provided either by mechanical ventilation or the presence of a sufficient size and number of permanent openings. Flammable gases, such as LPG, if stored inside, may only be stored in purpose-built compartments or buildings with fire-resistant walls and explosion relief. Only limited quantities should be stored and should not be placed under stairs, near waiting rooms or compressors. Risk assessments should be undertaken to take into account compatibility of substances stored and the suitability of the arrangements made. |

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| 17. Team members understand and work according to the standard procedures adopted. | Team members can describe how they use standard procedures to maintain a safe working environment, and how and where these are recorded and reviewed.<br><br>Standard procedures may be recorded in a team member or practice manual, in area references or in aide- memoirs around the practice. They should be up to date and easily accessible. |
| 18. The practice must have undertaken a thorough assessment of the risks arising from the use of veterinary medicines and substances hazardous to health within the practice. | The risk to Health and Safety from veterinary medicines and other substances has to be assessed under the Control Of Substances Hazardous to Health Regulations 2002 (COSHH). There is wide variation in risk – many are low to medium risk but there are some substances in veterinary practice, which pose a very serious risk to health.<br>Implementing measures to control the exposure to low or medium risk substances can be adequately achieved when they are assessed by their therapeutic group / type / route of administration etc. The practice can set out standard measures to control<br>exposures, for example:<br>• Injectable anaesthetics;<br>• Pour-on anthelmintics;<br>• Steroidal compounds;<br>• Antibiotics<br>Within these groups, practices must identify any specific medicines or substances that could have longer-term health risks, such as allergies e.g. Penicillin, or sensitivities e.g. latex.<br>Specific and detailed assessments and the resulting measures to control exposure must be made for high-risk substances such as:<br>• Any hormones;<br>• Oil-based vaccines;<br>• Gluteraldehyde disinfectants;<br>• Cytotoxic drugs<br>It should be noted that the lists mentioned are not exhaustive and practices should consider their own individual medicine/substance usage.<br><br>Safety data-sheets are not legally required for veterinary medicines and many medicine companies do not produce them. Practices should therefore ensure that they have access to the current version of either the Summary of Products Characteristics (SPC) or a data-sheet for each authorised medicine used or stored in the practice. Copies of the current NOAH Compendium of Data Sheets are acceptable to fulfil this requirement for |

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| | those medicine companies that participate. See http://www.vmd.defra.gov.uk/ProductInformationDatabase/ (for veterinary SPC) and www.emc.medicines.org.uk (for non-veterinary SPCs). |
| 19. Equipment used within the practice is well maintained and regularly serviced according to manufacturers' recommendations. | Evidence of servicing of all equipment, including but not limited to: anaesthetic machines, autoclaves, monitors, laboratory equipment, x-ray apparatus, air conditioning, heating appliances, maintained fire alarms, emergency lighting and fire extinguishers.<br><br>Frequency of servicing is determined by manufacturer or competent person recommendation. |
| 20. Team members are prepared for emergencies. | Team members are familiar with procedures for turning off water supply, electricity, oil, gas supply and compressed gases. |
| 21. The practice must have a written programme for the inspection and testing of all its electrical equipment, based on its specific risk assessment. | The written programme containing the findings of the risk assessment, together with: evidence of inspection of the electrical installation by a competent person and PAT testing and visual inspection records will be required.<br><br>For the electrical installation in the building, the frequency of the inspection (by a competent person) should be as directed by that competent person. For portable electrical equipment, cables and leads, formal visual inspection and testing are considered. Advice should be sought from a competent person regarding the appropriate frequency for these as this will depend upon the individual circumstances of a practice. Equipment should be labelled with the date of inspection, or a database kept. Failed equipment must not be used and repaired equipment must be tested before use. Residual Current Devices are required for any equipment used in wet conditions. The inspector will ask to see PAT testing and visual inspection records. |
| 22. All gas appliances require to be maintained in a safe condition. | The assessor will ask to see gas safety certificates. Carbon monoxide detectors should be in place and regularly tested wherever combustible fuels are burned.<br><br>Advice should be sought from a suitably qualified person regarding an on-going programme of examination. |

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| 23. Team members understand the fire evacuation procedure and how to alert others in case of fire. | |
| 24. Wherever patients are hospitalised, smoke and / or heat detectors must be placed adequately to alert team members who maybe in remote parts of the premises. | May be standalone smoke detectors or a maintained fire alarm system |
| 25. Where team members are on the premises working alone or resting, automatic fire detection devices must be in place. | The fire officer can explain how regular reviews of practice fire safety are carried out. Fire exits and routes must be clearly identified and unobstructed and circulation areas kept clear. Fire doors should be closed or maintained by appropriate hold-open devices to allow closure in case of fire.<br><br>A fire log book or other records should be used to record testing and servicing of fire alarms (if present), emergency lighting and call points, and team members training and evacuation procedures. A premises checklist may be useful. |
| 26. There must be regular maintenance of fire alarms and equipment and regular fire practice evacuations. | |
| 27. The practice must have performed a fire risk assessment. | |
| 28. If in a flood area, a flood plan should be in place and understood by the team. | |
| 29. Appointed persons for first aid receive current training appropriate to their role. | The appointed persons can describe how they have been prepared for their responsibilities which may just be stocking the first aid box and calling an ambulance. |
| 30. There must be an appointed person to take charge should someone fall ill or be injured, and to restock the first-aid box. A second person must be appointed to take charge if the first appointee is off duty. | An 'Appointed Person' is an individual nominated by their employer to take charge when someone is injured or falls ill. Their responsibilities include looking after the first aid equipment, e.g. restocking the first aid box and calling an ambulance. Appointed persons should not administer first aid unless trained to do so.<br><br>Note: Nomination of an appointed person is a minimum requirement, but practices should consider if an appointment of more than one person is necessary or if a first aider should be appointed. (A first aider is someone who has undergone a training course in administering first aid and holds a current first aid at work certificate (these are time-limited to three years). A first aider can undertake the duties of an appointed person.)<br>For further guidance, see HSE leaflet INDG214 |

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| | http://www.hse.gov.uk/pubns/indg214.pdf<br><br>The appointed persons can describe how they have been prepared for their responsibilities which may just be stocking the first box and calling an ambulance. |
| 31. The practice must have an accident book. | Team members should know where and how to complete an accident record and what to do with the form. Completed forms should be stored securely<br><br>An accident book is required by law and must meet the requirements of the Data Protection Act. It must record the following:<br>• Date and time of accident or occurrence;<br>• Full name and address of the person involved and the injury or condition suffered;<br>• Where the accident or occurrence happened;<br>• A brief description of the circumstances;<br>• In the case of a reportable disease, the date of diagnosis, the occupation of the person concerned and the name or nature of the disease.<br>Records should be removed and stored securely and information kept for at least three years. |
| 32. The practices files reports under RIDDOR as required. | Managers or first aid appointees can explain how they should report under RIDDOR and the criteria to look for. For further information, see:<br><br>http://www.hse.gov.uk/riddor/reportable-incidents.htm |
| 33. The practice must have a policy for how they segregate, store and dispose of all forms of waste. | The current waste audit should be available and team members should be able to describe how they handle different forms of waste.<br><br>Adequate waste receptacles should be used to allow immediate disposal of hazardous items. Full containers should be stored in hygienic conditions and be clearly identified.<br><br>Hazardous waste (referred to as special waste in Scotland) must be appropriately segregated, safely stored and disposed of by a suitably permitted waste contractor. |

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| | The inspector will ask to see evidence of:<br>• A contract with a permitted waste contractor(s);<br>• Policies and practice to segregate and label waste into appropriate streams and to store it hygienically;<br>• Consignment notes for hazardous waste disposal, which form the basis of a hazardous waste register for those practices in England and Wales;<br>•Waste transfer notes should be stored for two years.<br>•Hazardous waste registration for those premises in England and Wales that produce more than 500kg of hazardous waste per annum.<br><br>For both hazardous and non-hazardous waste, practices may wish to refer to the BVA Good Practice Guide to Handling Veterinary Waste for guidance. However, local variations exist and practices should consult the Environmental Agency or their own local waste management authority for information.<br><br>http://www.bva.co.uk/uploadedFiles/BVA_Good_practice_guide_to_handling_veterinary_waste_in_England_and_Wales.pdf<br><br>Non-hazardous (non-special) waste must be appropriately segregated, safely stored and disposed of by a suitably permitted waste contractor. |

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| 34. Lifting equipment is suitable for purpose and regularly inspected. | Team members can describe safety procedures in use and how inspection is carried out.<br><br>The practice must be aware of The Lifting Operations and Lifting Equipment Regulations 1998 and must carry out the necessary examination/testing of any equipment covered by the Regulations prior to use and thereafter have the equipment inspected regularly (L).<br>The Regulations require that lifting equipment is:<br>• Sufficiently strong, stable and suitable for its intended use;<br>• Positioned or installed to prevent risk of injury;<br>• Visibly marked with appropriate information for safe use;<br>• and that lifting operations are planned and supervised and carried out by competent operators.<br><br>Lifting equipment should be examined prior to first use and thereafter inspected regularly in accordance with recommendations of a competent person who shall issue a certificate of inspection and report of any action required. An example of equipment covered by the Regulations is overhead gantry cranes for lifting anaesthetised horses. It is unlikely that height adjustable operating tables for use with small animals where no 'lifting' as such takes place will be covered. |
| 35. Where firearms are stored on the premises and/or used in the course of practice business firearms certificates must be shown. | The practice must pass inspection by a Duty Firearms Officer in respect of any firearms/tranquillizer and dart guns. Individual veterinary surgeons must have been issued with the relevant firearms certificate These should cover adequate storage arrangements. |

# Module 16: Practice Team

## GENERAL PRACTICE

| Requirements | Guidance notes |
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| 1. The practice has an agreed team development policy which is communicated to the team. | Team members can describe how they access development activities appropriate to them. |
| 2. All clinical team members are able to access reference materials appropriate to their role and activities in the practice. | People can explain how they use resource materials to keep up-to-date and can rapidly access essential current information for any clinical situation that may arise. |
| 3. The practice has a structured procedure for the induction of new team members which is appropriate to the role. | Some form of checklist or structured programme will be expected and people will be able to explain how the induction procedure is carried out and over what time period. |
| 4. Team member appraisals are performed. | This must be at least once yearly but can be more frequent. |

# Module 16: Practice Team

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. A one-year CPD plan must be provided for the hospital team. | |

# Module 16: Practice Team

## AWARD POINTS

**This Module contributes towards the Award in 'Team and Professional Responsibility'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. Role responsibilities and day-to-day duties are reviewed regularly with input from the team member. | This should be supported with recorded role responsibilities and evidence of review. | A role description exists to define the role of the employee within the practice, their areas of responsibility and a clear understanding of their day-to-day duties | 20 |
| 2. Role responsibilities are communicated to the rest of the team. | Team members are able to describe the different roles and responsibilities of their colleagues and their own contribution to the overall functioning of the practice. | It may be useful to support this with a written list of responsibilities. | 10 |
| 3. Team members are supported with regular reviews to plan their training needs. | Team members have action plans for their development which are recorded and reviewed. | We would expect this to occur as appropriate to the individual but at least annually. | 20 |
| 4. Structured feedback for performance review is based on competencies and behaviours. | Team members can describe how they use documentation to ensure feedback is behaviour based and objective. | | 10 |
| 5. 360 degree structured feedback is used. | Team members can describe how they give constructive feedback to colleagues. | | 10 |
| 6. CPD is recorded online on the RCVS Professional Development Record. | | The applies to all veterinary surgeons and RVNs. | 20 |
| 7. New graduates completing their PDP are supported with regular development reviews with a named member of the practice team. | New graduates can describe how their mentor and the practice has supported them in their first year. | | 10 |

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| 8. CPD Development activity is evaluated and planned by the practice team. | Expect to see a plan and evaluations. | | 10 |
| 9. CPD Development activity is evaluated by the individual. | Expect to see a plan and evaluations, people can explain how they changed what they do as a result. | | 20 |
| 10. CPD and development activity is communicated to the rest of the team and information shared. | | There are changes in practice made as a result. | 20 |
| 11. | | | |
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| 13. Individuals have access to a range of suitable resources including the internet for research and communication for work purposes. | | This could include access to journals or databases. | 10 |
| 14. Membership of professional and representative associations is encouraged and supported appropriate to the practices need. | Professional journals are available in the practice and individuals can explain how membership of associations has assisted and informed their activities. | | 30 |
| 15. The induction programme is tailored to the individual team member and supported by ongoing coaching and mentoring. | Individual team members can describe how they have been supported through their induction programme and how this has helped them integrate into the team. | | 40 |
| 16. A protocol is in place to address the management of conflict and bullying in the workplace. | | | 10 |
| 17. The practice has a policy for dealing with workplace stress. | | This could include compassionate leave benefits, dealing with requests for flexible working hours and publicising access to VetLife. | 30 |

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| 18. The practice has a policy for dealing with substance and alcohol abuse. | | This should include publicising access to VetLife and other resources. | 30 |
| 19. There are regular practice meeting when all team members are encouraged to contribute items to the agenda and participate during the meeting. | Open and frank discussions with no barriers to feedback. | The inspector will ask to see minutes of previous meeting and a schedule of future meetings involving all departments in the practice (expected to be at least quarterly).<br><br>A general meeting of the whole team should occur at least annually. | 40 |
| 20. The team members understand the aims and objectives of the business to a level appropriate to their role. | | The assessor will speak to team members to ascertain their understanding. | 10 |
| 21. Communication of business performance to the team. | | This enables team members to understand how their roles contribute to the overall business performance. | 10 |
| 22. All team leaders have received training in risk assessment and are able to show how they use risk assessment in their day to day work | Team members can describe how they approach a new task that requires risk assessment and where to seek advice if necessary. | | 10 |
| 23. Accident records are regularly reviewed and action taken. | | Managers or team members can describe how accident records have led to review and give examples of changes made as a result of that review. | 10 |
| 24. The practice has a disaster recovery plan. | | For example fire or flood. | 20 |
| 25. The practice maintains equipment, premises and standard procedure information in an organised and accessible form. | Team members can describe how they can access equipment manuals and standard procedures relevant to their role. | | 10 |

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| 26. The practice has clear personal security policies in place and has communicated these to team members. | Team members can describe the security measures in place to enable safe working at all hours and in all areas. | Would include physical security - locks, lighting, surveillance, panic alarms as required, and systems, checks and rules on lone working, training on dealing with difficult situations, aggressive animals. | 10 |
| 27. At least one current member of the practice team has undertaken training in professional ethics in the last four years and provided internal training to the rest of the team. | | This might include an external course, webinar, online resources or documented self-study. | 20 |
| 28. At least one current member of the practice team has undertaken training in animal welfare in the last four years and provided internal training to the rest of the team. | | This might include an external course, webinar, online resources or documented self-study. | 20 |
| 29. At least one current member of the practice team has undertaken training in communications in the last four years and provided internal training to the rest of the team. | | This might include an external course, webinar, online resources or documented self-study. | 20 |
| 30. The practice has a policy of accepting students for EMS and actively encourages this activity. | | | 20 |
| 31. The practice has an induction and integration policy for EMS students. | | | 10 |
| 32. The practice is approved for VN Training. | | Practices would be expected to have at least one student in current training. | 40 |
| 33. The practice plays an active role in the local community. | | For example, school visits, charity events and agricultural shows | 10 |
| 34. The practice takes placement students. | For example, work experience pupils from local schools or college students on animal care courses. | | 10 |
| | | **TOTAL POINTS AVAILABLE:** | **570** |

**Comment [AR6]:** There is debate as to whether this should be moved to the Nursing Module

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| | | **OUTSTANDING:** | **460** |
| | | **GOOD:** | **340** |

# Module 17: Premises

## CORE STANDARDS

| Requirements | Guidance notes |
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| 1. The premises must be suitable and adequate for its intended purpose. | |
| 2. The premises must be in good decorative order, clean and well maintained so as to create an atmosphere of clinical cleanliness and efficiency. | |
| 3. The premises should be free of offensive odours. | |
| 4. All parts of the premises must be adequately lit and ventilated. | Ventilation could include fans, windows that are escape proof (or other natural ventilation) or mechanical ventilation. |
| 5. Buildings must be heated to fulfil minimum legal requirements (ordinarily 16ºC), as appropriate. | |
| 6. Where consultations are carried out at the premises, the practice must have one or more consulting areas, which provide a clean, hygienic environment for consultations in private. | The consulting area may be used for other purposes, provided that hygiene is not compromised.<br><br>Public/clients should not be able to see into the consulting room. |
| 7. The floor area and walls in the consulting area must be made of non-slip materials and able to be thoroughly cleaned. | Unsealed concrete would not be acceptable. |
| 8. The table area or examination surface in the consulting area must be made of materials suitable for thorough cleaning. | |
| 9. There must be clear segregation of clean and contaminated items and protective clothing, and safe storage and transport of waste materials, including sharps. | |

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| 10. Glass walls and visible prep areas/operating theatres may give rise to issues of consent and client confidentially, as well as potentially distressing clients, witnessing procedures taking place. Practices must have the means of screening off the rooms (e.g. blinds) so that the area cannot be seen if consent cannot be obtained from the relevant parties. | This will only apply to areas visible to the general public and is not expected for clinical areas, e.g. glass walled operating theatre in clinical area. |
| 11. The practice must provide a waiting room or reception area of adequate size. | |
| 12. The display of commercially retailed merchandise within the veterinary premises is permissible, provided the display is of an acceptably professional nature and of relevant goods. | Any animal food stuffs should be safely stored. |
| 13. Any other commercial businesses run from the practice must be of an acceptable professional nature. | Points to consider would include biosecurity, client dignity and client perceptions. |
| 14. Team members must have access to appropriate amenities. Team Members and public amenities should include toilets and hand washing facilities, which should be maintained in a clean and orderly manner. | Public and team members can share toilet facilities. |
| 15. Team members' refreshments must not be prepared in clinical areas. | |

# Module 17: Premises

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. In the consulting room privacy must be ensured by adequate soundproofing, and must allow complete closure from the public. | For example, doors and windows that close, windows with blinds. |
| 2. Food preparation, storage, and washing up facilities for team members must be separate from clinical areas. | Team members' rest areas must be separate from clinical areas. |
| 3. The area immediately surrounding the premises must be maintained in a clean and tidy state. | Team members are aware of the need to provide a hygienic and tidy front practice. |
| 4. Reception facilities must be provided which are easily accessible to clients and team members as appropriate. | Reception desk could have a low area to cater for clients with specific needs. An SOP should be in place to ensure clients can easily access reception facilities. |

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. The buildings must be constructed of brick, stonework, or other substantial materials. | |
| 2. The internal walls and floors of in-patient areas must be impervious so as to permit thorough cleansing and disinfection. | The join between the floor and the wall must have a curved finish to aid cleaning, with the coving being carried up the wall.<br><br>All joints in the flooring material or coving must be impervious and finished flush with the surface. Stick-on coving is not acceptable. |
| 3. Emergency lighting must be provided to allow the hospital to continue to function in the event of a power cut or electrical failure. | Background emergency lighting is adequate for general areas (see Surgery Module for theatre lighting). |
| 4. Adequate temperature regulation must be available for comfort of team members and efficient functioning of equipment. | Heating may be required so that the ambient temperature can be maintained above 18ºC in the working area of the building. In addition, cooling may be required to avoid working temperatures exceeding 26ºC. Temperatures should be monitored to ensure that they stay within these limits. |
| 5. The waiting area must be designed to encourage reasonable separation of dogs, cats and other predator/prey species, and nervous animals. | Where absolute separation cannot be achieved, a protocol for achieving separation as necessary should be available. |
| 6. There must be separate accommodation for hospital patients and animals being groomed. | Any boarding or grooming business must be separate from hospital facilities.<br><br>Public areas (waiting room, reception, public toilets) and team members' facilities (rest-room, toilets and offices) may be shared. |
| 7. Smoke detectors, which provide a warning in the residential accommodation, must be installed in the kennel area. | |

# Module 17: Premises

## AWARD POINTS

**This Module contributes towards the Award in 'Team and Professional Responsibility'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. All areas of the practice including clinical, non-clinical, residential and storage areas are maintained and cleaned to the same high standard. | | This ensures the presentation of the practice is of a uniformly high standard. | 30 |
| 2. Maintenance audits should be performed at least annually. | | There should be an effective reporting and action system for remedying problems and repairs should be carried out in a timely fashion. | 20 |
| 3. Adequate temperature regulation must be available for the comfort of team members and patients, and the efficient functioning of equipment. | | Heating may be required so that the ambient temperature can be maintained above 18ºC in the working area of the building. In addition, cooling may be required to avoid working temperatures exceeding 26ºC. Maximum/minimum thermometers may be provided and records kept. | 10 |
| 4. The waiting area allows for the separation of dogs, cats and other predator/prey species, and nervous animals. | | | 30 |
| 5. The office area is kept clean and tidy. | | | 10 |
| 6. Bulk stock items are easily accessible for team members. | | | 10 |
| 7. Clear signage outside the practice is of a professional standard and includes opening hours and out-of-hours provision. | | | 10 |

**Comment [A7]:** PSG proposes removing the Award points section of this module as it focuses on equipment and facilities not behaviours and outcomes. Points 1 and 4 have been moved to Infection Control and Outpatients respectively.

**Comment [A8]:** Moved to Infection Control

**Comment [AR9]:** Move to Outpatients

| | | | |
|---|---|---|---|
| 8. There is CCTV inside the practice. | | This should cover the reception/waiting area for the safety and security of team members. | 10 |
| 9. There is CCTV outside the practice. | | This should cover entrances and car parking facilities, for the safety and security of team members. | 10 |
| 10. There is security lighting outside the practice. | | This should cover entrances and car parking facilities, for the safety and security of team members. | 10 |
| 11. There are intercom facilities to communicate with clients. | | This enables communications with the clients prior to the door being opened, for the safety and security of team members during out-of-hours services. | 10 |
| | | **TOTAL POINTS AVAILABLE:** | **160** |
| | | **OUTSTANDING:** | **130** |
| | | **GOOD:** | **100** |

## Module 18: Surgery

### CORE STANDARDS

**If no surgery is carried out on the premises then Core Standards practices are exempt from the requirements of this Module.**

| Requirements | Guidance notes |
|---|---|
| 1. All surgeries are performed by an MRCVS or Vet Student under direct supervision. | |
| 2. Surgeries allow under Schedule 3 to the VSA are performed by RVNs or SVNs under direct supervision. | |
| 3. A designated area is used for the conduct of surgical procedures which has easily cleanable surfaces and a good source of illumination. | This area needs to be separated either temporally or spatially from other areas. |

# Module 18: Surgery

## GENERAL PRACTICE

| Requirements | Guidance notes |
|---|---|
| 1. The operating theatre must be available for the conduct of sterile surgery at all times, it must not double up as a consulting room. | This should be a closed room with no through traffic. |
| 2. There must be a scrub sink for the use of surgical procedures, which should be separate from a sink used for non-sterile items. | |
| 3. There must be a written protocol for the maintenance of a surgically clean environment and evidence it is carried out. | |
| 4. There must be an adjustable-height operating table. | |
| 5. Sterile packs for emergency surgery must be available at all times. | These need to be checked regularly to ensure they have been sterilised within a reasonable length of time. |
| 6. Appropriate internal and external sterility indicators for the system employed must be used to monitor the efficiency of the sterilisation technique. | |
| 7. Sterile gloves and gowns must be available and used where appropriate. | Maintenance of asepsis would normally require surgical gloves to be worn. |
| 4. Dental procedures can be carried out at the end of the day in the theatre, as long as an SOP is in place. | |
| 5. The area should usually only contain equipment for use in surgical procedures and x-ray equipment. | An autoclave can be placed in an operating theatre, provided that there is a suitable SOP for maintaining asepsis.<br>Endotracheal tubes and anaesthetic circuits should not be stored on the wall of the operating theatre. |
| 6. A separate area for the preparation of patients must be provided. | This does not mean that a practice has to have a separate room used exclusively for preparation purposes. The preparation area may be situated in a room that has another function; it cannot, however, be in the operating theatre. |
| 7. The practice must provide a range of suitable sterile surgical instruments, consumables and suture materials for the work undertaken. | |
| 8. The induction of, and recovery from, general anaesthesia are high risk for both patient and handler. There must be an area that is | |

| | | |
|---|---|---|
| | appropriate for the procedures to be undertaken, bearing in mind patient and handler safety. The induction area can also be the operating area providing surgical cleanliness/sterility is not compromised and is appropriate for the procedure undertaken. | |
| 9. | A means for displaying radiographs must be available in the theatre. | A laptop or mobile x-ray viewer or digital display screen would be acceptable. |

## VETERINARY HOSPITAL

| Requirements | Guidance notes |
|---|---|
| 1. A preparation room must be provided separate from the operating theatre for the pre-operative preparation of surgical patients. | |
| 2. Scrubbing up facilities must be provided, with suitable elbow, foot or electric eye operated taps, which are adequately screened from the operating table. | |
| 3. At least one operating theatre of adequate size must be provided and used only for the conduct of surgical operations. | |
| 4. Doorways must be sufficiently wide for access into theatre by trolleys. | |
| 5. The theatre must be designed and laid out to ensure sterility and facilitate cleaning. | This might include flat cupboard door fronts. |
| 6. There must be a high standard of asepsis. | Gloves, gowns, hats, masks and dedicated footwear should be used during aseptic procedures.<br><br>No outdoor shoes or clothing are allowed.<br><br>All those present in theatre must wear scrub suits and hats in theatre.<br><br>Consideration must be given to the order in which procedures are undertaken, with those most likely to introduce contamination being done last. |
| 7. Lighting suitable for the accurate illumination of surgical sites on the patient must be provided in theatre. | This lighting must continue to function in the event of a loss of power. An operating lamp must be supplied by an uninterruptible power supply or a generator sufficient to complete a surgical procedure.<br><br>Surgical head torches can be used. |
| 8. An operating table of adjustable height, and capable of holding the patient in a tilted position, must be provided in the operating theatre. | |

| | |
|---|---|
| 9. Orthopaedic operations must be performed as the only procedure in theatre (at any one time). | |
| 10. Suitable surgical instruments must be available for orthopaedic surgery, including facilities for the repair of fractures. | |
| 11. Electrosurgery and suction must be available for surgical use and are used appropriately. | |

# Module 18: Surgery

## AWARD POINTS

**This Module contributes towards the Award in 'In-patient Service'.**

| Requirements | Behaviours | Guidance notes | Points |
|---|---|---|---|
| 1. Surgery CPD has been undertaken in the last four years by a team member and there is evidence of dissemination to the rest of the team. | | . | 10 |
| 2. At least one MRCVS has completed a module of the Cert AVP in Small Animal Surgery and there is evidence of dissemination to the rest of the team. | | | 30 |
| 3. At least one MRCVS has a post-graduate qualification in Small Animal Surgery and there is evidence of dissemination to the rest of the team. | | This includes AP status or an old style Certificate | 50 |
| 4. The preparation area is frequently cleaned so as to reduce contamination. | | The area must be kept clean of loose hair, debris and litter. Assessors will ask to see evidence of cleaning schedules. | 20 |
| 5. The operating theatre is damp-dusted before each operating session. | | Evidence could be supplied in the form of a theatre maintenance log or compliance with a cleaning protocol. | 20 |
| 6. Surgical assistants (where used) are RVNs, SVNs, Veterinary surgeons or vet students. | | Operating theatre rotas will be requested. | 30 |
| 7. Team members and/or observers involved in sterile surgical procedures are attired appropriately. | | All team members are clear about required attire and comply with the rules. | 30 |

| | | | |
|---|---|---|---|
| 8. Any jewellery which may cause a potential breach of the sterile field is removed prior to entering the surgical area. | | All team members are clear about required attire and comply with the rules. | 10 |
| 9. There are scrub facilities available separate from the surgical area. | | | 30 |
| 10. Scrubbing up facilities are available with suitable elbow, foot or electric eye operated taps. | | | 30 |
| 11. Sterile, disposable scrubbing brushes are used or a recognised brushless system is used. | | | 10 |
| 12. Immediately before surgery a check is performed on patient ID and the procedure to be performed including anatomical location. | | Assessors will ask to see surgery protocols or checklists. | 50 |
| 13. Recording systems are in place that include all team members involved and location for each procedure. | | This information could be combined with an anaesthetic record.<br>This enables auditing of post-operative complications. | 10 |
| 14. Surgical sites are prepared using clippers, fitted with an appropriate blade. | | | 30 |
| 15. Clippers and blades are cleaned and maintained appropriately. | | | 20 |
| 16. For surgery where the risk factors deem it appropriate a second prep is performed in theatre in a sterile manner. | | For example spinal surgery may require a second prep using sterile swabs to ensure sterility. | 20 |
| 17. A range of surgical drapes appropriate to the surgery undertaken are available. | | | 20 |
| 18. A mechanical means of suspending extremities is available. | | This is to enable the preparation and maintenance of a sterile field encompassing the | 10 |

| | | | |
|---|---|---|---|
| | | entire limb. | |
| 19. Standards are in place to maintain the sterile field throughout the whole procedure. | | Team members must be familiar with standard aseptic protocols. | 30 |
| 20. Surgical packs initialled and dated by the person packing them and labelled for contents where required. | | | 10 |
| 21. There is a method of administering intravenous fluids in the surgical area. | | This might include suspended bags or mechanical pump. | 10 |
| 22. Electrocautery is available and used appropriately. | | Appropriate use includes training of team members in use, cleaning and maintenance. | 10 |
| 23. Suction apparatus is available and used appropriately. | | Appropriate use includes training of team members in use, cleaning and maintenance. | 10 |
| 24. A means of maintaining body temperature during surgical procedures is available and is used appropriately. | | This may be achieved by using a warm air device. | 30 |
| 25. Laparoscopic equipment is available and used appropriately. | | Appropriate use includes training of Team Members in use, cleaning and maintenance | 10 |
| 26. Arthroscopic equipment is available and used appropriately | | Appropriate use includes training of Team Members in use, cleaning and maintenance | 10 |
| 27. | | | |
| 28. Single use suture material packs are used exclusively. | | | 10 |
| 29. There is an area used for non-sterile procedures (e.g. dentals, lancing abscesses) which is separate from the operating theatre. | | | 30 |
| 30. There is a check system to prevent loss of surgical equipment in the patient. | | This should include gauze swabs. | 20 |
| 31. Team members have been adequately trained in cleaning, maintaining, sterilising and troubleshooting of instruments e.g. ultrasonic cleaning, lubrication, sharpening. | | Evidence may be provided through team members training records and speaking to team members to check their understanding. | 30 |
| 32. | | | |
| 33. Lighting suitable for the accurate illumination of surgical sites on the | | This lighting must continue to function in the event of a loss of power. An operating lamp | 20 |

| | | | |
|---|---|---|---|
| patient must be provided in theatre. | | must be supplied by an uninterruptible power supply or a generator sufficient to complete a surgical procedure.<br><br>Surgical head torches can be used. | |
| 34. The practice has a protocol for the follow up of all surgical cases. | | | 40 |
| 35. Clients are provided with detailed written instructions on post-operative management. | | At discharge animals should leave with appropriate information for post-operative care provision by the client. | 40 |
| 36. The practice carries out an audit of post-operative complications for a commonly performed procedures. | Open, honest evaluations with clear actions, no barriers to feedback. | This should include an audit of surgical site infections. | 30 |
| | | **TOTAL POINTS AVAILABLE:** | **770** |
| | | **OUTSTANDING:** | **620** |
| | | **GOOD:** | **460** |

# PSS
# Consultation Feedback

## Inspector Response 1

I think the new AWARDS are inspirational, and really do give practices a pathway for improvement. However I think the bar is set very high, even for good in ALL EXCEPT ESC. The ESC module is fine as far as it goes BUT ESC AWARDS should include Pain module, and a great deal of Practice Team, Client Care and Nursing and Surgery modules, and I feel very strongly about it.

As an Inspector from the very, very beginning, as one of the few inspectors of all species, I have seen an awful lot of practices. Mostly I have seen Practices benefit from PSS, but there are a few that tick the boxes for the sake of it and do not embrace what we are trying to achieve. I feel very passionately that the new standards and awards will allow a significant number of corporate ESC clinics to pass at Good or Excellent and they are NOT. On the other side I feel that some very good GP Practices will struggle to achieve 60% in every component within their modules.

I looked at the survey and wasn't quite sure how much weight or clout would be given to such a serious concern.

I also found some anomalies in the RCVS presentation as explained to X.

## Inspector Response 2

Overall I have to say that I am hugely impressed with the amount of effort and detail that has clearly gone into these proposals. I like the way the 18 main modules have been organised and consolidated in places - certainly some improvements on the old format - and hope the new PSS Manual, when published, will follow suit.

One concern is that I feel there will be an awful lot of work in assessing some of the new awards - lots of detail, and clearly a need to talk closely with numerous members of staff if the findings are to be valid. Just as an example -'Module 16 .10.18. The team members understand the aims and objectives of the business to a level appropriate to their role. The assessor will speak to team members to ascertain their understanding'.

I think this will require a new mind set for the assessors - currently one tends to spend a lot of time with the practice manager/boss going through the paperwork - and then speak on an informal basis to other staff members whilst doing the grand tour of the premises - always a bit pot-luck, depending on who is available to speak at the time.

I think the new scheme will require a much more structured approach - with as many staff members as possible being available to interview on a one-to-one basis. Obviously all good stuff - but may prove time consuming (particularly if a practice is seeking a number of awards) and will require some good organisation/liaison with the practice before the visit. Clearly training of the new assessors is going to be very important if any form of consistency is to be achieved (still currently a significant issue in my opinion). I do hope you will recognise the experience that current inspectors have and keep on at least some of the old-timers.

Of course the sixty four thousand dollar question is whether the new scheme will attract fresh members - especially from the vehemently anti-PSS brigade - who, as I'm sure you are aware, can be quite intransigent and vocal in their opposition to anything involving the RCVS. I suspect the better cohort of current PSS members will embrace the new awards with great enthusiasm. One can but hope that it also attracts new blood.

Just thinking further about the survey during my normal insomnia last night - would suggest adding to the Award points:

**Module 3 Client experience, & Module 17 Premises:** Add points relating to adequate and convenient car parking for clients (and staff). I know of one SA VH where parking has become a major problem due to encroachment of yellow lines. Definitely does not give the client a good experience of the practice if they cannot park very close. Also staff not happy as they have to park miles away and walk to work!

**Module 4 Dentistry:** Add points for having digital dental x-rays (far superior to old fashioned dental films).

**Module 5 Imaging:** 8. Add points for myelography (still has a place if MRI not available/affordable).

**Module 13 OOH:** Add points if the practice has its own ambulance to ferry patients to and from their OOH provider.

## Practitioner Response 1

Note: Feedback from all new/old staff from receptionists to VS in SA practice group.

In general we agree with the idea of PSS and have been members since it was started by BSAVA and that the scheme appears to try and distinguish the average practice with those performing at a higher standard. However we do not feel that it

1. Is understood by the public
2. Distinguishes practices enough
3. Really gives us any advantage as we would try to achieve most of what is covered anyway

We hope that even if practices do not achieve outstanding in all areas but achieve good marks in every area then the report will show which areas such as MRI/CT etc for clients to read.

Every time we have an inspection it seems that the manual layout has changed. We like to keep an electronic file (to save wastage of paper and keep it very relevant) and having spent a lot of time organising our files under Sections 1-9 we are now very disappointed to find they have been mixed and matched to form 18 modules. By organising our information by Section we can direct any member of staff to exactly the right area for them to find out more information at any point at any time (we keep one paper copy in case of computer/electrical supply failure).

There has been a general feeling that some of the comments we have had over the years have been just to find something for us to do rather than convey any real advantage (other than maybe an aesthetically pleasing one) and have meant we have incurred costs to comply when the funds could have been used to fund more CPD or buy new equipment (having to put in a prettier flooring in the cat and dog wards rather than just have a concrete floor that could be hosed down was one example). Advice should be accompanied with very clear reasons why it gains an advantage to our patient/client care in these cases.

We are assuming that the largest number of practices in the scheme are GP (none of us remember seeing anything other than a total percentage of practices in the scheme) and are therefore hoping that the new scheme will better differentiate the different levels of GP practice.

Having looked through the award points scheme it does seem that GP are being included under the same umbrella as referral/VH's so we are not sure how relevant the final points will be – how many GP practices will actually have access to MRI/Scintigraphy/Slit Lamps/angiography etc or take referrals? Does this mean that GP practices are being discriminated against as we cannot achieve those points?

Some areas seem discriminatory – old practices will not be able to easily comply with some points e.g. fitting sinks in wards as there is limited space; CCTV cameras may not be relevant for rural practice compared to inner city? Are positive NPS – realistic for small independent GP?

What happens with Award Points such as CPD dispensing course – it is under Veterinary Hospital as a requirement but not GP yet accounts for 50 points. How does this work in the good/outstanding categories. It seems that both are under the same umbrella. If a GP needs this then it should be under GP requirements not VH. If it doesn't want happens to those 50 points?

Should the VH part have a separate award point scheme so for example if we say only VH are required to fulfil Award Point 10.3 then as it stands for Module 10 (as we are using examples from there)

Total points available 360

Outstanding 290

Good 220

Would it be better?

Total points available GP 310 VH360

Outstanding GP 240 VH290

Good GP 170 VH 220

Finally without the behaviour boxes being completed it is difficult to assess exactly how the scheme will work.

**Additional comments:**

SA

M1

- What is meant by proper ventilation?
- How can there be 40-80 points for CPD in anaesthesia but only 40 in other modules? Is anaesthesia twice as important?
- What is adequate CPD?
- Why does CPD have to be part of a certificate course?
- Checklists – we seem to require more and more lists which leaves less and less time for the patient? Should this be more defined? If we have more routine cases and less complex cases do we get full points if we use the form then? How often would you have to use them to comply?
- Are SVNs allowed to monitor anaesthesia?
- What is an appropriately ventilated recovery area?

M2

- How do you want evidence of frequency of meetings? Is this going to involve lots of records? We all talk about cases within the team but don't take formal minutes?
- Referral protocols – what if you don't take referrals? Do you lose these points?
- Lots of vague references – regular etc? What is meant by these? Small teams could end up spending more time having meetings and writing up minutes than seeing patients? Consideration for running a business – if not viable and fails then less choice for clients….

M3

- What sort of documented self study?
- Referral co-ordinator – what if you do not take referrals? Are points lost?
- Can some of this feedback be verbal?
- Should we really be educating clients about PSS? Should the RCVS be educating the public about practices that don't comply?

M4

- What counts as CPD for nurses – diets?
- What is appropriate ventilation
- Why does it have to be CPD as part of a certificate course – how do you define equivalent?
- Why is there a point about dental ethics? What about ethics in other areas?

M5

- Why CPD in last 2 years when other modules are 4 years?
- Seem to be more lists required & more paperwork evidencing training etc? Thought this was supposed to be less work not more? Is it not about what we do rather than having a list to say we did it? Easy to have a list but can they put it into practice? You will only be here for ½ a day to assess 2-3 awards – anyone can change their behaviour for a short time?
- Wet processing x-rays – do you lose points if you don't?
- Some of the points are for equipment that will never be used by a GP so GP practices will immediately have a smaller pool of points to work with to achieve outstanding? Is this fair? Will it only be referral practices and hospitals that can gain outstanding? How many GP practices have MRI/scintigraphy/slit lamps/retinography etc.

M6

- Are some of the requirements specialist for referral centres/hospitals? Is this discriminating against practices that want to do their own OOH but would rarely use these items /techniques e.g. CSF sampling/peritoneal dialysis?
- Are VS & VNs not trained in CPR? If they need further training how often should it be and to what level?

M7

- Every ward needs its own sink…fine for new builds but very difficult for a lot of old practices? Is putting a sink in a small ward not going to increase the risk of spread of infection via aerosol?? Are practices in old buildings being discriminated against?
- How realistic is it for GP practices to have negative air pressure?

M8

M9

- Presume outside labs are ok for histopath?
- Lab training – more records? Does it need to be annual or just new staff/new tests? If you do it regularly why do you need to train again? Should we all retrain annually to do cat spays?

M10

- Can the training in dispensing be online? Does nurse SQP training count?
- What if a practice isn't an internet retailer? Do they lose the points? Is that fair – surely most are not?
- Are you sure that written protocols for endo/ecto parasites will not encroach on clinical freedom? Should this be more about recommendations for parasite control than specific products?

M12

- Nursing care plans – are these not included in normal hospital notes – do all cases need specific separate plans? More paper to scan in/keep?
- RVN additional qualifications? Discriminatory…most RVNs with this work in referral/hospitals? Or does SQP/PHC count?

M13

- So does this mean you get 80 points if the ECC is outstanding (30 + 50)?

M14

- Can we have an example of a WDP? Concerns that these are interfering with clinical freedom.
- Are annual reviews of vaccination/parasite control really necessary?
- WTP – similar thoughts to WDPs

M15

- Again lots of evidence required which are normally verbal discussions. How will staff feel about extra recording etc?
- What evidence is required to be "clear and sympathetic"? Case records/observing client consults?

M16

- Mostly sound but a lot involve a lot of time for management staff which in small practices can be difficult to find that time. Balance required.
- Nothing about support of owners of practice?
- Nothing about client behaviour? Surely there should be an expectation of courteous and reasonable behaviour on their part also? What about disgruntled clients being able to post reviews on line that you cannot do anything about despite following all complaint/concern/dispute guidelines? This causes lots of stress to staff and often it is felt there is no protection from RCVS in these situations when team members have bent over backwards to comply and help.

M17

- CCTV & intercoms seems a bit OTT for rural practices. Unnecessary expense?
- Privacy for consults good but soundproofed rooms – that means then that there should be cctv in all rooms and/or panic buttons – we have certainly had situations when staff have raised an alarm as clients become threatening/abusive in a consult room and staff needed rescuing. Just look at misuse of soundproofed rooms in recent news!

M18

- Notices being displayed are a good suggestion but in practice you end up with all the walls covered and you cannot easily clean/disinfect! Notices should be discrete & essential – notices for everything means no-one takes notice of them!!
- Lots of referral elements in here so does that discriminate against GP practices as will never be able to attain those points.
- What if you do not have ethylene oxide? Do you lose the points?
- Requirement for CPD at certificate level & specialists discriminates against GP practices

**Farm:**

- How practical is recording a RA immediately before sedation etc?
- Positive NPS – realistic for GP?
- Wet processing x-rays – do you lose points if you don't?
- Records of ultrasound exams – clarification?
- Washing and disinfectant facilities – clarification – same room or area?
- What is the relevance of wearing gloves to the container 7.26
- Internet retailers – if not applicable what happens to the points?
- Realistic to expect written consent for major surgery/treatment on farm?
- What is meant by point 9.1 GP?
- What if don't use an automated device for OOH calls? Points awarded or not?
- How realistic is point 11.4?
- Lifting equipment – is that in referral hospitals??
- Ethylene oxide as SA

## Practitioner Response 2

**Anaesthesia Core Requirements 1.4**

Anaesthetic induction - given the QC's opinion obtained by the Nurse's Council the legality of any nurse involvement in the administration of induction doses of anaesthetic (even if pre-calculated/non-incremental) is questionable until Schedule 3 is re-written. This section merits redrafting.

**Anaesthesia Module Sections 1, 2 and 3**

The scoring of this section gives undue weighting to the presence in the clinic of trained personnel. My point is that a single member of staff could have undergone all the further training demanded and thereby would have accrued 150 points.

However this single member of staff has holidays, nights off duty, weekends off duty, sickness absences, and heaven forbid, even entire years out of the practice on maternity leave. During which time the whole basis for the practice claiming anaesthesia excellence under this module has been shot to ribbons.

**Clinical governance module**

It is very difficult to achieve 'Outstanding' in this category without 'contributing data' to external projects/studies (a total of 60 points). Is this really what the PSS is going to demand of independent private clinical practice? The purpose of a Practice Standards Scheme?

**Client Experience module**

**5.** Monitoring the time taken to answer the telephone…. Do I really have to raise reasoned objection to this proposal/demand?

**8.** A method of informing clients when running behind scheduled consulting times… Perhaps a receptionist with a watch…? Or do we have to invest in an expensive hospital-style flashing display?

**14.** 'End of Life Options' When I can understand this requirement I might be able to comment upon it.

**27.** An SOP for posting medicines… Exactly what standard of practice allows the posting of POMs?

In my opinion a poorly thought through module.

**Diagnostic Imaging Core Standards**

**16.** 'There **must** be a system of personal dose monitoring'…. Why? Our RPA has calculated that if one member of our staff took each and every x-ray at our clinic, remained within the controlled area but 1m outside of the primary beam, the TLD badge (the standard monitoring device) would be unable to register the scattered radiation received by the staff member. Consequently, and providing that we work to our local rules, we have been advised that to use these badges is worthless and we have therefore discontinued using them. So please tell me why the PSS demands that there **must** be a system of personal dose monitoring…?

**Diagnostic imaging module**

**1.** 'Diagnostic images are attached to patient records' OK for digital jpegs attached to PMS computer records. But how do you physically 'attach' standard x-rays to computer records…or to hand-written card systems?

**5 & 6.** Same problem as for the anaesthesia module with weighting based on additional training, which may all be invested in a single member of staff with all the consequences of absence.

**ECC Module Core requirements**

**7.** 'A full-time RVN must be employed at each premises…who shall be directly involved in such care'. If this is truly important to the PSS then the requirement should be for the constant presence of an RVN, for a single RVN cannot be present 24/7, 365 days a year. Nights off, weekends off, holidays, sickness absences, maternity absences, will all result in the clinic being deprived of the RVN that this standard considers so vital…

**ECC Module**

**1.** 'If covering for another practice…' There are numerous requirements in the proposed Standards that start 'If…' In other words requirements which are not relevant to the majority of practices. And yet scoring points are ascribed to these 'requirements'. This non-availability of points will be highly relevant, even unfair, for those trying to achieve recognition at the 'outstanding' level. Perhaps instead negative points should be awarded to those practices for which the requirement is relevant who then fail to meet it.

**3.** 'At least one RVN…must be on the premises during all the hours of operation of the clinic'. This requires clarification - advertised hours of opening, 24/7, anytime a vet is called back OOH etc? 40 points are at stake so we need to know.

This is a pivotal module for a couple of Awards. And yet it threatens to be unobtainable for smaller practices doing their own OOH work - requiring 'members doing 30% CPD on ECC work…acid base/lactate/bloodgases/epidural pain management/oxyglobin (whether or not it is usefu/available) together with the 20 points 'wasted' unless 'If covering for another practice…' is relevant.

**In-patient module**

As a comment, it is virtually impossible to achieve 'outstanding' in this module unless you are able to have staff on-site 24/7 (Requirement 14 & 16 = 80 total points) Which has the knock on effect that you cannot achieve 'outstanding' in the In-patient Service Award. Which may be the intention, I wonder if this is entirely fair? I can accept non-provision of 24/7 attendance as precluding excellence in OOH provision, but as a consequence this removes any chance of 'outstanding' for In-patient service at those clinics lacking in-house accommodation or lacking the need to provide (and finance) genuine 24/7. Has there been no consideration of the use of webcams, which can now provide both sound and vision for off-site monitoring by duty staff between return visits to the clinic?

**Lab and Post-mortem Core module**

Item **24,** appears to be a repeat of item **12.** and item **25.** of item **9.**

**Lab and Post-mortem General Practice**

Item **4,** seems to be a repeat of Core module item **18.**

**Lab and Post-mortem Award Points**

**6.** 'A haematology analyser is available and used appropriately to inform clinical decision making' = 30 points. It is well recognised that haematology analysers are pretty good at assessing normal blood samples, and pretty rubbish when it comes to abnormal ones. Their differential count is unreliable, their platelet estimations woeful (clumping issues). And yet the PSS demands that we have one. In truth, the important results for 'clinical decision making' come from performing a PCV and a smear. And yet these techniques are presented only as an afterthought (incorrectly printed as an addendum to the previous requirement 5. 'Electrolyte analyser') to the possession of an haematology analyser. I'm sorry but I feel the ability to perform PCVs and to properly read a smear is far more important and it should be worth 30 points in itself. To give the points simply to the possession of the analyser flies in the face of the stated objective of these reforms which were to get away from building/equipment and to recognise skill/ability in the clinicians and support staff.

**8.** "If bacteriology…' Same issues as other 'If…' clauses.

**Medicines Core Standards**

**12.** 'An adequate supply of medicines...**must** be readily available' An odd demand, however practical, in this age of the internet and prescriptions

**16.** Schedule 2 drug list omits Methadone which now has a veterinary license.

**Medicines Module Award Points**

**12.** 'The PMS identifies products under the cascade and prompts the user to label correctly etc'. This may be asking too much of the PMS. It would have to identify a drug, know which species it is licensed for, which conditions in that species it is licensed for and which it is not etc. A step too far I fear. 20 points hang on an impossible demand.

**13.** 'The PMS automatically labels products used under the cascade' Similar issues.

**Medical Records Award Points**

**3.** 'The clinical record system is set...to allow data mining….' Some PMS simply cannot provide this in a meaningful way as standard wording/clinical conditions was/were not central to the planning when the PMS was conceived and is difficult to introduce these retrospectively.

**Nursing Module Veterinary Hospital**

**1.** 'At least one RVN is employed' Same issues as discussed above - if the employment of a RVN is warranted under the PPS then how do you cover their absences…. Indeed how can one allow their absence and remain of Hospital status?

**Out of hour's module**

**2. 3. and 4.** Without a good score in this module it is very difficult to achieve a reasonable status in either 'Patient Consultation Service' or 'In Patient Service'. And it is very difficult to have a good score in this module unless you subscribe your OOHs to an ESC (**2.** = 10 points), subscribe to a practice which is "Good' ('or better….' *sic*) at ECC (**3.** = 20 points), or subscribe to a practice that is 'outstanding' at ECC (**4.** = 30 points).

There is of course the option to do it yourself…. As I pointed out above, even 'just' to be 'Good' at ECC may be beyond the reach of some smaller practices. And this coming from a College that wants to encourage practices to do their own OOH work!

**6.** 'If the practice takes referral cases….' Same issue as previously, but here the points awarded (10 points) are extremely significant where the difference between 'Good' and 'Outstanding' is only 30 points.

**Practice Team - Award Points**

**7.** Supporting PDP for New Graduates. Irrelevant to a practice which does not have new graduates working for them and therefore points unavailable to them.

**Premises - Award Points**

**6. 7. 8. 9.** This is a small module with limited total points and very little separation of the award levels (Good = 70 Outstanding = 90 Total points = 110). It is heavily dependent on technology/installations - external CCTV, internal CCTV, security lighting, intercom. Without investing in these it is impossible to achieve these award levels. I thought the PSS was trying to get away from assessment of the physical form of practice premises?

**Final comments**

Public awareness of the PSS is virtually zero. OnSwitch has carried out surveys - not once has anyone suggested to them that they made their choice of practice on the basis of its membership of the PSS. It will be for the practices to use their membership and promote it as their USP.

However, the descriptors must help practices in this promotion. We would certainly consider applying for assessment of a module if we thought that we could achieve an '**Outstanding'** classification. We would be far less likely to sign up if we could only achieve a **'Good'** classification…. I know it means more than that, but to the public it will sound like **'Adequate'** and little more. We need a stronger descriptor for this category.

And then there is the cost of getting modules assessed. Unless we can see a financial driver we are even less likely to apply. For example - Award 1 has 6 modules, Award 3 six modules, and Award 5 a massive eight modules. With a little (paper) work our practice could achieve 'Good' in all of these. Will we apply….? Probably not. Award 2 might attract us - a single module and one in which we can achieve 'Outstanding'. Award 4 - perhaps - but while we would be 'Outstanding' in Diagnostic Imaging, we would only be 'Good' in Laboratory and Post-Mortem. Though we could reach outstanding in Lab and PM if we bought a haematology analyser…. Back to the issue of equipment..

**Solutions**

**Anaesthesia Modules 1, 2 and 3**

Restrict the points any one person can garner to one of these sections - if a practice wants points from more than one section then another member of staff must have done the CPD and earn the points (Similar solution under Diagnostic Imaging)

**Out of hours module**

Given that this module contributes to two 'service' awards (let's stress the service/convenience aspect here), and that most OOH cases are not genuine emergencies, and if they are, they are easily and competently dealt with by 1st opinion practitioners…. add another section ***'Does the practice provide its own, in-house OOH service?'***

40 points Then have the other categories if you subscribe/delegate to another service with the points reflecting the level of expertise provided practice to which you delegate.

**'Good' and 'Outstanding'**

How about 'Superior' and 'Outstanding' Then I'd sign up! (And I'm the sort of practice you want to attract - former member of the PSS but left it several years ago)

## Practitioner Response 3

Note: FA Practice director.

I was reading through the PSS consultation document and had a few comments I wanted to pass on. I will copy this to RCVS, but thought getting something into BCVA was also helpful.

1. There is no recognition anywhere for practitioners that have taken additional qualifications, certificates, diplomas (PhDs!), achieved advanced practitioner or even specialist status. That could fit under 'practice team', 'outpatients' or even 'surgery'. In general considering there are many fewer farm vets cf pet vets the number with (and studying for) additional qualifications seem higher on the farm side. These qualifications do count in both the equine and small animal awards.

2. A number of farm practices do have hospitalisation facilities for calves and sheep and some have the ability to hospitalise larger animals, either for surgery or for things like embryo transfer programmes. I think the ability to hospitalise large animals should be taken into account with the scheme - it allows different farm animal practices to distinguish themselves. I would suggest a practice that has a clean room and gaseous anaesthesia is repairing a calf hernia to a higher standard than one doing it with xylazine/ketamine on a bale in the calf shed!

3. I would like more emphasis given to other procedures and skills that set different practices apart. I am thinking embryo transfer work, fertility testing (how about having points for a vet who's done the BVCA bull course?), dye testing, laparoscopic D/A surgery, paraprofessionals, farmer training, CPD for other vets etc. I love the way we need a heated stage on the microscope but no requirement to have an EEJ or an AV..... It is 2015 I think the practices that engage well with their clients are doing more than a herd health plan (compulsory anyway), the odd newsletter and farmer meeting. I would like to see this area more beefed up.

4. I'm unsure why the 'surgery' module makes up a part of 'advisory/consultation service award'. I think an award acknowledging the OOH and emergency work that we do would be valuable. Reasonable response times to genuine emergencies, sufficient staff on call, equipped, back up etc.

5. This may be a bigger aspiration than the tweaks I have suggested above - but I think what farmers would find more appealing would be practices graded for different species - 'outstanding for cattle' and 'good for sheep' or whatever. Maybe even split beef/dairy. I think that would be more meaningful than being outstanding at client service or team and professional responsibility. It would set practices apart. I think a lot of the emphasis seems to be in the wrong areas. Not what a farmer new to an area might be looking for. We need to be mindful that this is useful to our customers - parts of this are not.

I like the idea of the new system, and we are thinking of joining the PSS, but reading through the document I suspect that 75% of farm practices can go for the outstanding awards with almost no extra effort. I'm not sure it does enough to distinguish between practices - and I thought that was the whole idea!

## Practitioner Response 4

Note: Independent Veterinary Advisor.

Looking at the consultation in general I have a few observations.

**Advanced Practitioner**
At a few points there are references to extra points for having an AP. I'm concerned that this is another step away from the old style certificate. I'm concerned that number 2 of the Anaesthesia awards seems to give equal weighting to "a module of the CertAVP" and the CertVA. One module would not be equal to a certificate.

**Infection Control**
It is implied, but I think it is better to state good antibiotic use, than focus on resistance. The whole point is to use what we have more wisely, not just consider resistance.

**Written Consent for off label...**
Disappointing that individual written consent is still required. Verbal is perfectly acceptable and blanket would be better. I don't understand the PSG being content with this.

**Hospital**
At least one VN – minimum half the nursing staff I'd say.

**OOH**

This is unclear as it seems to suggest that only a practice that can pass as an emergency clinic can gain outstanding in this area. This is wrong. The emergency clinic business model is to do everything that night. The practice will do what the animal's needs dictate. Both can be excellent.

**Firearms**
Both SA (not sure what SA beasts need shooting) FA and EQ, all it needs state is that each vet who uses the firearms/dart gun, must have their own FAC (copies should be allowed for inspection as leaving an FAC is not advised). A separate inspection for storage is not necessary.

**OOH care**
I notice the module states rest can be on the premises, so this might not count as rest. I also notice that the weighting for awake and on the premises of 60 points means that it is unlikely anyone without permanent night staff can be outstanding. We should not be encouraging a 24hour service culture!

**Premises**
Core – consulting room can be used for other things. Yes, but just not simultaneously. There is precedent for this as section 18 Surgery says an op room must be separated temporally or spatially.

**FARM**
Same comments on infection control and weighting of good use not just resistance (and anthelmintics).

**Surgery written consent...** Not a chance of this on every occasion, even at all. Equine owners definitely!

**General**
Where the evidence of excellence? There should be something whereby a practice gets extra points for post graduate qualifications (those of pertinence). Perhaps under practice team "a culture of promoting further education and learning". A practice with several cert holders is likely to be a far better practice than one with none.

**Other thoughts**
How do referral centres fit in this? A friend has an orthopaedics place, hospital standard, yet can't fit PSS as he has no dental machine. It needs to be made clear within the scheme that referral practices can apply and have irrelevant sections ignored. This won't entail a change to the original standards, just the ability for inspectors to disregard sections that simply don't apply.

## Practitioner Response 5

Note: Additional SPVS response 1.

Professionally progress is always likely to be sought by the more 'engaged' members of any profession. In our case I would expect the more forward thinking/ambitious/engaged/etc to be the ones involved in SPVS, RCVS, etc, etc. Following on from this there is a slight risk in this that the view that there has to always be progress might be seen as the view of the entire profession which might not be true.

If the PSS became compulsory in order to raise standards, which appears to be what the RCVS wishes to achieve, then the costs of running a practice will increase. That cost has to be passed on to the public.

There is currently a part of the population which will not pay for treatment of their pets. There is also a part which is prepared to pay a minimal amount for treatment if they feel it absolutely necessary. If across the board all practices have to improve their standards then that section of the population who are looking to source cheap veterinary care may no longer be able to find that care.

Is compulsory advancement of standards going to enlarge the proportion of pets that receive no care? Would it be wise to allow the public to choose the level of care that they can or are willing to provide for their pets, including low cost care.

I am sure the RCVS will have considered the above and would not want to adversely affect the welfare of 'the lesser fortunate' animals whilst striving to increase the welfare of the 'more fortunate' by enforcing higher costs of care to the public. I thought it worth mentioning just in case though.

## Practitioner Response 6

Note: Additional SPVS response 2.

**A first opinion practice response to the revised PSS proposals:**

We feel the committee has been rather disingenuous in the way they have asked for views from the people they claim to be promoting. We have been in the practice standards scheme from the start and have been a veterinary hospital for 40 plus years so we felt obligated to try and provide an input into the proposals going forward. However, we feel that the people driving this reform are only paying lip service to the request for input from practices that will be affected by their proposals. The document is huge and the proposals far reaching so it would have been reasonable to expect that any document being presented for review would indicate the changes that were being made and on which comment was being solicited. It is virtually impossible to dedicate the time to go through the basic PSS requirements on a line by line basis to find what obligations have been introduced for the various levels. We are afraid that we have not had the time to do this and are concerned as to what might have been included. Changes should have been separately listed for comments. At the very least someone should have been responsible for getting the Module numbers correct on the download information.

On a similar basis it is ridiculous that the system offered as a means of submitting our responses does not allow for a partly completely report to be saved. This is a very basic computer facility but significantly limits our opportunities to complete it in amongst a busy practice environment. Again one has to question if the parties involved are sincere in seeking our opinions.

**General Points:**

- Whilst totally understanding and supporting the pursuit of excellence more attention needs to be given to the reality of life on the ground. Even the RCVS's own review suggested that in order to flourish in the future practices needed to take back some of the work that is currently being referred. We currently refer very little and believe that we provide veterinary medicine and surgery to a high standard and would question what the certificate type approach would bring to the vast majority of what we do that the extensive CPD we undertake does not achieve. Whilst totally supporting the concept, there is a very fine line as to how this can be achieved. The bottom line is that we are a commercial organisation and everything has to be paid for by the client. Endless auditing also requires resource which costs money. We are concerned that if this process continues with the same apparent lack of fundamental understanding of the way the real world works the whole scheme could have some very undesirable unintended consequences for the vast majority of clients.
- The focus on RVNs is completely unrealistic and untenable. RVNs are in very short supply – not in terms of the number qualifying but in terms of the retention of their services. We are

lucky enough to employ a high percentage of RVNs but it is as a result of offering them rotas that largely do not involve out of hours or weekend work. RVNs understandably want a good work life balance and this needs to be reflected in the proposals.

- Outstanding awards should be achievable by a good first opinion practice. X comments about a banner in Wales on a school stating 'we are good but we are aiming to be outstanding' identifies a very fundamental lack of understanding of the way the world works. The fact that you would be pleased that the school your child was allocated to was trying to improve would be a good thing as you are presented with no other option and just have to keep your fingers crossed that it happens quickly enough for your child. One cannot get the same level of comfort from knowing that your veterinary practice was still trying when potentially there were other options in the area. The difference between the private sector and a more commercial environment must be understood.
- We are surprised that the RCVS has decided to adopt an Ofsted type approach because of all the recent bad press it has attracted. We feel that the whole system will be abused. Just as with schools, Practices will work hard to achieve 'outstanding' in one element and then attribute it on their marketing and web site to the whole practice. This will achieve little.
- No consideration seems to have been given to differentiate a branch surgery with access to a hospital as opposed to a standalone small practice without any access to equipment, labs etc. In rural practice it is totally unrealistic to provide full facilities in every location where, for client convenience, we carry out routine first opinion consultations but we would maintain that they are much better provided for by having unrestricted access to our hospital with its out of hours cover and full range of equipment than they would if it was just a standalone practice with the same facilities at the branch location.
- Consideration needs to be given to the level of documentation that is being proposed and the impact this will have on resources within the company and the subsequent 'on cost' to the client. Whilst I am sure everyone would support auditing to the 'n'th' degree would they be prepared to pay for it? In today's very cost conscious and competitive world the proposals need to have their feet firmly based on the ground or they will price veterinary services outside of the pocket of a lot of people.
- Finally we would repeat what we have said repeatedly and consistently at every level of this review. As the RCVS has been unable to establish a differentiation in the public's mind of the existing three levels why on earth are they trying to complicate the proposition still further?

**Review of Awards**

**Module 1**

Point 2 – too many points associated with this requirement.

Point 3 – too many points associated with this requirement – where is the evidence that says this level is required to be outstanding?

Point 14 – a SVN should be added to monitoring of an anaesthetic

Point 17 – unclear what this means exactly

**Module 2**

Point 12- far too many points attributed to this point.

**Module 3**

Point 8 – besides offering tea and apologies we are unclear what is expected here as the clients will already be within the building.

Point 10 – Not sure what this Pre-PSS inspection client questionnaire is designed to achieve and how frequently it will need to be used.

Point 17 – In a 24 hour a day operation this is totally impractical if this is really to be 'an' individual and it is unclear if this is designed for referrals in or out.

Point 26 – To give this item 40 marks is ridiculous – this does nothing for the client experience and whilst nice to have does not merit 40 marks.

Point 27 – Unclear what this point requires – there is certainly no need to 'deliver' repeat dispensed medications and it would push costs up exponentially.

**Module 4**

Point 9 – do not feel this is appropriate or applicable.

Module 6 – which we have taken as Module 5

Point 11 – we are unclear what this element is doing in a small animal award.

Module 16 – Emergency and critical Care which we have taken to be module 6

We are unclear if this is supposed to relate to general practice or is just a stand along out of hour provider. We feel that some of this should be included in the out of hours provision we provide but by no means all of it.

Point 1 – Clarification on what exactly is felt to be appropriate – in practice totally impractical to implement. What happens to the marks if you don't cover for another practice – if you just don't get them then you are effectively being penalised as this reduces the margin between good and outstanding.

Point 2 – the percentage allocated to this aspect is far too high for a rural practice – this sort of thing just pushes up costs or reduces the likelihood of even bothering to do out of hours which will end up with the client having to drive miles to their nearest out of hours clinic – hardly a benefit to the client of us being a member of the scheme! What is meant by the ECC team? – not really appropriate to general practice. This relates to my earlier point of all practices must be able to achieve outstanding in all elements or they may be commercially disadvantaged.

The allocation of marks in the point is also too high – the difference between good and outstanding is 110 and this one item accounts for nearly half of the difference.

Point 5 – the list is far too specific and individual clinician may not feel the need for some of these – again we would question if this would just push prices up unnecessarily – we have no experience of needing anything like this level for the type of ECC we deal with. If the practice can supply supplementary oxygen then there should not be endless points for different ways of doing it. Consideration should be given for the likelihood of drugs etc going out of date – the requirement should be more pragmatic.

This whole module seems to be totally out of touch with reality – if the objective is to push everyone into big out of hours clinics then that is one thing but consideration must be given to the lack of animal welfare that would result in rural areas. Please get real.

**Module 7**

Point 14/15/16 – The requirement for an RVN needs to be replaced by and RVN or SVN otherwise it is totally impracticable.

**Module 9**

Point 8 – these marks should not be lost is the practice does not do bacteriology on site – comments ref reallocation of marks above applies here too.

**Module 10**

Point 11 – what happens to the marks if we are not an internet retailer?

Point 12/13 – it is difficult to see how every single drug is categorised for all the possible incidences where it should come under the cascade regulations – this has to be down to the dispensing veterinary surgeon whose responsibility it is and should remain.

**Module 11**

**Module 12**

**Module 13**

Point 6 – what happens to the marks if we don't take referral cases?

**Module 14**

**Module 15**

**Module 16**

Point 13 – we do not agree that every individual should have their own induction program – we feel it is essential that all members of the team have the same induction program on joining the company which will include a team specific addition – i.e. nurses – vets – reception.

Point 25 – where on earth do we go to get professional ethics training and why do you assume we have not got very responsible professional ethics already.

**Module 18**

Point 7 – why do the scrubbing brushes have to be disposable – just pushes up costs.

Point 23 – what happens to marks if you are not using the laser.

Point 28 – what happens to the marks if you are not using ethylene oxide.

We have assumed that we have to get all the marks in order to get any marks for each section but what is the situation reference the collection of modules for the awards – is it done on a total of the points or does each individual element have to be outstanding to obtain an outstanding award?

Further consideration should be given to the naming of the modules – we are not sure what some of them mean so what the public are supposed to do we don't know.

ROYAL COLLEGE PRACTICE STANDARDS SCHEME – SMALL ANIMAL

DRAFT MODULES FOR CONSULTATION FEB.15

[redacted]

Hard copy done as having done this on line originally – it crashed half way through!

MODULE 1
Page 12 point 1 - guidance notes need to be a bit more specific about what type of CPD is required – does a lunch and learn on a new drug count?
Page 14 point 1 – what constitutes the "team" e.g vet/nurse dealing with a particular animal or one of the vets or nurses in the surgical area on that day. Need to be specific.
Page 16 point 16.iv – should this not be cardiac rate and rhythm?

MODULE 3
Page 26 - labelled as module 10…
Page 28 point 14 - some of the staff interpreted this as to include palliative care and if this is the intention then it will need to be a vet or a senior RVN - needs clarifying.

MODULE 4
Page 32 – labelled as module 3
Page 33 – labelled as module 3
Page 33 point 3 – is placing the corner of a screened plate in the mouth or taking lateral or d/v v/d x-rays of the jaw be sufficient? If not, this needs to be clarified.

MODULE 5
Page 41 point 17 - left hand column - no mention of "depth" – needs to go in after exposure factors
Page 45 point 18.iii – Is this full marks for urography AND OR angiography – needs to be clarified.
Page 45 18.iv – Do you get full points for having one flexible endoscope where you do GI work but cannot do lower airways? ? 5 marks for GI and 5 marks for bronchoscopy? Needs to be clarified.
Page 45 18.v – Again do you get full points if you have one rigid endoscope that is only suitable for using in the GI system? ? 5 points for a large rigid endoscope and another 5 points for being able to do arthroscopy / rhinoscopy.
NO MENTION OF LAPAROSCOPIC abilities NEEDS adding
NO MENTION OF CT SCAN ability NEEDS adding
Page 49 point 20 left hand column - NEED x-ray in front of ECG

MODULE 6 ECC – labelled as module 16
Page 51 point 5 - NEED to include in the list, x-rays and ultrasonography
Page 51 point 4.v – NEED to include aPPT, PT (and BMBT)
Page 53 cont. of point 5 – Should you be a listed member of the "Tox Box scheme" (no cost involved and a few rules to comply with regarding costs? We just phoned the Poisons B and they added us to the list.....
Page 53 point 9 - Should this read FAST and E-FASTscans rather than T-FAST??

MODULE 7 infection control
Page 59 point 4 - ?Include management of utensils e.g. litter trays, feeding / water bowls / bottles

MODULE 8 In-patients
Page 62 left hand column - NEED to include BCS and acute pain score

Vet. hospital
Page 64 point 1 - NEED Isolation facilities suitable for infectious diseases and others e.g. animals on chemotherapy
Page 64 - NEED Must have access to multimedia monitoring facilities 24/7
Page 64 - NEED Must be able to provide enteral feeding e.g. NE, J Peg or Peg tubes
Page 64 - NEED Must have the ability to place thoracic drains & indwelling urinary catheters
Page 67 - NEED ability to monitor 24/7 critically ill patients e.g. ECG, BP, SPO2,
Page 67 - NEED ability to provide enteral feeding
Page 67 - NEED ability to place and manage thoracic drains & indwelling urinary catheters

MODULE 9 lab and PM
*What if you have a good lab system but are not an ECC – should you not be able to accumulate points for all the tests carried out and listed under module 6??*

Page 76 point 2 - Left hand column NEED "and cytology"
Page 77 - NEEDS the practice has the ability to measure (page 51 and page 52 in ECC AWARD POINT system) adding to the list
4.i
4.ii
4.iii
4.iv
4.v
5.iv and blood typing
Page 77 point 12 and13 – *How would the practice demonstrate this on the day? Is there going to have to be photographic evidence?*

MODULE 10 medicines

Page 89 point 33 – Reads for storage, administration and disposal (NEEDS DISPENSING adding) and do you only want SOPs??

Comment: *Should there not be a requirement that if delivered ,that not only do they have the SOP but they also have the facilities to deliver the medications safely (appropriate room, fume cupboard, needle free administration, special PPE, facilities to hospitalize safely with regards to waste disposal etc.)?*
*Though not a legal requirement, the safe preparation of cytotoxic/ cytostatic medication should be prepared in a class II microbiological safety cabinet and there are guide lines as to the safe administration and preparation in terms of PPE etc. These are available from ECVIM*

Page 94 - Additional point NEED The practice has a protocol(s) for the medical treatment of neoplasia e.g. CHOP, COP etc.

MODULE 11 medical records
Page 98 point 2 - NEED BCS and acute pain score adding to list
Page 102 point 7 - NEED to include BCS (relevant if very over weight)

MODULE 14 out patients
Page 118 point 5 - NEED adding to the list of protocols

Obesity
Hormonal: diabetes / hypo
hyper thyroid / adrenal
Oral disease
Pain management

MODULE 15 pain management
Page 22 point 5 comment:
*Glasgow pain score is validated only for acute post operative pain and only validated for dogs.*
*There is no validated acute pain scale for cats but the Colorado scale is helpful.*
*All pain scales suffer from interobserver variation. This applies to all, VAS scales, LICKERT scales. What is important is that ONE scale is used through out the practice.*
*There is no validated pain scale for chronic pain , nor for measuring QOL that is widely applied. Many have been developed for a variety of diseases though all suffer from subjectivity leading to variation. From : N Palmer BVSc MSc (Clin Onc).*

MODULE 16 practice team

Page 127 point 16 - Right column – NEED liquid nitrogen
NEED rather than just x-ray machine state "imaging equipment" or will have to list x-ray, CT, MRI, scintigraphy, ultrasound
NEED autoclave, and ethylene oxide equipment
You have mentioned stress twice down as work related stress on page 128 and down as "stress" on page 129
Page 130 point 19 - Right column first paragraph NEED EO, ultrasound and CT equipment adding to the list
Page 129 point 18 - Right hand column NEED chemotherapy adding to the list of examples
Page 133 point 34 - Right hand column NEED in the 4th paragraph, second bullet point "Policies and practice to segregate AND LABEL into appropriate streams and to store it hygienically" (it has to be traceable back to the practice after leaving the premises)
Page 139 point 22 - Middle column NEED TO BE MORE SPECIFIC
e.g. fire and flood?

MODULE 18 surgery
General practice page 148 - NEED if the practice carries out chemotherapy there must be a written protocol for (or not for) carrying out surgery on an animal undergoing a course of chemotherapy.
Page 150 point 4 - Guidance notes NEED large animals must be transported between the preparation room and theatre on a trolley.
Page 24 point 24 - Do you mean they HAVE to be used at all times or ARE AVAILABLE?
Page 24 - NEED There is an area identified that can be used for the administration and kennelling of animals receiving chemotherapy medicines (e.g. low through put of staff and other animals)

**RESPONSE TO THE RCVS CONSULTATION ON THE PROPOSED DETAIL OF THE REVISED PRACTICE STANDARDS SCHEME**

The British Small Animal Veterinary Association (BSAVA) exists to promote excellence in small animal practice through education and science. It is the largest specialist division of the BVA representing over 9,000 members, the majority of whom are in general practice and have an interest in the health and welfare of a wide range of small companion animals.

The BSAVA support the RCVS Practice Standards Scheme and through representation on the Practice Standards Group and have been involved in the working groups which developed the modules. We appreciate having had the opportunity to comment throughout the development of the revised Practice Standards Scheme, and support the move away from inspections based on paperwork and facilities and the introduction of provisions that relate to the standards of care. However, we appreciate that this is a process that is still developing and hope that our comments will contribute to that process.

**How clear do you think the Awards are to the profession, and to the public?**

In general we believe that the concept of the awards should be understandable to the profession. However, while we appreciate that the structure of the awards is intended to encourage practices to improve standards, by working towards different awards, concern has been expressed about whether this added level of complexity will be understood by the public and whether they will be able to actually use the awards to be able to compare and choose between practices:

*"Although I think the concept is understandable to everyone, I don't understand the point of setting different areas for recognition. Either the whole Practice functions as a whole in every area or it doesn't. Are the public supposed to choose a Practice because it scores on A&E or image? Is A better than B because it scores higher? This is likely to cause big problems and divisions and because we are so dependent on our Staffs' abilities, how can we guarantee consistency and continuity."*

While we appreciate the reasons for choosing the designations good and outstanding, since they are used by Ofsted and already understood by many members of the public, we think that it will be important to make the differences from Ofsted clear in the following respects:

1. Ofsted inspections are compulsory
2. The Ofsted scheme has 4 Outstanding/Good/Requires improvement and Inadequate
3. The PSS is a voluntary scheme, and the awards are a voluntary add on within the scheme, therefore not all practices will achieve these designations.

If these differences are not made clear the public may assume that practices that do not have awards at good or outstanding levels are in need of improvement or inadequate.

There is still concern in the profession that there is little awareness or understanding of the scheme by the public, changes to the scheme will need to be well communicated if public understanding is to be improved.

**Are the Awards titles correct and are they configured to the right modules?**

We think that this question is probably most appropriately answered by talking to members of the public to see if these titles are understandable and cover the areas of most importance to them in selecting a veterinary practice.

One member has suggested that award titles could relate to specific disciplines:

*"Maybe special interest areas would be appropriate; this would be where a Practice is very keen on a Discipline but has nobody at Certificate or Diploma level*."

We do consider that the Emergency and Critical Care Award should include, as a mandatory minimum, the Inpatient care, Pain management and Nursing modules. However, we acknowledge that there may need to be amendments to some of these modules to ensure that they can be achieved by Emergency Service Clinics as well as practices providing a daytime or 24 hour service.

**Are the awards pitched at an appropriate level?**

We think that the expectation of achieving approximately 60% of points for good and 80% for outstanding in a module is appropriate. However we also note that there is a significant difference in the number of points within modules and modules within awards. We think that it would be helpful if they were more even as clients will probably not grasp that some awards are easier to achieve than others. It will be important to clarify whether (and how) practices will be able to promote achievement in individual modules.

**Do you agree that practices should only be able to outsource their OOH to practices that meet or exceed their own accreditation level?**

In general we think that this is sensible provision and appropriate for practices that outsource their OOH to another provider. However, as there may currently be practices which share rotas with practices who are at different levels in the PSS, if they are to be included in this provision we would suggest that, as with the requirement for Veterinary Hospitals below, they are given a grace period in which to comply with this provision. It is also important that practices outsource their out of hours to practise which are able to deal with the full range of species treated.

**The revised Scheme also stipulates that, within five years, Veterinary Hospitals must provide out-of-hours cover from their own premises. Do you support this proposal?**

Yes, we agree with this provision as we think that a large number of members of the public (and some members of the profession) would assume this to be the case already. However, if veterinary hospitals are to do this they must do so at a level that meets their daytime accreditation level.

**What do you think about the proposed IT system aimed at supporting the scheme?**

BSAVA are broadly supportive of the proposals for an IT system which will allow uploading of documents as we believe that it has the potential to make tracking of paperwork easier and that

many practices will appreciate a reminder system. However, we do not think that the IT system will replace the need for a useable manual as many practices will wish to study the manual, both in deciding which awards to work for and during the preparation process. It will of course be essential that appropriate security is in place to prevent unauthorised access to any data held on the system.

**General comments on modules and awards**

1. While we support the modular structure of the scheme we think that this has introduced some anomalies within the modules in which requirements and additional award points have been included. As a practice may apply to be examined for awards separately it will be important to cross reference that some general provisions or provisions from other modules relevant to the functioning of the module being applied for are not overlooked – e.g. The Nursing module should include the requirement that all RVNs employed by the practice have Professional Indemnity Insurance in place (Practice team requirement 2. and points for being an approved VN training practice (Practice Team point 30). E.g. Infection Control should include requirements from the surgical module relating to maintenance of a surgically clean environment, sterility indicators and surgical gloves and gowns. We realise that this may mean that some requirements are included in more than one module but we think that this would be better than giving an award when provisions relevant to the practical impact of the module are not in place.
2. Some modules are quite complex and the number of points within them large; some further consideration could still be given to streamlining (see for example comments on module 3).
3. Short modules (these tend to be the new areas) would benefit from inclusion of points that are covered elsewhere. We believe these points should be duplicated to avoid someone being able to claim they are outstanding while not covering some essential points – Nursing and Infection Control seem to be the most relevant here – see my notes in point 1 above.
4. We consider that it would also be helpful when preparing for an inspection if, in each module, the points were laid out in the same order e.g. premises, staff/training, equipment, protocols, behaviours. We understand that the new IT system is intended make the requirements clearer, but many practices actually like to work through the manual in the order it is written.
5. There is inconsistency between modules in the number of points awarded for similar achievement. The most obvious example being how many points awarded for having someone with a CertAVP (or equivalent) in the practice and how frequently CPD needs to be updated. In Anaesthesia you may achieve 40 points per module (up to 80), in Dentistry it is 30 points (though as far as we are aware there is currently no provider for the CertAVP modules), while for Surgery you may only receive 20 points.
6. There are still many examples where the points are awarded demonstrating possession of equipment items, where appropriate these should be reworded to make it clear that it is the behaviour in the use of the equipment that gains points rather than just having the equipment available, as this is likely to be seen as continuing to promote a tick box inspection. It will also be important to provide the profession with more detail about how behaviours will be inspected and assessed to provide reassurance that this will be a robust and transparent process.
7. While we acknowledge that it will often be easier to inspect processes for delivering care we believe that practices which are able to demonstrate successful outcomes by other means should be able to achieve points for this. We firmly believe that clinical audit relevant to the subject should be included as a method of earning points in all modules.
8. Modules relating to Emergency and Critical Care and Out Of Hours - we still have concerns that these two modules seem to be conflated in the scheme, and while the manual states

that any practice can achieve the module in ECC (and therefore as it stands an award in Emergency and Critical Care Service) the basic requirements for the ECC module are taken from the ESC standard and don't always translate well when applied to day clinics. Specific comments on these two modules are included below.

## Comments on individual modules

**Module 1 Anaesthesia**

- Requirement 10 - a clock or watch showing seconds must be visible to any team member monitoring an animal under anaesthesia or sedation. We would recommend that this is replaced by "a means of accurately timing HR/RR".
- Points 8 & 9 - need clarification regarding when reference is being made to the AVA checklist and when using the ASA risk assessment .

**Module 2 Clinical Governance**

- The guidance notes in point 5 appear to relate to point 4.
- Point 8 - guidance is needed on how frequently regular review is required.

**Module 3 Client Experience**

(NB at the top of Page 26 this is referred to as module 10 instead of module 3)

- Point 5 – guidance on monitoring time taken to answer the telephone. Does the monitoring need to be constant, frequent, regular or occasional?
- Point 7 - regarding reminders – we would suggest that this is amended to: "There is a reminder system in place for a range of common conditions". Although the suggestions vaccination, follow-up examination, dental checks and parasite control have been moved to the guidance the points against them suggest that they will still be used as requirements rather than suggestions.
- Points 11, 13 & 14 - could be combined into one: "A member of the team has undertaken "... with individual points listed.
- Points 15, 16 & 17 - could be similarly combined: "Team members are…". With regard to point 16 we would consider that offering options, considering animal welfare and discussing finances should be part of the core standards as they are covered in the code and supporting guidance.
- Point 17 - "There is an individual that acts as referral coordinator that takes responsibility for all records and ensures all processes are followed". We consider that this point needs clarification as it implied that one person is responsible for all referrals. While we acknowledge that it may be appropriate for one person to take responsibility for ensuring that processes are followed we think that it should be made clear that the process of referral is most appropriately carried out by the clinician responsible for the case.
- Point 26 - refers to team being educated – while other references refer to training – is there a reason for this difference in nomenclature for this particular point?

**Module 4 Dentistry**

- The reference to dental compressor >250bar written scheme of examination is in the current standards but does not appear to be in this section although it does appear in section 7 Infection control.
- Point 2 – is the reference to certificates in the guidance relevant to veterinary nurses?
- Point 3 - clarification is needed regarding whether fulfilment of this point within the last 4 years would also fulfil (and gain points from) point 1. Also although there is reference to a dental module of cert AVP we are not aware of anyone currently providing this.
- Point 5 – replace' covered' by 'treated'.
- Point 9 – presumably magnification only needs to be available / used where appropriate rather than in all cases?
- Point 10 - local anaesthesia - should this include a wider provision for analgesia or if this is meant to specify local anaesthesia should there be a separate requirement for systemic analgesia?
- Point 12 – further guidance is needed, is this meant to refer to drainage from the mouth or waste disposal from the practice (drainage from the tub / dental table)?

**Module 5 Diagnostic imaging**

This has been labelled as Module 6 on page 44.

- Points 5&6 – if completed within last 2 years does completion of 6 provides points for 5 as well?
- Points 10 & 11 – standing MRI and scintigraphy would appear to be more appropriate to the equine module
- The overall points do not add up correctly (possibly as a result of points 10 & 11).

**Module 6 ECC**

(This module includes requirements for Emergency Service Clinic)

(This is referred to as Module 16 at the top of page 51)

Comments in this section predominantly relate to how these provisions would be applied to a general practice who might wish to achieve the award in ECC and need to fulfil the requirements of an ESC as stated on page 9 of the manual (practice premises wishing to achieve the Award in Emergency and Critical Care Service must also meet the Emergency Service Clinic (ESC) requirements within the Emergency and Critical Care Module).

With respect to the award points this module still appears to be predominantly a list of facilities and procedures with little emphasis on behaviours or outcomes.

- Requirement 1 - “A full-time veterinary surgeon must be employed at each premises who shall have overall responsibility for all emergency and critical care and professional matters within the clinic”. Will this apply to all practice models where, in contrast to most ESCs, which are primarily providing cover at night, there are several VS working during the day, all of whom may deal with ECC cases?
- Requirement 3 - “A one-year CPD plan must be provided for the ECC team”. Would this be interpreted to refer to ECC CPD for the whole practice team or all CPD?

- Requirement 5 "When covering for another practice, a written agreement must be entered into with the client practices which includes a written policy on surgical complications of their cases and daily reporting of clinical records back to the client's practice." Presumably for a practice that is completing this module to achieve an award in ECC but is not providing services to other practices this would not apply and the opportunity for awarding points could not achieved?
- Requirement 19 - "A practice team member is dedicated solely to monitoring the condition of each anaesthetised patient until fully recovered at all times". While this may be appropriate for ECC cases would it be required for all cases in a general practice seeking award in ECC?
- Point 2 - "Members of the ECC team demonstrate that at least 30% of CPD is specifically relevant to ECC work". Again if this were being applied to a whole practice rather than an ESC would this be applied to whole practice team or as in other modules to certain members of the practice attending a course and sharing knowledge?
- Point 4 - "The practice has the ability to measure…. could be rephrased as "evidence of appropriate use" in order to demonstrate that it is the behaviour and not just possessing the item of equipment that gains points.
- Point 9 - the reference to FAST and T-FAST scans seems very specific, perhaps it would be better to reword in terms of having protocols for triage of patients, the specific reference to FAST scans could be included in the guidance.

**Module 7 Infection Control**

- Requirements 6 & 12 - could be combined
- Requirements 10 & 13 - appear to be the same
- Veterinary Hospital requirement 2 - "Vacuum autoclaves are compulsory for wrapped packs/drapes". Does this mean that ethylene oxide is not acceptable?
- Point 3 - hand washing / sanitising facilities are available in the waiting room. Presumably this refers to client access which should also be available to clients (not just team members) in other parts of the practice?
- Point 4 – it seems that there could be other useful protocols here such as minimising hospital acquired infections, antibacterial use protocols, preparation for surgery etc.
- Point 5 – uniforms – further guidance would be useful for this point
- Point 6 -every ward area has its own dedicated sink with hot and cold running water. Perhaps (in order to demonstrate flexibility with different practical scenarios) this would be better worded as "the practice must demonstrate that there are measures in place to prevent the spread of infection between wards" - with hand washing facilities / separate equipment availability in the guidance?

**Module 8 In-patients**

- Requirement 3 guidance – "The practice must have at least one kennel suitable for a large breed of dog or have a plan in place for this facility if the need arises". Presumably this is only a requirement for practices that treat dogs – there are now a number of "Cat only" and exotics practices that do not normally treat dogs?
- GP Requirement 4 – facilities to maintain body temperature must be available – we would suggest the addition of ' and can be demonstrated to be used safely' as there seem to be a number of reports of burns and overheating where pads are overheated or monitoring is insufficient.

- Requirement 6 – intravenous fluids must be available - we would suggest addition of “and an appropriate means of administration".
- Requirement 7 – range of diets – surely this should be Core under meeting welfare needs as per the Animal Welfare Act?
- Veterinary Hospital requirement 7 – "sanitary” should presumably read "suitable"?
- Point 2- the wording suggests this handover is between the vet and the nurse where presumably it is meant to relate to their handover to other staff when they are off duty?
- Point 15 – is this meant to refer to overnight /OOH following on from point 14 or at all times? Does the fulfilment of point 15 achieve 40 points or 60 points (points for 14 & 15), similarly does the fulfilment of point 16 achieve 60 points of 120 points for the fulfilment of 14, 15and 16?

**Module 9 – Laboratory and Post Mortem**

We think there should be provisions included about the recording and reporting of laboratory results as well as carrying out the tests.

- Requirement 11 – “the practice laboratory meets any statutory requirements” – this would benefit from some guidance regarding what these statutory requirements are.
- Requirement 16 - could be combined with requirement 5.
- Point 5 – the guidance regarding smears should be in point 6 relating to haematology
- Point 10 – we agree that this should also be in the infection control module

**Module 10 - Medicines**

- Requirement 1 -we are delighted to have BSAVA medicines guide referenced here but we feel that as this is a Core requirement and that it should actually refer to the primary legislation (VMRs), which are likely to change and the requirements of the VMD as the primary enforcement agency. References to the BSAVA and other guides would be more appropriately included in the guidance.
- Requirement 4 – “The advertising of POM-V and POM-VPS products may only be aimed at appropriate persons, which does not include the general public. This includes adverts on websites, brochures and those displayed in retail areas to which the general public have access.” As this may change during the lifespan of this guidance would it be more appropriate to reword this in a more generic way that medicines may only be advertised to appropriate groups of people and put details re POM-V / VPS in the guidance?
- Requirement 15 – re disposal of Schedule 2 drugs - we would suggest that this is amended to make it clear that this refers to larger amounts of stock and not smaller amounts of waste as this appears to be a constant cause of confusion.
- Requirement 17 – as it has now been agreed that Ketamine should be rescheduled to Schedule 2 should this be amended?
- Requirement 29 – lifetime consent – We understand the importance of this, especially for many exotic species but question whether lifetime consent is allowable for antibacterials?
- Veterinary Hospital – Requirement 1 and Awards point 3 – is the BCVA Medicines Course acceptable in the SA module?
- Point 9 – regarding the existence SOPs - should there be some expectation that these not only exist but are used and monitored?

**Module 11 – Medical Records**

- This module appears to require very few points - just having a computer, which can be used to search records, update deaths and record weights would enable a practice to achieve good in this module.
- Point 4 - "The practice is working towards standardised medical nomenclature" –we think there needs to be further guidance here on exactly what is required and the reasoning behind this.

**Module 12 – Nursing**

We think that possessing training practice status should earn points in this module. This module could also be expanded by ensuring that specific references to RVN's in other modules, especially the Practice team, are included here.

- Point 8 – additional qualification - does the inclusion of BSc mean that degree nurses will gain these points automatically; we think that this could be divisive between nurses, or is this intended to apply to degrees other than veterinary nursing degree?

**Module 13 Out of Hours**

This seems to be a very short module and appears to favour practices using an OOH provider rather than providing OOH cover themselves. The module could be improved by including the OOH provisions from the in-patient module and other modules, as even those practices which may use an OOH provider will need to make provision for the care of their own inpatients.

Further consideration needs to be given to rewarding practices that carry out their own OOH to a high standard. While we understand that any practice can work towards the ECC award - this still seems to be written for ESC (see comments in Module 6).

- Point 2 - refers to provision by ESC rather than a practice which is outstanding in ECC.
- Points 3&4 – does the use of a practice that is outstanding in ECC gain 30 points (point 4) or 50 points (points 3&4)?
- Point 5 - regarding minimising transfers – does this mean that if a practice undertakes its own OOH that this by definition counts as "minimising transfers" and therefore earns points?

**Module 14 – Out-patients**

- Requirements 2-5 - whilst we accept that there are mobile clinics and small animal practices may carry out house calls the emphasis on vehicles seems inconsistent in a small animal module which in the GP and awards sections relates to consulting rooms.
- Requirement 6 – "The practice must have a means of estimating or establishing the weight of species routinely treated" again this appears to refer to all species - is it not reasonable to expect scales for 'the majority of species treated' in small animal practice?

- Requirement 8 - on PPE refers to clean clothing for consulting – this is a core standard while there are points awarded for "work uniforms are worn during clinical activities". Would clean white coats / consulting tops fulfil both requirements? In which case it seems inconsistent that points may be achieved for this in one module, while it is a core requirement in another module.
- The points in this module are currently awarded almost entirely for having diagnostic and treatment protocols available - we think that there should be some assessment of the behaviour around the protocol not just a check that one exists. We also think that there should be protocols for the reproductive control of the species normally treated.

**Module 15 Pain Management**

- Point 2 – reference to Glasgow pain scale- while we understand that this has only been provided as an example we think that it is important that the correct pain scoring scales are used for the type of pain being assessed. The Glasgow pain score is only validated for dogs in acute pain. It should be noted that the short form composite measure pain score (CMPS-SF) is now only available from New Metrica, and while it is currently available on free licence for non – commercial use consideration should be given to recommending a product from a single company and whether use in veterinary practice might ever be considered as "commercial" use and attract a charge http://www.newmetrica.com/cmps/.
- Point 5 refers to a standardised peer review system - does this mean something published in the peer reviewed literature or something that has been reviewed by your peers? The guidance refers to acquiring the appropriate pain scale, again it is important to emphasise that one scale will not be appropriate for all species / circumstances.

**Module 16 – Practice team**

This is a very long module with many individual items achieving a small number of points - it would benefit from subdividing into clearer sections. Most of the core requirements relate to health and safety so we would like to see more emphasis on communication and less on having policies and documentation.

- Requirement 2 - all veterinary surgeons and RVNs employed by the practice have Professional Indemnity Insurance in place. We think this should be duplicated in the Nursing module.
- Point 3 – refers to non-clinical team members – surely this should apply to all team members?
- Points 8, 9 & 10 - perhaps the order of these should be reversed - plan, evaluate, communicate, they could even be combined into a single point - though points could still be given for each area.
- Points 25-27 - could be combined into a single requirement with points for each subject.
- Point 30 - this should (also) be in the Nursing module.

**Module 17 Premises**

Perhaps this should be combined with the Outpatient module to make one larger module, which encompasses both the premises and what goes on within it.

- Point 2 - re separation of species in the waiting room - should this be in the out-patient module?

**Module 18 Surgery**

- Core standards - it seems regrettable that this is all that is required at Core for something that is so fundamental to our work; while we accept that other relevant requirements may have been covered in other modules having so little in this section gives a poor impression. Consideration should be given to cross referencing to Core requirements in other modules that are relevant such as anaesthesia and infection control.
- GP requirement 3 - there must be a written protocol for the maintenance of a surgically clean environment and evidence it is carried out – this should be repeated in infection control (similar comments to be made regarding sterility indicators and surgical gloves and gowns in 6&7).
- Point 20 - a means of maintaining body temperature during surgical procedures is available. We would suggest adding – “and used appropriately”.

**RCVS PRACTICE STANDARDS SCHEME REVIEW FINAL STAGE CONSULTATION – BVA RESPONSE**

**1)** The BVA is the national representative body for the veterinary profession in the United Kingdom and has over 15,000 members. Our primary aim is to represent, support and champion the interests of the veterinary profession in this country, and we therefore take a keen interest in all issues affecting the profession, including animal health and welfare, public health, regulatory issues and employment matters

**2)** We welcome the review of the Practice Standards Scheme and understand that the new structure has been designed to address issues that were raised in response to a consultation issued in 2012, as well as extensive feedback from the current members of the Scheme, and the wider profession. Our response to that original consultation raised issues such as lack of public understanding of the Scheme, too much focus on box-ticking, inconsistency of approach between inspectors, over-interpretation of the standards, and lack of pragmatism in assessments.

**3)** We are satisfied that the new structure goes a long way towards addressing many of our previous concerns and for that reason we are broadly supportive of the drafts. In particular we are pleased to see a more 'behavioural' approach to inspection and a movement away from excessive box-ticking; greater flexibility; and a pathway for improvement and means of recognising those practices which are striving for excellence. We were pleased to have been closely involved in the development of the drafts through our direct representation on the RCVS Practice Standards Group and via our specialist divisions who have played a key role in the development of the species specific elements of the modules. Our responses to the specific questions asked in the consultation are detailed below.

**4) How clear do you think the Awards are to the profession, and to the public?**
We broadly support the proposed structure of the Awards, which have been specifically tailored to take into account the differences between small animal, farm animal, and equine practice. The principle of allocating award points to clauses in the modules is supported. We believe that the proposals go a long way to balancing the desire for focus on behaviours and outcomes, which are often subjective, and the need to offer a Scheme which is entirely fair and must therefore inevitably rely on a degree of 'box-ticking'. We agree that the Awards are likely to be clear to the profession. However, throughout the process we have stressed that it will be crucial for the new Scheme to be understood and valued by the public for it to be successful as the Scheme's value as a marketing tool will be a key consideration for practices signing up. Whilst it may be that the principles underpinning the Awards are sufficiently clear to be understood by the public, unless the Scheme is adequately marketed then the majority of clients and potential clients will remain unaware of its existence, and therefore its significance.

**5) Are the Awards titles correct and are they configured to the right modules?**
Yes, we agree that the Awards titles are correct and configured appropriately across the modules.

**6) Do you agree that practices should only be able to outsource their OOH to practices that meet or exceed their own accreditation level?**
Yes, we support the proposal that practice should only be able to outsource their OOH to practices that meet or exceed their own accreditation level. We believe it would be entirely reasonable for a client choosing an accredited practice to expect

that OOH provision was of at least the same quality. Any other approach could damage the credibility of the Scheme.

**7) What do you think about the proposed IT system aimed at supporting the scheme**

We support the principle of a bespoke online IT system which will allow practices to make applications online, and upload documents prior to inspection. We agree that this is likely to make more time available on the day of the inspection, allowing assessors to engage more effectively with the practice team and provide advice and guidance. However, as with all new IT systems, the success will depend entirely on the functionality and ease of use, and we would urge the College to take all steps necessary to ensure that the system is delivered not only on time and in budget, but is adequately tested to ensure that it fulfils its objectives of offering convenience to practices and more efficient processing of evidence for assessors.

**8) Do you think the proposed price increase represents value for money?**

We understand that there will be not insignificant increases in fees, both for annual registration and for new applications and that, as the Scheme is not run for profit, any surplus will be reinvested for the benefit of the Scheme. It is reassuring that the College has indicated that this reinvestment could include marketing to the public and the profession. We strongly support the principle of improved marketing to the public and would be interested to receive further information quantifying how increased fees could translate into an increased marketing budget.

**9) Do you have any suggestions for improvements to any of the modules and/or the number of points assigned to each Award?**

As already mentioned, we are broadly supportive of the design and allocation of the Awards and points, but would like to draw attention to some specific details:

- Small Animal Dentistry module: it has been suggested that the requirements under the Hospital accreditation that dentistry must never be performed in surgical theatres, and sterilised dental packs should be used for each procedure, should apply across all accreditations as these requirements relate to hygiene and infection prevention which should be paramount in all practices. As it may not be practical for many core and general practices to assign a theatre to dentistry only, we suggest that these accreditations should instead be required to demonstrate how they manage the risks of cross contamination
- Small Animal Emergency and Critical Care module: it has been suggested that in addition to the veterinary surgeon, it should be a requirement that a Registered Veterinary Nurse is on the premises during all the hours of operation of the clinic. As this may not be practical for some smaller practices we support the current wording of clause 9 but suggest that the module could *recommend* that the team member is an RVN

We are aware that our specialist divisions will be submitting comments on the detail of the awards and we are happy to support them as experts in their individual areas of work.

**10) Additional comments?**

In order for the Scheme to build on its success and achieve additional buy-in we strongly believe that the terms core, general practice and hospital must be pre-fixed by 'RCVS Accredited' and the College should take steps to ensure that these terms are protected.

**11)** In conclusion, we are broadly supportive of the proposed new structure for the Scheme although we remain concerned that engagement and buy-in from the

profession and the public will continue to be an issue until such time as the College is able to devote significant resources to raising awareness of the Scheme as an important tool in raising veterinary standards.

**March 2015**

# SPVS Feedback to the 2015 Draft PSS Consultation

NB: Where the first person is used it related to the person submitting the comments.

## General comments:

1. **I think the new scheme** - essentially, required standards for different types of practices and then the option of further award in specific areas - **is a good idea.**

2. If PSS is aiming to bring up standards of vetting and improve animal welfare **do we have a defined goal of what this actually means** or are we pandering to our own interests. I.e. just because we can do it does not mean we should.

3. **It is not true that if you are not in (PSS) you are not up to standard**. We have had our VMD inspection and passed without issue. We are a VN training centre and give no concerns to our centre and a 100% success rate with our apprentices. We have a strict health and safety policy in place with annual inspections by an outside body. We comply in every way possible with every bit of legislation as far as I know. My practice manager does what she can and I do the rest.

4. Interesting that when it comes to difficult questions it is down to PSG but still happy to call it the RCVS PSS when talking it up how about separating it properly, **PSG PSS anybody**?

5. Enticing practices to raise their standards by demonstrating to them a positive effect both financially and in job satisfaction by raising their standards might be ..... an option. **If the scheme enables practice owners to see a return on their efforts then there may be a greater number of practices signing up to it.** Maybe the inspectors could have more of a consultancy role rather than a 'ticking of a box' role. The end result would be the same, raised standards, the reasons for practice raising the standards would be very different.

## Specific Points:

1. **Controlled drugs**:

VMD guidance - There is no requirement to have the destruction of Schedule 3, 4 and 5 CDs witnessed except where a veterinary surgeon or pharmacist has produced a Schedule 3 or 4 preparation for use under the cascade. Best practice recommendation: Due to the well known abuse of ketamine, it is considered good practice to have the destruction of ketamine witnessed.

RCVS PSS: Ketamine may be the subject of misuse and, therefore, must be stored in the controlled drugs cabinet and its use and witnessed destruction recorded in an informal register
I'm not sure why the PSS needs to go above the VMD rules.

2. **Reception**:

a. **Module 3 page 27**:

Number 7: How would parts 1 and 4 work? Presumably 1 and 3 would be covered by booster/health check reminders but would a card with an appointment time on it be considered sufficient for the other two?

Number 8: Don't really see that this is feasible as appts can be running late one minute then the vet can catch up or an intervening appt can be cancelled and they are back on schedule. Also a client may already be en route when an appointment overruns and it would be dangerous for them to answer the phone whilst driving. Would it be considered sufficient to inform and apologise when the client arrives, inform them how late (approx) we are running and ask if they would rather rebook for another time?

b. **Module 17 page 145**:
Number 6: I think that the idea of CCTV at the reception area would be very Big Brotherish and, although it is supposedly for staff safety, I don't think it would be viewed that way.

3. **Advanced Practitioner**:
At a few points there are references to extra points for having an AP. I'm concerned that this is another step away from the old style certificate. I'm concerned that number 2 of the Anaesthesia awards seems to give equal weighting to "a module of the CertAVP" and the CertVA. One module would not be equal.

4. **Infection Control**:
It is implied, but I think it is better to state good antibiotic use, than focus on resistance. The whole point is to use what we have more wisely, not just consider resistance.

5. **Written Consent for off label**:
Disappointing that individual written consent is still required. Verbal is perfectly acceptable and blanket would be better. I don't understand the PSG being content with this.

6. **Hospital**:
'At least one VN – minimum half the nursing staff I'd say'.
This comment led to a discussion about the shortage of nurses and a comment was made asking why PSS didn't require all GP practices to become TP's to help the RVN shortage situation (see later under RVN).

7. **OOH**:
a. This is unclear as it seems to suggest that only a practice that can pass as an emergency clinic can gain outstanding in this area. This is wrong. The emergency clinic business model is to do everything that night. The practice will do what the animal's needs dictate. Both can be excellent.

b. The need for clear description (re OOH) is in the CoC and should not need the PSS to make it clear. If the only thing a client gets from it is restrictions on how far you can outsource you OOH, it is a waste of our time and money.

c. I notice the module states rest can be on the premises, so this might not count as rest. I also notice that the weighting for awake and on the premises of 60 points means that it is unlikely anyone without permanent night staff can be outstanding. We should not be encouraging a 24hour service culture!

d. I am one of those who thinks that a Vet Hospital should distinguish itself by having its own oohr's service rather than outsourced and certainly I don't agree with one hospital outsourcing to another 10 miles away. If the out of hours care is described and required to be described to clients, they could make their own mind up if it was described to them openly and honestly, and was a requirement in the new PSS to make that clear. A very clear difference is accessibility to case notes 24/7. In 'client speak' that means if there are no case notes all the previous investigations are likely to have to be repeated at greater cost than if they were available, missing history of disease conditions can be a problem for the diagnosing clinician and for the

patient and client, if a relative who is caring for the animal while the owner is away then they are likely to have far less 'memory' of the case notes that have gone before, animals injured and attending one hospital which outsources its oohr's have to be transported to another premises at night and in the morning which is not the same as staying in the one premises in comfort defined by the description of the care provided, the client themselves may be responsible for the transport of their pet night and day from one place to another …… If the same applied to choice of daytime practice where the case notes were not available to the diagnosing and treating vet, would that be a) acceptable, or b) chaos, c) within or outside the RCVS code of conduct?

e. It seems to me that a Hospital having to have an on site OOH service is unreasonable - if two Hospitals within 10 miles of each other cannot use each others' service that would be wrong.

8. **Firearms**:
Both SA (not sure what SA beasts need shooting) FA and EQ, all it needs state is that each vet who uses the firearms/dart gun, must have their own FAC (copies should be allowed for inspection as leaving an FAC is not advised). A separate inspection for storage is not necessary.

9. **Premises**:
Core – consulting room can be used for other things. Yes, but just not simultaneously. There is precedent for this as section 18 Surgery says an op room must be separated temporally or spatially.

10. **Farm**:
a. Same comments (see above) on infection control and weighting of good use not just resistance.

b. Surgery written consent – not a chance of this on every occasion, even at all. Equine owners definitely!

c. I cannot see why a SA practice has the award 'Emergency and critical care' yet Equine and LA do not - don't they have emergencies...?

d. Where the evidence of excellence? Actually this applies to all specialties'. There should be something whereby a practice gets extra points for post graduate qualifications (those of pertinence). Perhaps under practice team "a culture of promoting further education and learning". A practice with several cert holders is likely to be a far better practice than one with none.

11. **Referral centres**:
How do referral centres fit in this? A friend has an orthopaedics place, hospital standard, yet can't fit PSS as he has no dental machine. It needs to be made clear within the scheme that referral practices can apply and have irrelevant sections ignored.

12. **IT**:
RCVS has a poor record with IT. I think the system should be outsourced.

13. **Pop up vets**:
a. "pop up vets" who are in a corner of a pet shop a couple of variable hours a week in middle of day (key as close prior to OOH service opening so calls go to non OOH sites eg local vets).

Where is this building/model " fit for purpose " …who is responsible for that Vet Space and building – it isn't a practice and how does CoC and PSS work in this specific context?

Mobile vets and branches are very different as you have a point of contact at a main site or ambulatory mobile and access to records …this Is not the case with pop up.

b. I am just one of many practitioners who have voiced concerns about 'cheap vaccination clinics with no named vet doing the vaccinations and no oohr's service except from the guidance on their website 'see your local vet if needed oohr's' without any prior arrangement.(The inference being how does the new PSS apply to these).

c. Cheap vaccinations don't serve much purpose when clients phone at midnight when they really need emergency help and they haven't got any money.

d. My issues with the whole CoC and PSS are sites that are not real practices and are pop up. They are in pet shops one day a week, a few hours a week say 1-4 so no OOH no records no anything. So this doesn't touch them …

14. **Charging**:

a. A comment ref charging being down to PSG:

Are you sure you wouldn't rather call it the PSG PSS? What percentage of representatives on PSG are single practice, single vet members? What percentage are in practices just to core standards? The pricing structure is anti competitive and should be reviewed.

b. So, who defines what a branch practice is; what justifies it having lower fees compared to its competitor's non branch practice. What justifies core cost being the same as higher levels?

15. **Support for Practices to help comply with PSS**:

Will PSS name companies that can help – I noticed 2 bereavement resources were named and had web addresses – is that appropriate? (Can any company be listed?). I am not sure PSS should name any company that can help …..

16. **Inspections**:

I want: Unannounced inspections and random drop in assessment in between the regular sessions.

17. **RVN's**:

To increase RVN numbers, perhaps there should be a requirement for every PSS practice above core standard to be a training practice and for any practice employing more than one RVN to be required to train at least one student or even required to have at least 1 student for every 2RVNs employed. That way, those practices wouldn't be continuing to sponge off the rest of us that do train.

18. **Fees**:

What justifies such a significantly lower fee for a branch?

What justifies the same fee for say a hospital standard practice with more to be monitored than a core standard practice?

19. **Cost of doing the scheme and resources**:

a. What assessments were made of the time and cost impact on small practices of involvement in the scheme and how were those assessments made?

b. We do not have large HR resources that the corporates have. My reluctance to join PSS is lack of time and the fact that the goalposts kept moving far more than most small practices can keep up with.

c. I work in excess of 50 hours per week and I have a full clinical caseload. The only way I could consider getting all things in place for PSS is to do it at weekends / evenings and I do not want to. I want a quality of life.

19. **Branches**:
How does the scheme differentiate or define a premises as a branch rather than a principal?

20. **Things not covered**:
a. There are areas that are hardly covered at all - competence of the vet, skills of the vet, overall service received at the surgery, overnight care, presence of experienced or expert staff / duration of qualification, RVNs, clinical standards and protocols, the ownership and ethos of the surgery etc..

These are difficult things to grade I would imagine, especially as the profession has limited accepted grading system for vets cf the medical profession.

b. Has anyone questioned how a compulsory PSS would be enforced by a body with no power over practices anyway? My practice is owned by a limited company, I could be struck off tomorrow and would still be a director.

## Points for Clarification:

1. What is the definition of " Clinical Support Staff " …Vets and Nurses are defined so who are clinical support staff ?

2. What does PSS mean by " Client training " ……

3. PSS states clearly that Vets and VN need to demonstrate CPD ….there isn't a requirement for anyone else ..any reason why ? Given PSS is a Practice Standard not clinician standard.

4. How does the scheme differentiate or define a premisesas a branch rather than a principal?

## Comments About the Relevance of PSS to Clients:

1. We have been PSS Tier 2 accredited since its inception. On each occasion the inspector gave us glowing reports, including the one spot inspection we had. I have been asking clients about it, and none seems to think it has any value. The general feedback I get is that it is seen as a box ticking exercise. They are far more interested in the relationship they build with the practice. I have yet to find a client who saw it as a factor in deciding to use us or stay with us, or that it added value to their opinion of our practice.

2. My perspective is and has always been the measuring of customer understanding and the lack of relevance to the pet or horse owner in their world, from owners perspective.

3. The purpose is to give clients confidence in the practice that carries that logo. It is not working. I definitely will not renew.

4. Cat Friendly Clinic is a customer facing standard that means something to cat folks. So if CFC can have relevance then other standards can too. The Only difference between CFC and PSS is the marketing and communication about what CFC is across the globe, engaging with Cat owners via press, media and social space. So for customer relevance to exist any "standard" has to have marketing strategy and customer relevance. International Cat Care have a clear plan for CFC programme and have made great steps forward on limited resources.

5. We are Cat Friendly Gold standard, as well as Hospital and IIP. Clients certainly appreciate these things when the standards are explained to them.

6. There has been a tendency for all clients and even all vets to claim that theirs is the best and not want to sing the praises of each standard which then becomes self defeating like building a castle and knocking it down again to level everything. I don't like the marketing by some vet practices claiming to be 'state the art' without any definition of what that means, or 'caring vets without actually saying who they actually are even when clients are inside their clinic'. However, using the standards does enable us to inform the public what we are doing and ensure that what we are telling them is externally verified. Some people on this debate have pointed out that many public assume many things are the same between different practices which is probably a fault of ourselves (all of us) in not explaining it properly.

7. The definition and levels of care of the awards can easily be reviewed and understood by those in the industry, but I doubt that clients could or would.

8. It would be good to be able to refer animal owners to our standards of care and have RCVS back us up when we adhere to them.

9. Kirsty and Phil have demonstrated for many years now that location location location is often the most important consideration. Could it get that the PSS is possible a slight 'navel gazing' exercise. Does the general public care or know enough to care about the inter practice differences in care delivery?

10. We as a profession consider it very important and we recognise that there are differences but does the general public? I was questioned many moons ago by my accountant why we spent so much on CPD? Surely a vet is a vet was his view. When I asked him if all accountants were 'equal' he considered that no, they were not. If a fellow professional is unable to figure out that there might be a difference in care then how likely is it that the general public will?

11. This does all depend on whether raising standards is what we are all looking for. If we are looking for a rating based 'client attraction' scheme then a tick box exercise with a number of stars is likely the easiest and cheapest way.
    Who decides the overall goal?
    Who needs to be motivated to reach this goal and how will this be done?
    Who pays for this and who will ultimately benefit?

12. Clients often fall into 3 categories;

    a. A third will want everything
    b. A third wont

c. And a third might if they knew about it

13. All I have read in the [PSS consultation] doc seems good in principle - I am a layman of course and cannot comment on anything clinical.

    But, the big issue is that one of the 'aims' is that the scheme should be: be clear and understandable to the public. I doubt this revision will even get close to that. Here are some reasons why I feel this way:

    Clients rarely remember more than 20% of anything we tell them - anything the RCVS or the scheme says won't even reach 20% of my clients, even if I send them all a letter/email, they either won't read it or won't go on to look at the scheme. On balance I would not expect even 5% of clients, if asked a year after introduction, would even know what we are talking about.

    Lets say a few clients do 'get it' - how will they determine whether practice A is better than practice B - the 'award' names will not be understood by the average client - what exactly is 'in-patient service' or 'diagnostic service' and how important/relevant is it to a client/patient. And how are the awards related to tell me, the client, if a practice with the 'in-patient service' award is better than a practice with the 'client service' award. I think my basic feeling with awards is that they are fine for the profession but completely useless for the client.

    Clients, all of us, have a limited view of life - if they like the place they go to they are not likely to switch just because the practice down the road has an extra award.

    How can this be corrected to make it client friendly and hence 'valuable' to a practice?

    It has to be some kind of easily understood rating scheme - check out Michelin, AA, RAC stars. Or Trip Advisor Hotel Classes, or Vet Help Direct reviews, see:
    http://www.vethelpdirect.com/practicedetails.php?id=664&town=Barton-le-Clay&county=2#reviews

    They all work on a scale of 1 to 5 - any more categories than this is too many. Actually, the Vet Help Direct method, could, potentially, be used for PSS and still be understandable by clients, though not quite as simple as the flat star system.

    Fundamentally, the scheme should encourage practices outwith the PSS to join and those within to stay. From discussions with many vets I doubt the scheme will do either very well - there are many who see this as something that RCVS should not be involved with - especially when it gets down to HSE, work contracts and PAT testing, frankly there are plenty of rules out there to cover these issues and I doubt whether an inspector could win an argument about PAT testing! Hence, that kind of thing will end up in court and the RCVS will look very silly.
    So, think again about the marketability of the scheme and what should be included. And maybe recognise the veterinary is a Retail Service and as such is a business. Businesses do things to make a profit, without marketability what would be the point of a non PSS business becoming one?

## Comments about the Relevance of PSS to Staff:

1. I decided to go with IiP. We passed well with very complimentary comments. When the time came for review, I asked my staff, individually and in private, what difference they felt IiP had made to the way

we ran the practice and their experience of working for me. Every single one said it had made no difference, I was wasting my time, and should not bother continuing. What they really valued was that we had a flat hierarchy, with an open door policy to me and my wife (our practice manager), which had been in place for years.

2. For now we see it is something that doesn't help my marketing at all of the practice but a great audit to make sure the practice is up to speed on a lot of the stuff that makes our practice run better. And keeps us legal

3. The new PSS should be a good team motivational tool I agree. Marketing is largely up to us. Most clients assume vet practices are inspected as a matter of course.

## General Comments about PSS:

1. Marketing is largely up to us. Most clients assume vet practices are inspected as a matter of course.

2. For there to be clinical standards there also has to be an acceptance that practices are different …some do better care than others …all vets are not the same.

3. The philosophical bit that our professional political bodies struggle with ….the fact that some practices are not doing the basics seems to always be swept under the carpet or side stepped …..

4. The minimum standard for surgery or any activity involving GA is there has to be a VN with that pet at all times …not a well informed clinical support person – whatever that is.

5. Customers can only judge by what we share with them and a practice that's shows me round , lets me meet team, talks about qualified teams doing care and then saying Yes we charge more it is because we do more – then that leaves me as a customer with a choice …..and many will choose the more $££$£$£ option when they can see they actually get something for it and many wont ….but we will have a transparent playing field on which we all play.

6. If you can't find a VN to work for you, or choose not to pay for one, the public still has a right to know whether you use VN's or not. It may mean your fees would have to rise to a point your clientele will not accept if you did. That's fine, but clients are paying for what they are getting, and should know that. We have two vets, two VN's and an ANA. Only our VN's monitor anaesthesia, although our ANA is trained in case of a Saturday morning emergency. I don't agree that only VN's should be allowed to monitor GA. But, if a practice does not use VN's, the public should know, and know why it is important.

7. Yes, there is a shortage of VN's but clients should still know whether you use VN's or not. This is not just for GA. It is all areas of nursing, and vets and nurses consult on hospitalised patients all the time. Our nurses do come up with ideas the vets haven't thought of, and non VNs simply do not have the knowledge to contribute as fully.

## Additional Ideas to Include in PSS:

I wonder if there any opportunity to gain points by taking part in a clinical data- gathering project such as VetCompass or SAVSNET ? It would help to involve more practices and they would then gain the benefits of a better evidence base

## Thank you's and compliments:

1. A big thank you to X for all the hard work she and others are putting on pss on our behalf.

2. I think the new draft is a huge improvement. Pretty much all my previous reservations are dealt with, I think. Thanks to X and co.

3. It was the behaviours I have always wanted, feeling it has been to much a of a box ticking exercise up to now. You were right, on reading it through, the changes are very positive. It is well on it way to showing what I wanted PSS to show, and why I joined it in the first place. And it leaves a practice free to develop as much as the team wishes.

4. I'm all for raising standards and increasing client and animal care and I'm impressed with anyone who freely gives their time to help that happen.

## Criticisms:

1. Just read consultation document . Think will not renew. We have been Tier 3 hospital for years but it seems can work really hard for that or be core but pick an award and hey presto can advertise as RCVS rated us as outstanding! Confused now angry. Think will be best to leave until compulsory then aim for core and 1 outstanding award!!!

2. Enticing practices to raise their standards by educating the public and enabling the public to choose a practice based on a rating scheme has so far not worked. I would see no real reason that a new scheme would be any different in its effect. There is no shame in saying that we tried and failed, let's not spend more time and money on it.

## Why we are doing this:

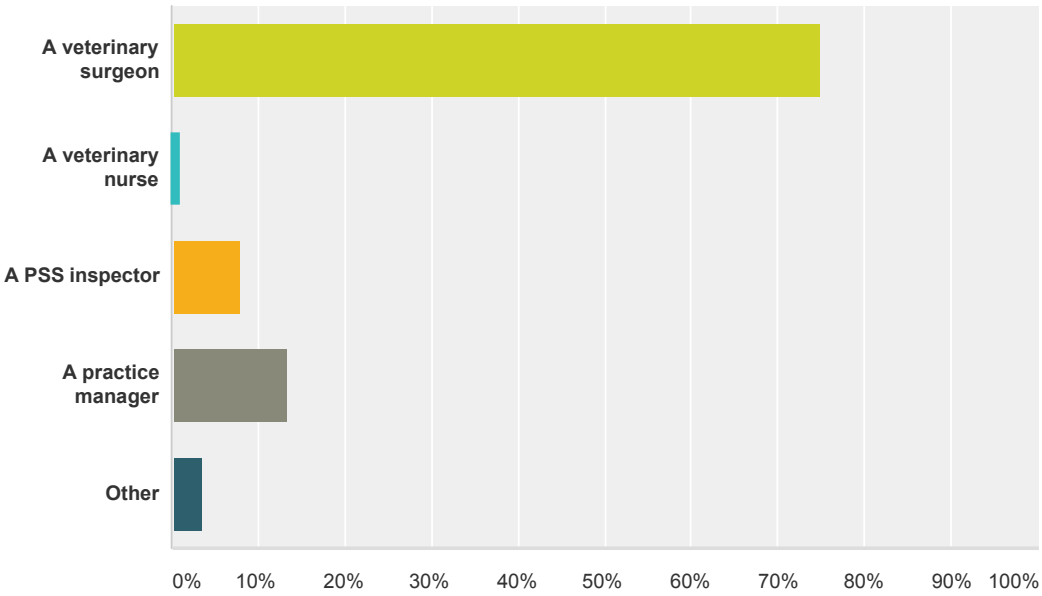
1. This year I had a vet locum tell me of a practice that had wanted to employ him this year, 2014. They had no hospital cages, cats recovered in their carriers, dogs recovered on mats on the floor attached to rings in the wall by their collars. This was not the worst of it.

2. 2 or 3 years ago I spoke to a vet who did a lot of surgery. He said other vets were often amazed at how much surgery they get through. They commonly have 2 to 4 ops going at the same time. I asked if there was someone monitoring anaesthesia full time, as his team was not that large. The answer was, there is always someone around. Sometimes, four vets were operating, one nurse (by no means always a VN) was overseeing all four GA's. Once the ET tube was out, the animals were pretty much left alone in their cages in the kennel room as the teams got on with preparing the next ops. His fees were low for his area. I wonder how many clients, had they known, would have moved to higher fee practices with higher standards of care.

## About you

### Q1 Are you a:

Answered: 91 Skipped: 7



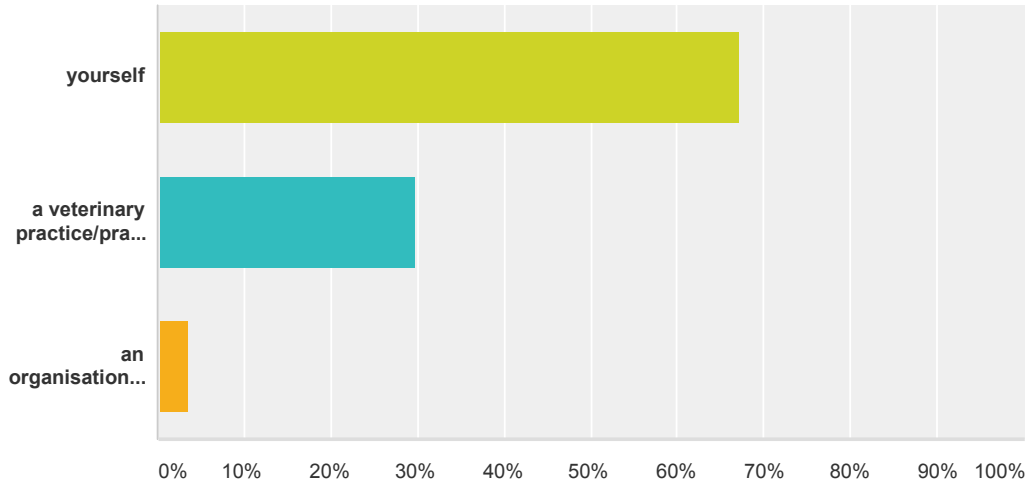

| Answer Choices | Responses | |
|---|---|---|
| A veterinary surgeon | **74.73%** | 68 |
| A veterinary nurse | **1.10%** | 1 |
| A PSS inspector | **7.69%** | 7 |
| A practice manager | **13.19%** | 12 |
| Other | **3.30%** | 3 |
| **Total** | | **91** |

| # | Other (please specify) | Date |
|---|---|---|
| 1 | A member of VetCompass RVC | 3/24/2015 5:33 AM |
| 2 | & RVN | 3/23/2015 9:23 AM |
| 3 | Head of Clinical Services, PDSA | 3/23/2015 8:41 AM |
| 4 | Head of Clincal Nursing | 3/23/2015 5:32 AM |
| 5 | PCA | 2/17/2015 7:33 AM |

## About you

### Q2 Are you responding on behalf of:

Answered: 91 Skipped: 7




| Answer Choices | Responses | |
|---|---|---|
| yourself | **67.03%** | 61 |
| a veterinary practice/practice group | **29.67%** | 27 |
| an organisation, eg a representative body | **3.30%** | 3 |
| **Total** | | **91** |

## About your organization

### Q3 If you are responding on behalf of an organisation, please enter the name of it below:

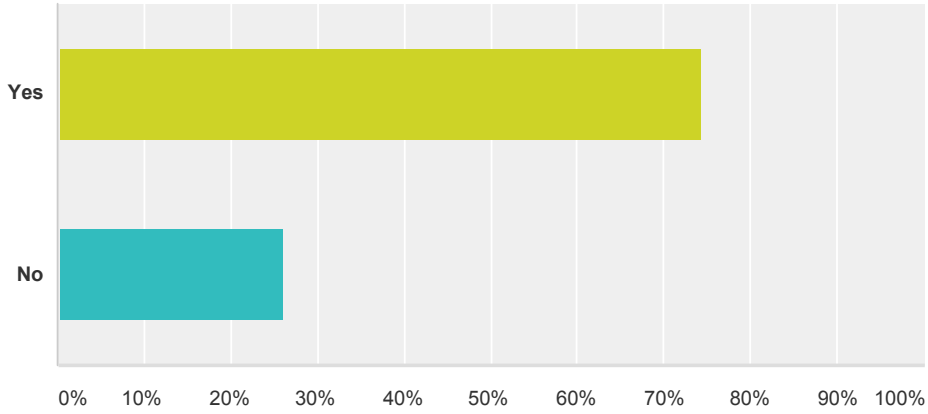
Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | VetCompass RVC | 3/24/2015 5:33 AM |
| 2 | PDSA | 3/23/2015 8:42 AM |
| 3 | VetCompass Programme, RVC | 3/22/2015 2:35 AM |

## About your practice

### Q4 Is your practice group an accredited/candidate member of the Practice Standards Scheme?

Answered: 27 Skipped: 71

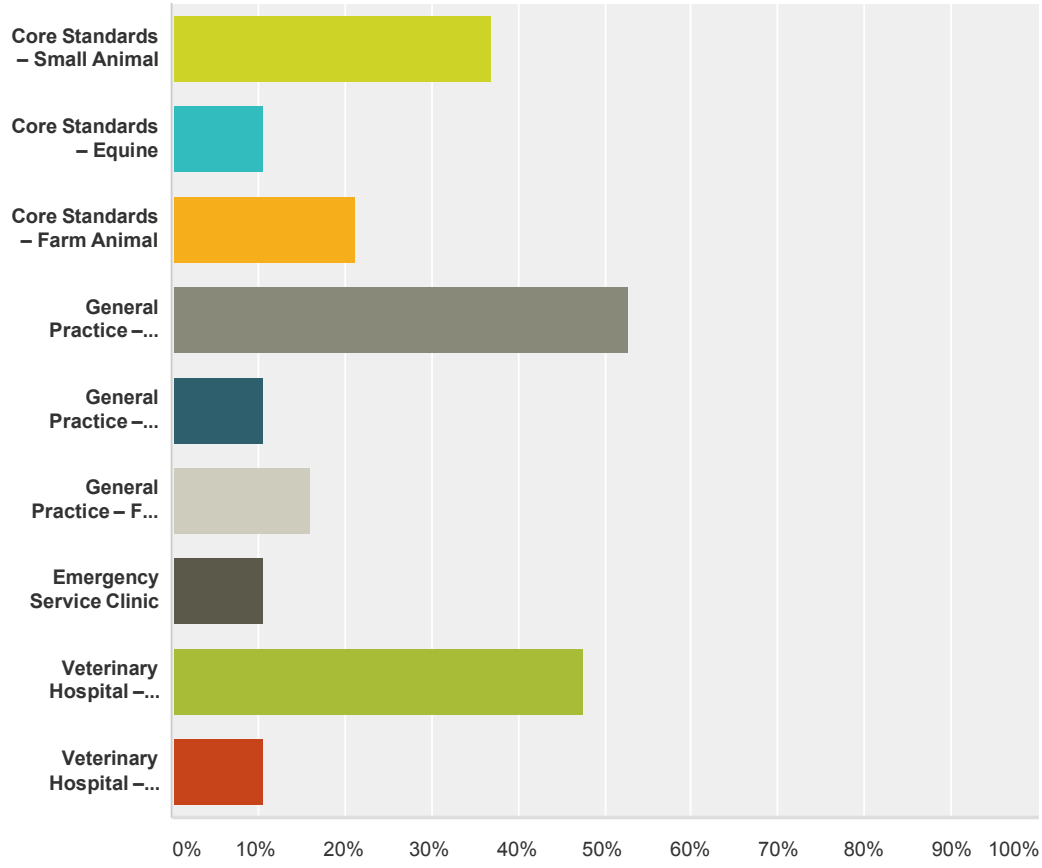



| Answer Choices | Responses | |
|---|---|---|
| Yes | **74.07%** | 20 |
| No | **25.93%** | 7 |
| **Total** | | **27** |

## About your practice / the Scheme

### Q5 What type of accreditation(s) does your practice group hold / is your practice group applying for? (Tick all that apply)

Answered: 19 Skipped: 79

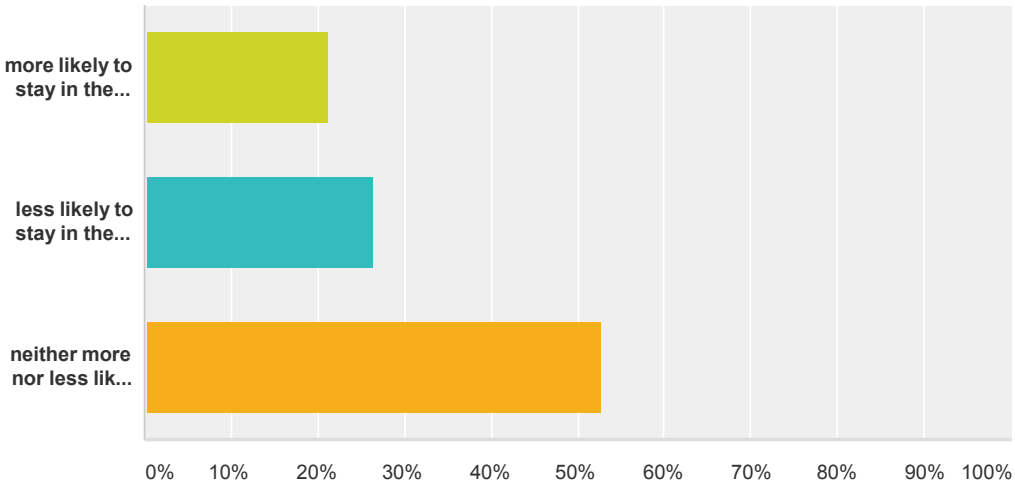



| Answer Choices | Responses | |
|---|---|---|
| Core Standards – Small Animal | **36.84%** | 7 |
| Core Standards – Equine | **10.53%** | 2 |
| Core Standards – Farm Animal | **21.05%** | 4 |
| General Practice – Small Animal | **52.63%** | 10 |
| General Practice – Equine | **10.53%** | 2 |
| General Practice – Farm Animal | **15.79%** | 3 |
| Emergency Service Clinic | **10.53%** | 2 |
| Veterinary Hospital – Small Animal | **47.37%** | 9 |
| Veterinary Hospital – Equine | **10.53%** | 2 |
| **Total Respondents: 19** | | |

## About your practice / the Scheme

### Q6 Having read about the changes to the Scheme are you

Answered: 19 Skipped: 79




| Answer Choices | Responses | |
|---|---|---|
| more likely to stay in the Scheme | **21.05%** | 4 |
| less likely to stay in the Scheme | **26.32%** | 5 |
| neither more nor less likely to stay in the Scheme | **52.63%** | 10 |
| **Total** | | **19** |

## About your practice / the Scheme

### Q7 Please give a reason for your answer:

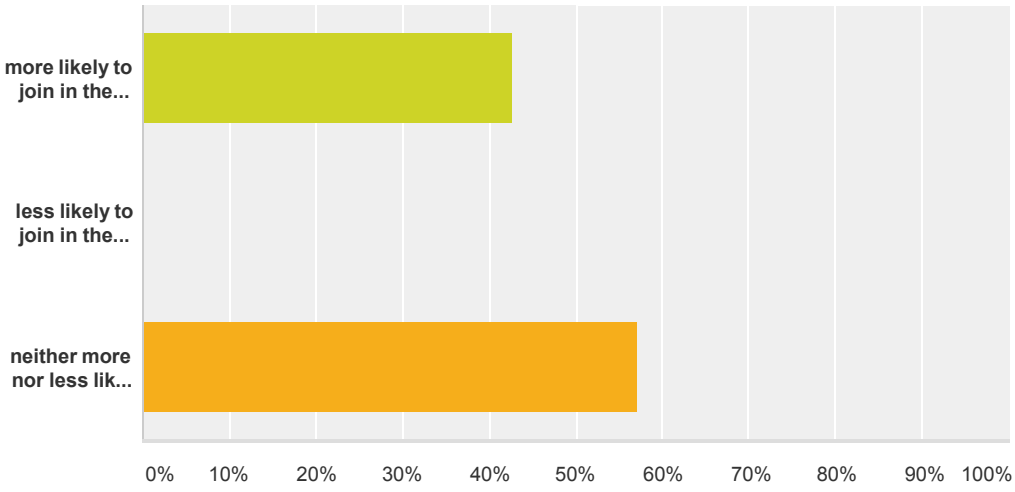
Answered: 10 Skipped: 88

| # | Responses | Date |
|---|---|---|
| 1 | Covers better depth of service provision | 3/23/2015 9:24 AM |
| 2 | No intention to leave anyway | 3/23/2015 4:57 AM |
| 3 | It is not transparent or fit for purpose or responsive, but there is no alternative that meets hospital standard | 3/22/2015 9:50 AM |
| 4 | If demands involved with complying with scheme continue to increase to the detriment of the cost / benefit, leaving may become the only sensible business decision. | 3/18/2015 8:24 AM |
| 5 | Too onerous for a small practice to deal with | 3/18/2015 3:05 AM |
| 6 | we will wait and see whether our views are considered and also how the new modules work in practice. | 3/17/2015 12:37 PM |
| 7 | We are part of the scheme as there is nothing else available to assess standards of practice but we would be aiming to achieve those standards anyway. We do not believe that the PSS offers any advantage in marketing ourselves to the public and we feel that there is still a lot of additional administrative work created by the scheme, especially as the layout/sections/modules have changed every 4 years so all our files have to be re-organised every time. We also feel that a lot of points are made that would mean additional expenditure to tick a box/be awarded points and they are not applicable across the board eg old buildings vs new builds or rural practice vs inner city | 3/11/2015 12:47 AM |
| 8 | It appears to be too time consuming for a small practice with a limited staff. | 2/23/2015 10:38 AM |
| 9 | At first glance there is even more paperwork than at present, everything has to be written down, particularly protocols for diagnosis/treatment etc. I feel a great opportunity has been missed to streamline the process. | 2/18/2015 10:13 AM |
| 10 | I always felt that the current PSS focus on paperwork and not the care provided to our patients. | 2/17/2015 6:00 AM |

## Changes to the Scheme

### Q8 Having read about the changes to the Scheme is your practice

Answered: 7 Skipped: 91

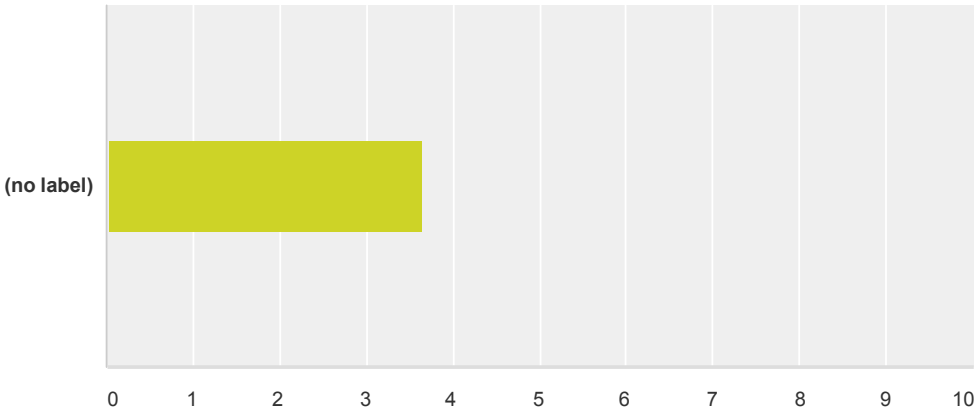



| Answer Choices | Responses | |
|---|---|---|
| more likely to join in the Scheme | **42.86%** | 3 |
| less likely to join in the Scheme | **0.00%** | 0 |
| neither more nor less likely to join in the Scheme | **57.14%** | 4 |
| **Total** | | **7** |

## Awards

### Q9 Thinking generally about the Awards, on a scale of one to five, how clear and understandable are they to the profession? (where 1 is not at all clear, and 5 is very clear)

Answered: 70 Skipped: 28




| | 1 | 2 | 3 | 4 | 5 | Total | Weighted Average |
|---|---|---|---|---|---|---|---|
| (no label) | **5.71%**<br>4 | **14.29%**<br>10 | **14.29%**<br>10 | **42.86%**<br>30 | **22.86%**<br>16 | 70 | 3.63 |

## Awards

### Q10 Please give a reason for your answer:

Answered: 37 Skipped: 61

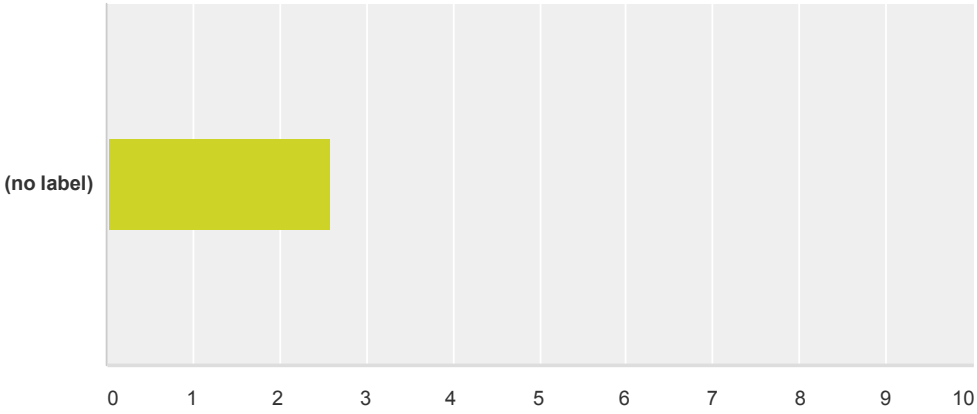
| # | Responses | Date |
|---|---|---|
| 1 | pretty well laid out in the proposal | 3/24/2015 9:15 AM |
| 2 | They are well publicised and written in clear English. | 3/24/2015 7:00 AM |
| 3 | its clear enough, just not sure about the relevence | 3/23/2015 9:31 AM |
| 4 | Too complex; busy Vets wont have time to fully analyse all this | 3/23/2015 9:25 AM |
| 5 | Defining objective criteria for subjective assessment on a half or even a full day, with perhaps 20 members of staff is foolhardy. It would not be possible to assess the behaviours of each member of staff in each of the headings mentioned. Furthermore, some staff will inevitably be on leave, CPD or in long ops and unavailable for assessment. This, once again, brings the whole procedure down to box-tickin e.g. is there a written system of work for 'good consulting practice', is there written protocols for pain management and access to the WSAVA Gold standard document? And so on. This aim to provide Oftsed reports may appear laudable in Belgravia House, but I doubt many clients would change surgery on the basis of a single assessment. Finally, the Ofsted process has itself received mixed press lately, with excessive pressure on, in this case, clinicians and nurses. This is of particular importance if the proposed compulsory PSS registration comes to pass - I'd have no problem with the old system being compulsory. This new scheme is a flawed process which has not been thought through. Keep the old system. | 3/23/2015 8:56 AM |
| 6 | Appear detailed and clear for the user | 3/23/2015 8:44 AM |
| 7 | It took me several reads through to understand and with the document being so long, I am not sure everyone will invest that effort - it needs to be simpler and shorter | 3/23/2015 6:08 AM |
| 8 | Quite complicated to understand, had to read the document several times and it is very long | 3/23/2015 5:35 AM |
| 9 | Aims and categories are clear, but not clear whether the good or outstanding applies to just that categories (ie good considering they are a GP) or as a whole (compared with all practices this one is GOOD. The latter has more clarity | 3/23/2015 5:04 AM |
| 10 | If you raise an issue the RCVS PSS answer is not in accordance with the code. The answers from the RCVS ( eg OOH and advertising) are contorted. The standards are not applied logically or equally and so are the subjective opinion of an inspector. | 3/22/2015 9:54 AM |
| 11 | Achieving excellence is about the constant striving to improve: these awards offer a framework for continual improvement within practice and also reward success. | 3/22/2015 2:41 AM |
| 12 | Detailed guidance given - good but some occasional ambiguity - bad. More guidance is promised for highlighted items - good | 3/20/2015 4:40 AM |
| 13 | I think the profession do understand the different awards | 3/20/2015 4:29 AM |
| 14 | Many are familiar with Ofsted categorisation so the PSS following similar is positive | 3/19/2015 12:35 AM |
| 15 | Increasing complexity is likely to lead increased confusion | 3/18/2015 8:28 AM |
| 16 | Things maybe understandable to other members of the profession but .... | 3/18/2015 3:08 AM |
| 17 | There is a huge inequality in the effort required to gain awards. The profession might reasonable expect that the effort to gain an ECC accreditation might be similar to one to achieve an in-patient accreditation. In fact just 10 topics worth 540 points are available in ECC. In in-patient section there are 125 topics with a maximum of 3000 points. this is ridiculous. | 3/17/2015 12:42 PM |
| 18 | The similarity to Ofsted should be clearer to many | 3/16/2015 12:36 PM |
| 19 | It has taken me some time to understand how the award system works; I wonder how much time busy practitioners will want / be able to put in to get to grips with the new scheme. | 3/16/2015 4:26 AM |
| 20 | The awards appear to be across the board and we do not think that you can apply them to GP & Hospitals equally | 3/11/2015 12:49 AM |
| 21 | initially a lot to assimilate but then quite clear | 3/9/2015 6:58 AM |
| 22 | They purport to focus on outcomes but do not. | 3/7/2015 12:58 PM |
| 23 | 5 | 3/3/2015 1:42 AM |

| | | |
|---|---|---|
| 24 | 'GOOD' sounds like 'ADEQUATE' Needs a stronger descriptor | 2/27/2015 2:13 PM |
| 25 | Easy to follow marking scales and much more user friendly than previously -accumulation of points is appealing | 2/26/2015 1:45 PM |
| 26 | Easy to follow points system but it is unclear whether a practice requires say a certificate holder in anaesthetics or whether it is site specific | 2/23/2015 10:59 AM |
| 27 | I think that the awards are clear, but my concern is about the 43% of practices that are not in the PSS. As Nick Stace has said, the general public think that all practices are inspected. | 2/23/2015 10:51 AM |
| 28 | I feel I understand what was meant by the award | 2/18/2015 1:50 PM |
| 29 | Too many words too little time. The public do not understand the current system they will never understand this. | 2/18/2015 10:15 AM |
| 30 | I am not sure that I see the relevance of individual awards over and above the standards themselves - Surely all of these areas, if deemed appropriate, should make up part of the associated practice standard grouping? | 2/18/2015 10:11 AM |
| 31 | I find the idea of a panel of people deciding upon what constitutes 'good or 'oustanding performance in clinical areas uncomfortable as these are surely subjective rather than objective areas. | 2/18/2015 1:36 AM |
| 32 | very concise and detailed - good that practices can decide what awards they wish to take part in | 2/17/2015 7:40 AM |
| 33 | These are all behaviours that we should be displaying. | 2/17/2015 6:04 AM |
| 34 | still very unclear about how it will it work in practice | 2/17/2015 5:32 AM |
| 35 | Seems quite clear | 2/17/2015 5:28 AM |
| 36 | I have been practising for over 2 years and I still don't understand the system, despite docs and post on magazines and forums | 2/11/2015 6:11 PM |
| 37 | Fairly straightforward to understand | 2/10/2015 7:34 AM |

## Awards

### Q11 And how clear and understandable are the Awards to the public? (where 1 is not at all clear, and 5 is very clear)

Answered: 70 Skipped: 28




| | 1 | 2 | 3 | 4 | 5 | Total | Weighted Average |
|---|---|---|---|---|---|---|---|
| (no label) | **30.00%**<br>21 | **17.14%**<br>12 | **30.00%**<br>21 | **11.43%**<br>8 | **11.43%**<br>8 | 70 | 2.57 |

## Awards

### Q12 Please give a reason for your answer:

Answered: 42 Skipped: 56

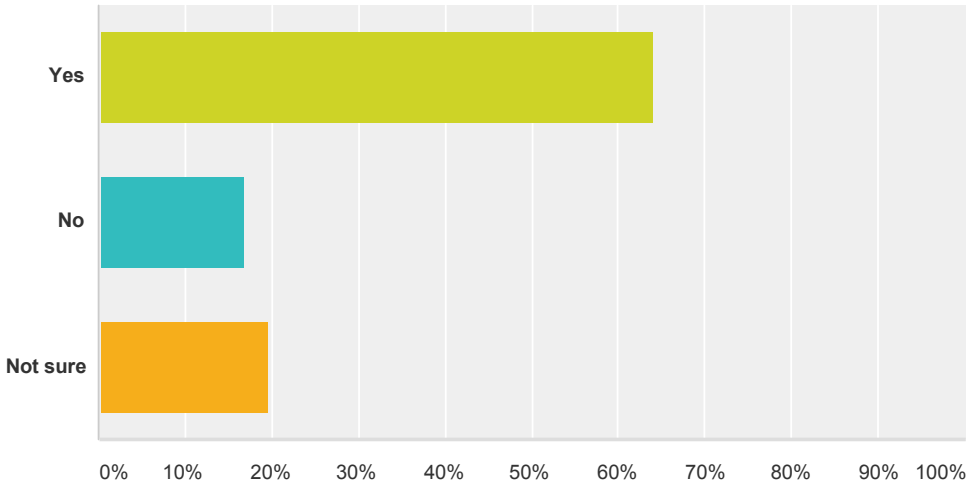
| # | Responses | Date |
|---|---|---|
| 1 | Lack of understanding by the public - just not used to seeing/grading their vets in that manner. | 3/24/2015 9:15 AM |
| 2 | I think that some members of the public will take time to research the meanings of the Awards but others will not have much of an idea of what they are. They may feel comforted when they see the certificate on the wall of their practice, but they won't have heard of the Awards prior to then. | 3/24/2015 7:00 AM |
| 3 | our clients won't care | 3/23/2015 9:31 AM |
| 4 | Public can't understand present system let alone complex one like this | 3/23/2015 9:25 AM |
| 5 | Limited general public knowledge | 3/23/2015 9:25 AM |
| 6 | I worry they could be too complex in terms of so many minor awards but think regardless of this they are a step in the right direction. | 3/23/2015 8:55 AM |
| 7 | Providing the appropriate communications are put in place to protect the reputation of those practices that choose not to apply for additional modules | 3/23/2015 8:44 AM |
| 8 | The good and outsntading designations seem to make sense but the pet owners I have discussed this with do not really understand the award names - language used is very skewed to profession not public | 3/23/2015 6:08 AM |
| 9 | Too complex and the language used not good for the general public to understand | 3/23/2015 5:35 AM |
| 10 | Not sure as depending on prev question, the public may make assumptions about what GOOD or OUTSTANDING is Is it Good for Norfolk, good for this practice or good compared with all practrice? Wouls someone expect OUTSTANDING to be the pinnacle of services or just doing well with what they've got? This becomes v difficult in the clinical and diagnostic areas and the devil is in the detail. Outstanding for one client will mean different things to another. So in a way the awards will serve to educate clients in their expectations (as well as practices), just as the stds do currently. For this reason they must be evidence based and not anecdotal or set in commercial interests. | 3/23/2015 5:04 AM |
| 11 | The ability of PSS core practice to advertoise that they have an out of hours service is a breach of trading standard, If they shut they should be obliged to state that they DO NOT offer an OOH service. If they appear the same to the public as a 24hr staffed Tier 3 because of contorted PSS then it is not fitr for purpose. There are multiple corruptions regarding contractural relationships with OOH that undermine the viability of PSS | 3/22/2015 9:54 AM |
| 12 | I think these could be a great incentive, but they could also be used to give a confusing picture to the public if they were advertised on practice websites. E.g. a practice obtaining an award in surgery could easily imply that they are a specialist practice in this area. The titles of some of the areas are also quite vague (e.g. 'practice team'), and it would not be clear what this meant without some research or explanation. The number of possible awards also runs the risk of confusing clients if these are intended to be widely publicised - for example how would a client decide between attending a practice that was excellent at surgery or diagnostic imaging but offered a poor client service or staff support. I think these levels of assessment should contribute to the overall grade that is applied to a practice and in giving feedback to the practice, but I am not sure how helpful it is to try to communicate this information to the public. | 3/22/2015 7:55 AM |
| 13 | Because of their limited knowledge about the existence of these schemes (initially at least), I think the public will see the good or outstanding and read both as saying the practice is good. The lack of a reported result will not register as a 'poor' result to the public for the same reason: their lack of a frame of reference. It will then be up to individual practices or practice groups to explain these results to their clients . It is good that there are no 'failing' results as this encourages practices to keep working to improve but being publicly denounced (as some schools suffer from). | 3/22/2015 2:41 AM |
| 14 | So far, no promotion | 3/20/2015 6:43 AM |
| 15 | I am uncertain re this point.. so 3. Publication of the detailed requirements will not mean a lot to many clients but some explanation will improve understanding tremendously | 3/20/2015 4:40 AM |
| 16 | I think the public will struggle to understand the differences between the awards and the actual base accreditations | 3/20/2015 4:29 AM |
| 17 | This will be a generational issue...older clients may not be familiar with this. | 3/19/2015 12:35 AM |
| 18 | They are unaware of the present system, how will this change help rectify this.? | 3/18/2015 8:28 AM |

| | | |
|---|---|---|
| 19 | Difficult for the public to understand as they have no knowledge of the internal workings of a veterinary practice | 3/18/2015 3:08 AM |
| 20 | As above. The client would expect "excellent in client service" to be an equal achievement to "excellent in in-patient care". the fact is one is massively easier to achieve than the other. | 3/17/2015 12:42 PM |
| 21 | The public, by and large, know very little about the PSS, they just expect that their practice will be 'accredited / inspected' by the governing body. The introduction of the Award scheme will most likely be incomprehensible to them in most cases. If you were to tell them that their practice had a special Award in 'Team and Professional Responsibility', what would that mean to them? | 3/16/2015 4:26 AM |
| 22 | In general the public do not seem to be aware nor care what they are about. | 3/11/2015 12:49 AM |
| 23 | The general public have little if any understanding of the PSS and the innumerable different letters and post-nominals and now with the Dr title pre-nominals available to VS. Providing more sub-divisions merely makes this confusion worse. | 3/7/2015 12:58 PM |
| 24 | 4 | 3/3/2015 1:42 AM |
| 25 | 'Good' sounds like 'Adequate' Needs a stronger descriptor | 2/27/2015 2:13 PM |
| 26 | Akin to ratings given to hotels etc. -public should find this much easier to understand. | 2/26/2015 1:45 PM |
| 27 | The public will have little idea as to what is being measured and I suspect it will have little impact on the care and the result of that care as far as they are concerned. Has anyone actually carried out a cost/benefit analysis to the client of the awards? | 2/23/2015 10:59 AM |
| 28 | Most clients do not know about or have much interest in the existing scheme. The awards may cause further confusion, particularly as not all practices are covered. All schools are inspected by Ofsted. | 2/23/2015 10:51 AM |
| 29 | See above it is irrelevant to them. The yalready expect a "high" standard, and will complain if they feel that standard is not met. | 2/18/2015 10:15 AM |
| 30 | I think these add further "shades of grey" to a system that I would argue few members of the public currently have a grasp of. I see little point in offering areas of individual accreditation in areas that practices may excel if they are poor elsewhere and this does not form part of their accreditation - This could be seen as misleading, especially if only applying for statuses in which you are likely to be excellent. Do the public really understand the Ofsted inspection awards (do Ofsted themselves for that matter!)? I think this is debatable in its own right | 2/18/2015 10:11 AM |
| 31 | The use of an existing nomenclature is likely to be helpful however I am not sure 2 levels are sufficient to clearly inform a client as to the level of capability in the centre. I also have concerns that a member of the public may confuse these awards with the scope of specialisims. | 2/18/2015 1:36 AM |
| 32 | Clients will understand the 'good' or 'outstanding' and general practice etc I think they will struggle with what Core standards are | 2/17/2015 7:40 AM |
| 33 | Public don't even understand the difference between accredited and non accredited practices | 2/17/2015 6:23 AM |
| 34 | I think the public generally are very ignorant of what the standards mean. Hopefully with better promotion to the public they will be more interested in the awards. | 2/17/2015 6:04 AM |
| 35 | There is not enough publicity. | 2/17/2015 5:41 AM |
| 36 | general public dont understand the scheme as it is, so they will be even more confused. | 2/17/2015 5:32 AM |
| 37 | I'm not sure the clients will necessarily understand the different areas of award | 2/17/2015 5:28 AM |
| 38 | Awards and extra information will make the scheme even more unclear to the public. The public dont fully understand the scheme as it stands and extra levels will make it even less clear and more difficult to compare practices | 2/16/2015 12:45 AM |
| 39 | clients don't know what they mean | 2/12/2015 3:19 AM |
| 40 | In my opinion, the most they understand is the difference between a day vet, an ECC and a referral practice. | 2/11/2015 6:11 PM |
| 41 | lack of a need for the profession to explain the difference . Lack of direct to public marketing of scheme | 2/11/2015 10:44 AM |
| 42 | Don't think the general public will understand the fine detail of this | 2/10/2015 7:34 AM |

## Awards

### Q13 Are the titles of the Awards appropriate?

Answered: 72 Skipped: 26




| Answer Choices | Responses | |
|---|---|---|
| Yes | **63.89%** | 46 |
| No | **16.67%** | 12 |
| Not sure | **19.44%** | 14 |
| **Total** | | **72** |

## Awards suggestions

### Q14 Please suggest more appropriate titles for the Awards:

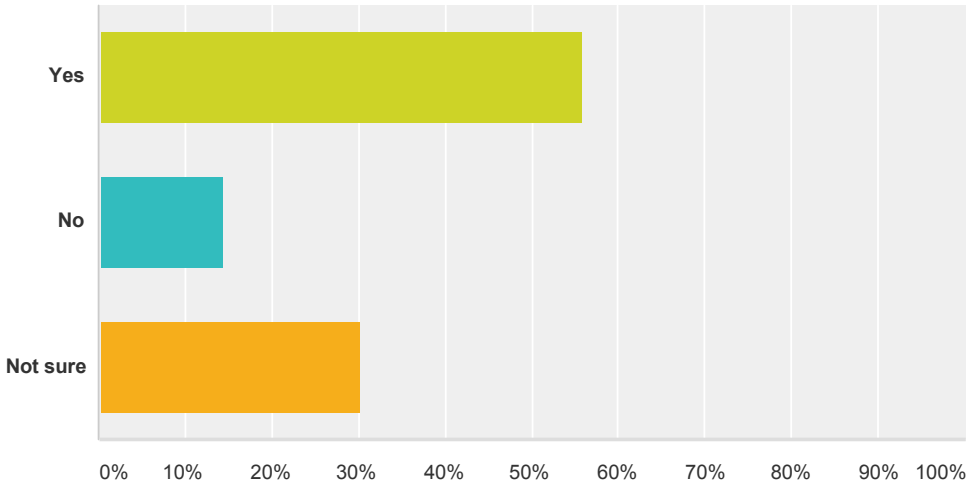
Answered: 16 Skipped: 82

| # | Responses | Date |
|---|---|---|
| 1 | as at present | 3/23/2015 9:25 AM |
| 2 | I would suggest the public inputs to this | 3/23/2015 6:09 AM |
| 3 | Very difficult for Veterinary professionals to be fully aware of what appeals to clients, would suggest asking customers/public for their thoughts | 3/23/2015 5:36 AM |
| 4 | Daytime only Practice, 24 hr practice. Practice with no ability to treat minior species as it has no vivaria or other equipment required. | 3/22/2015 9:55 AM |
| 5 | Don't feel the present system will achieve the desired objectives whatever the titles used. | 3/18/2015 8:29 AM |
| 6 | Star rating would be better. eg AA hotel star rating | 3/18/2015 3:09 AM |
| 7 | I would drop the 'Team' part here - just call it 'Professional Responsibilities' - with a plural on responsibility. | 3/16/2015 4:29 AM |
| 8 | Patient Consultation Service should refer to clinical care, the current title is confusing | 3/15/2015 3:07 AM |
| 9 | AS the scheme does not measure what it claims to measure this would be entirely meaningless. | 3/7/2015 12:58 PM |
| 10 | Above my pay grade | 2/27/2015 2:13 PM |
| 11 | To cover all practices a scheme of grading similar to the star rating of hotels. Clients would have the choice of the standard of practice they wished to use. | 2/23/2015 10:53 AM |
| 12 | I don't think there should be any. I do not wish the current system to be changed for at least a decade. | 2/18/2015 10:16 AM |
| 13 | I do not think the awards are appropriate | 2/18/2015 10:11 AM |
| 14 | perhaps a wider range would be more appropriate? Perhaps the term outstanding should be dropped to reduce the risk of confusion with specialism? | 2/18/2015 1:37 AM |
| 15 | Excellent. | 2/17/2015 5:41 AM |
| 16 | For the member of public: colours, stars, or any toher symbol they are more used to. For professionals, bearing in mind the amount of foreign vets practicing within the UK, using some clearer and more universal codes/names. | 2/11/2015 6:14 PM |

## Awards

### Q15 Are the Awards configured from the correct Modules?

Answered: 70 Skipped: 28




| Answer Choices | Responses | |
|---|---|---|
| Yes | **55.71%** | 39 |
| No | **14.29%** | 10 |
| Not sure | **30.00%** | 21 |
| **Total** | | **70** |

## Awards

### Q16 How do you think the Awards should be configured instead?

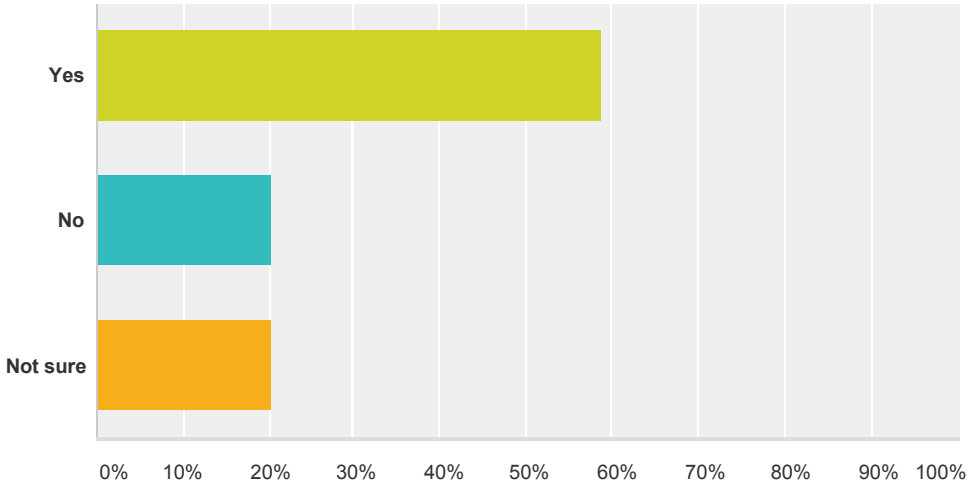
Answered: 19 Skipped: 79

| # | Responses | Date |
|---|---|---|
| 1 | i'm just not sure an awards scheme is appropriate | 3/23/2015 9:32 AM |
| 2 | stick to what we know | 3/23/2015 9:25 AM |
| 3 | It is wrong to tie together ESC and emergency and critical care in the current way. To be outstanding in ECC, it seems a practice must be an ESC. The issue here is that a vet must be awake at all times, even if there are no cases. This is spurious and not related to patient care. The requirement is more relevant to a practice offering cover to a number of other practices and therefore having an increased workload. This is not related to ECC activity. As long as the professional team is there when needed, the ongoing care of a ECC patient has to be dependent on a team of ECC experts who are available to give that case undivided attention when necessary. This may mean better care in a referral centre with multiple interns/specialists, or in a GP or hospital with several vets and RVNs all within 10-20 minutes who can take over the case in turn day and night and be called in at the drop of a hat with no delays. Very often more than two people will be needed for a ECC patient, and they will need to be multiskilled and particularly competent at surgery and diagnostics or be able to call on such a person quickly (within say 20-30 min) Again, a non ESC may have superior manpower in this regard. The patient should not have to be moved to complete its treatment, unless for specialist referral. ECC happens all day, not just at night. This needs some careful thought so as not to mislead the public. It should also not be possible to attain any points in an OOH award for handing OOH outside the practice, however good communications are. This is misleading to the public by implying that the practice does its own OOH, and is a weakness of the current PSS. Only the OOH clinic should be able to gain points. | 3/23/2015 5:44 AM |
| 4 | With the code in mind. Practices should not be allowed to present an image which is a trading stadards issue merely to comply with PSS expectataions. If practices are expected to label unauthorised products as the VMRs this should be applied every day all day - it is criminal law. If the PSS tier3 24hr title is acciurate then practices should direct clients to the nearest 24hr facilities, not just the ones far away they both like and dont feel in competition with. It would be woprth removing the corruption. | 3/22/2015 9:58 AM |
| 5 | Hard to say until they are in situ. Any gaps will then become clear. | 3/20/2015 6:44 AM |
| 6 | The emergency and critical care award seems easy for an existing ESC to achieve. Should not the award include such modules as Anaesthesia, Pain Management +/- In-patients to be more aspirational? | 3/20/2015 4:51 AM |
| 7 | To complicated to go into | 3/18/2015 3:10 AM |
| 8 | Each award should require a similar effort, so that they are approximately equivalent. they are dramatically and absurdly differing in effort at the moment. | 3/17/2015 12:43 PM |
| 9 | Award 1: add elements from module 12 , Nursing. The public would expect Nursing to be a part of their vet's professional responsibilty to them and their animal. Award 2: this Award seems a bit too easy to obtain, what does it actually mean? Add elements from module 16, practice team and module 17, premises. | 3/16/2015 4:48 AM |
| 10 | Dentistry module position in in-patient service becomes irrelevant to referral hospitals not offering dentistry - failure to get any points in one part of module removes ability to get the award for in patients | 3/12/2015 6:08 AM |
| 11 | If there was nothing previous to the awards then they are fair enough but having had 9 sections previously why create extra work for practices by changing from 9 to 16? | 3/11/2015 12:50 AM |
| 12 | ESC should include all pain module and much of in patient, client care and surgery modules | 3/9/2015 6:59 AM |
| 13 | Try actually measuring outcomes (or admitting that this is probably not possible). | 3/7/2015 12:59 PM |
| 14 | I think a farm animal in-patient/hospitalisation section is a glaring omission | 2/23/2015 4:13 AM |
| 15 | I think they should be based on client satisfaction, not yet another tick box exercise. | 2/18/2015 10:17 AM |
| 16 | I do not think the awards are appropriate | 2/18/2015 10:12 AM |
| 17 | Should be scrapped or at lest in addition to what is required within core/hospital etc - much duplication | 2/17/2015 11:18 AM |
| 18 | I am concerned that the out of hours service has to e=be at the same level of accreditation: this poses problems for 1-2 man practices where there is no choice in OOH providers | 2/17/2015 5:29 AM |
| 19 | I don't understand them that much as to figure it out. | 2/11/2015 6:15 PM |

## Awards

### Q17 Are the Awards pitched at an appropriate level?

Answered: 68 Skipped: 30




| Answer Choices | Responses | |
|---|---|---|
| Yes | **58.82%** | 40 |
| No | **20.59%** | 14 |
| Not sure | **20.59%** | 14 |
| **Total** | | **68** |

## Awards

# Q18 Please describe the level at which you think the Awards should be pitched:

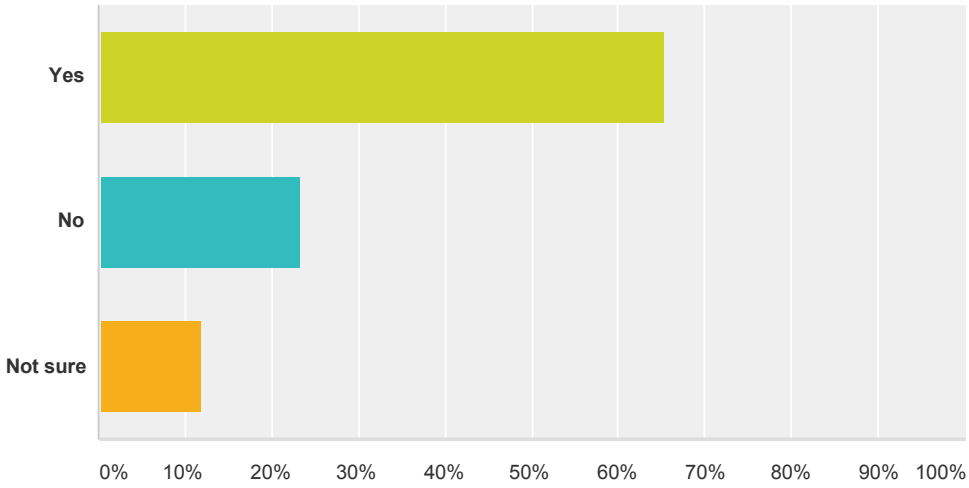
Answered: 18 Skipped: 80

| # | Responses | Date |
|---|---|---|
| 1 | not always - see comments (this is my second submission - 2 more modules to comment on) | 3/23/2015 11:15 AM |
| 2 | not sure; scheme is too complex to make a judgement | 3/23/2015 9:33 AM |
| 3 | see previous, it all sounds like points get prizes | 3/23/2015 9:32 AM |
| 4 | There is still great variation in the level of detail, approach and writing of the awards (difficult we know!). Behaviours are important and well described in the pain module, but less well elsewhere, where a reliance on CPD with no outcomes or resulting behaviours could do with improvement. We need agreed definitions of outstanding and good before we refine the modules, to facilitate even treatment and clarity for the public and profession. I couldn't find these anywhere. Although they should be achievable at good level,they must be challenging to be outstanding and include some elements in each award that are truly 'cutting edge' and indicate current best practice in their areas. in some modules, for example diagnostics, the outstanding level is still set way too low with no requirement for the ultrasound, endoscopy and radiology skills needed to diagnose complex or emergency cases in general practice. Depending of course on the definition of outstanding. Just waiting for the complaints of 'why are you outstanding in diagnostics but couldn't pick up the pericardial effusion / free abd fluid /pancreatitis? | 3/23/2015 6:35 AM |
| 5 | Very biased towards day time & general practice with lots of points being irrelevant to other sectors | 3/23/2015 5:38 AM |
| 6 | Honesty and trasparency - free from subjective opinion of inspectors. Free from pretending and box ticking. | 3/22/2015 9:59 AM |
| 7 | See my previous reservation about Emergency and Critical Care Award | 3/20/2015 4:52 AM |
| 8 | Any level of award is meaningless to the public who think that all practices are inspected | 3/18/2015 3:11 AM |
| 9 | Think you need a separate award level for referral hospitals | 3/12/2015 6:08 AM |
| 10 | We do not believe that you can have points for things that are clearly referral level when the majority of practices must be core or hopefully GP | 3/11/2015 12:51 AM |
| 11 | patient consultation and in patient services are very tough, multifaceted compared to diagnostics and ESC | 3/9/2015 7:01 AM |
| 12 | Another meaningless question. | 3/7/2015 1:00 PM |
| 13 | My rough estimate is that to gain good in an award would require little investment. To gain outstanding would require significant investment. As a client, I would almost certainly want to send my kids to an outstanding school. I suspect similar would happen if the client understood the awards. Yet this could mean a significant increase in price to client, little increase in benefit and potentially price veterinary medicine beyond the reach of the majority of pet owners | 2/23/2015 11:01 AM |
| 14 | I think the entire concept is wrong. | 2/18/2015 10:18 AM |
| 15 | Good=what any reasonable practice should do Outstanding=I beleive this term is confusing. I believe levels should be determined by more subjective measures than the usual paperwork associated with PSS inspections | 2/18/2015 1:39 AM |
| 16 | many/all should be within basic assessment | 2/17/2015 11:18 AM |
| 17 | they just seem too complicate, too many levels, how is the general public going to understand them | 2/12/2015 3:21 AM |
| 18 | More aimed to protect animal welfare than pleasing clients for fear of having a complaint. | 2/11/2015 6:16 PM |

## Out of hours

### Q19 Do you support this proposal?

Answered: 69 Skipped: 29




| Answer Choices | Responses | |
|---|---|---|
| Yes | **65.22%** | 45 |
| No | **23.19%** | 16 |
| Not sure | **11.59%** | 8 |
| **Total** | | **69** |

## Out of hours

### Q20 Please give a reason for your answer:

Answered: 21 Skipped: 77

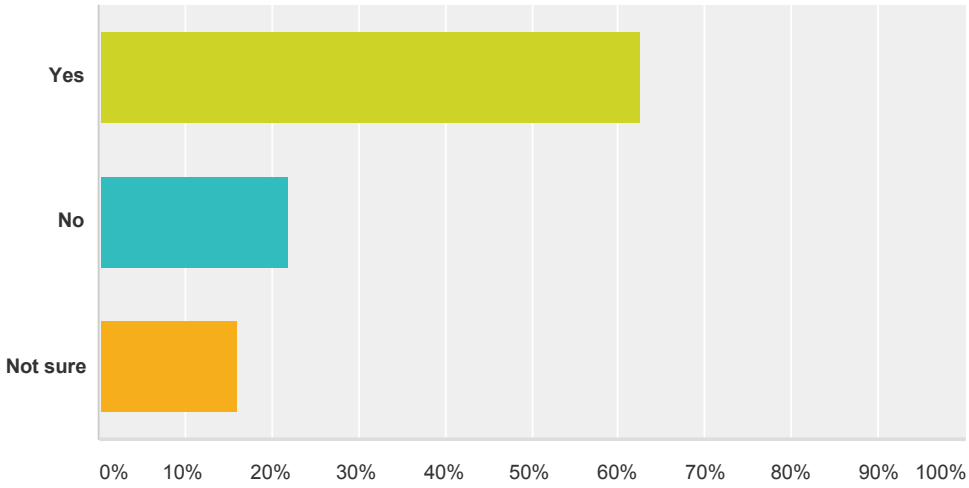
| # | Responses | Date |
|---|---|---|
| 1 | We are a small practice in a rural area; there is only one practice we can realistically share our out of hours service with and its not in the scheme. if you impose this I will have no choice but to withdraw from the scheme | 3/23/2015 9:35 AM |
| 2 | overly controlling, doesn't take account of local issues or relationships | 3/23/2015 9:33 AM |
| 3 | This might present difficulties to practices sharing rotas. Suggest that practices outsourcing their OOH stop saying they have an out of hours service. Period. The fact that the RCVS Code of Conduct says they have to have arrangements does not mean they have to advertise they offer an emergency service (this is a throw back to guidance years ago when advertising was first allowed). Practices outsourcing should direct the clients to where the service is and state the relevant accreditation (s.) ie We are closed from 7pm - 8.30 am. xx consortium (or yy ESC) have agreed to see our cliets outside these hours. They are accredited by RCVS at GP / core / ESC level. or They are not accredited by RCVS. Or outside nornmal hours we share emergency cover with ABC vets (RCVS GP practice), DEF vets (RCVS Core accredited and HIJ vets (no accreditation) Very straightforward and the market remains free with the client informed. Of course no need to list all this if not in the scheme. | 3/23/2015 6:45 AM |
| 4 | Hospitals should be able to outsource to ESC for new patients if they choose - undoubtedly hospitals should have 24 hr in patient care but this should be split from the requirements for accepting new emergencies - they require different skills and staffing arrangements | 3/23/2015 6:12 AM |
| 5 | Think it is more important that the requirement should be that they have an ESC accreditation | 3/23/2015 5:39 AM |
| 6 | The whole OOH obligations are a mess. My nearby practices have websites that look as though they offer comprehensive facilities when they are closed and they refer clients past Tier 3 sites that have the abilkity to save the patients life. This is an obligation under 1.1 of the code that the RCVS PSS are turning a blind eye to. If the PSS is fit for purpose then personal and competative relationships should be swept aside andf animal welfare and clinical standrads availavle should prevail. The whole of the VMR should be applied or they should be changed. We should not just practice the sections of criminal law that we like. | 3/22/2015 10:02 AM |
| 7 | IN certain areas of the country, there may be no dedicated out-of-hours providers. As such, small local practices may have banded together collegiately to cover their OOH. This new ruling would force some practices to not be able to contribute to these shared rotas and hence they would have to leave the pool and then take care of all their own OOH. | 3/22/2015 2:44 AM |
| 8 | Not all ESCs will be Veterinary Hospitals but will almost certainly provide superior care than Vet hospitals with no veterinary surgeon on site | 3/21/2015 12:36 PM |
| 9 | A practice has little control over whether or not their OOH participates, and in rural areas, sourcing another and going through the upheaval of changing just for this reason is too big an ask. | 3/20/2015 6:45 AM |
| 10 | And if this is not available but they meet all other requirements! | 3/18/2015 8:32 AM |
| 11 | In an emergency any level of care is better than no care at all. | 3/18/2015 3:12 AM |
| 12 | It should possible to outsource to a practice of equivalent level OR an ESC centre | 3/17/2015 12:45 PM |
| 13 | It is possible for a dedicated ESC to exceed the standard for hospitals in most areas but fail in some, that are not directly linked to the standard of care provision. The current special status of ESC with certain exemptions addresses that | 3/15/2015 3:11 AM |
| 14 | Possible contingencies where (as a one-off occasion) the best treatment/availability for a patient may not be from a practice matching this description - agree that this should be the case as far as possible | 3/13/2015 8:03 AM |
| 15 | As the scheme does not measure outcomes dictating what 'level' of practice a day practice can outsource its night work to is pointless. The RCVS would do better to regulate the quite frankly dreadful provision of OOh services offered by the corporate lock ups with more teeth. | 3/7/2015 1:06 PM |
| 16 | For a small practice with a staff emergency situation, such as illness, one might be grateful to use the services of a colleague with a different standard of practice. | 2/23/2015 10:58 AM |
| 17 | I see no reason why this should be the case | 2/18/2015 10:14 AM |
| 18 | systemn works ok . dont alter it | 2/18/2015 8:15 AM |

| | | |
|---|---|---|
| 19 | As long as it is made clear to the public attending the practice where the out of hours is outsourced, surely it is for them to decide if it is acceptable to them? I believe it would place too high a burdon on general practices to comply with this. Perhaps hospitals may be able to cope with 5 years notice? | 2/18/2015 1:40 AM |
| 20 | I can see the logic but the flaw is where there is no choice of out of hours provider. I work in a 1.5 man practice and use an out of hours providers who whilst good is not part of the scheme. This would create an intolerable work load for me as a vet if I couldn't outsource my OOH | 2/17/2015 5:31 AM |
| 21 | finding it more confusing than before | 2/12/2015 3:21 AM |

## Out of hours

### Q21 Do you support this proposal?

Answered: 69 Skipped: 29




| Answer Choices | Responses | |
|---|---|---|
| Yes | **62.32%** | 43 |
| No | **21.74%** | 15 |
| Not sure | **15.94%** | 11 |
| **Total** | | **69** |

## Out of hours

### Q22 Please give a reason for your answer:

Answered: 56 Skipped: 42

| # | Responses | Date |
|---|---|---|
| 1 | Hospital patients should be managed by the admitting vets or their colleagues, not handed over to another team. | 3/24/2015 9:15 AM |
| 2 | It's easier for clients to attend their local hospital and better fro patients as there's no need to transfer them between sites for care. There is also the opportunity for the patient to see their usual vet as soon as usual hours resume. | 3/24/2015 7:02 AM |
| 3 | don't think this is necessary | 3/23/2015 9:36 AM |
| 4 | just not relevent to me | 3/23/2015 9:33 AM |
| 5 | Continual care avoiding moving of patients - complete service | 3/23/2015 9:26 AM |
| 6 | Those who aspire to be recognised as the top tier should provide top tier access to OOH | 3/23/2015 9:19 AM |
| 7 | Whilst I agree that for the vast majority of hospitals this should be the case I am not 100% convinced that is ought to be mandatory. Though this is based on a feeling nothing more concrete. | 3/23/2015 8:57 AM |
| 8 | Will need to understand the impact that this may have upon third party out of hours providers u[pon which so many practices now depend, if it drives some out of existence this would be detrimental to the veterinary profession and work/life balance of many veterinary surgeons | 3/23/2015 8:46 AM |
| 9 | There needs to be some ability to outsource in extreme cases where full staffing is unavailable | 3/23/2015 7:46 AM |
| 10 | People expect a hospital to have an A&E department. Actually I never had a problem with practices outsourcing their OOH being Day Hospitals as long as it was in the practice name clearly. I think that's; fairly self-explanatory | 3/23/2015 6:46 AM |
| 11 | as before hospitals should provide 24 hr in patient care but the requirement to see new cases is different and should be able to be outsourced. Monitoring in patients and seeing new emergencies are different skill sets and require different staffing set-ups. Further form the clients perspective, one of the big challenges with emergency \|OOH care is cost and requiring all hospitlas to offer new emergency admissions as opposed to centralising this in an area will only put costs up to clients (or will lead to more cross subsidisation and increased vet costs generally). The profession should be focussing on the best care for the future in terms of both animals welfare and client care and this is likley to require more flexible models allowed. As currently written it seems the scheme is desperately trying to hold on to the past and using regulation to achieve that. | 3/23/2015 6:17 AM |
| 12 | Agree that they need to provide an overnight clinical team for inpatients however see no reason why OOH cases cannot be outsourced to another site. It will compromise patient care if staff are not experienced/trained in ECC and will potentially be a step backwards with reagrds to staff welfare if they are going to be working nights & days | 3/23/2015 5:52 AM |
| 13 | I do - but you allow my nearby sites to ignore this and pretend they also do in their marketing when they outsouce to distant Tier 3s and are inm fact completely closed and unable to offer records or any supportive contact regarding ongoing treatment of an animal. You need to make it worthwhile investing in the facilities and staff required to be a Tier three not erroding the value of such a tittle, but faciulitating Tier 1s to emulate Tier 3s and avoid their use when they are shut. | 3/22/2015 10:05 AM |
| 14 | The grade of veterinary hospital implies that practices are intending to provide an excellent service to their own clients, and I think this should include a dedicated OOH service. | 3/22/2015 7:57 AM |
| 15 | Veterinary hospitals are likely to be seeing very specialist cases during OOH (ie their own case-loads, to begin with) and so shoudl be providing tier own specialist OOH. Passing these highly technical cases that require emergency OOH back to standard OOH providers that have to work without access to the original case notes is not good practice. | 3/22/2015 3:31 AM |
| 16 | Excellent idea for inpatients, with the caveat that a vet should be on site at all times, although this would significantly impact on recruitment and go back to a traditional OOHs model, but I don't think its eitehr necessary nor good for patient care to have to have on call for incoming emergencies at Vet Hospitals, particularly if there is no vet on site | 3/21/2015 12:37 PM |
| 17 | It is not for an outside body to dictate a business model. Many such organisations may exist in a very satisfactory manner, and they will simply stop participating. | 3/20/2015 6:46 AM |
| 18 | OOH care of patients should not go down a notch when the day team go off duty | 3/20/2015 4:53 AM |

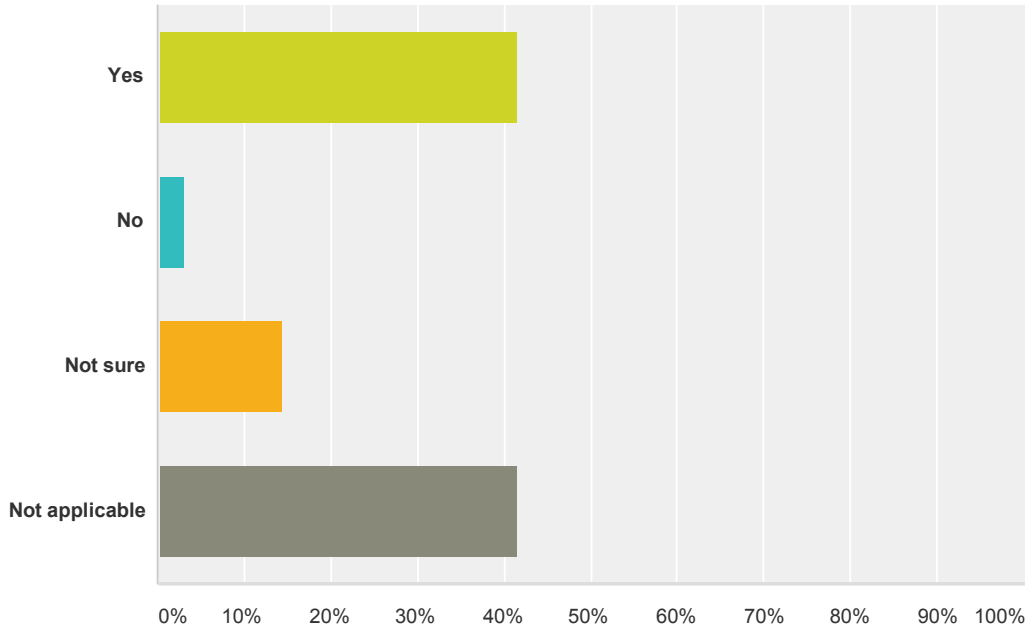
| | | |
|---|---|---|
| 19 | People may have chosen a practice because of the award and they are entitled to that level of service 24/7 | 3/20/2015 4:30 AM |
| 20 | Staffing issues. Recruitment and retention of vets particularly. | 3/19/2015 12:37 AM |
| 21 | I feel strongly that it is not in the animals best interests to be transported to and fro an external OOH service | 3/18/2015 3:42 PM |
| 22 | Centrally planned models rarely deliver the quality of service a local community wants or needs | 3/18/2015 8:33 AM |
| 23 | Why should this be necessary if out of hours can be provided by outsourcing to a reputable company. | 3/18/2015 3:15 AM |
| 24 | This will restrict achievement of Hospital status to large practices or those with sufficient density of local practices to run a viable out-of-hours specific service. It will be impossible for small practice to move up to Hospital status without breaching working time directives. Of course if practices move down a tier because they cannot fulfil the requirement to do their own OOH, then they will also stop fulfilling other requirements. So the overall effect on standards will be downwards. The current arrangements should continue. Hospitals must have in-patient care, but can contract new-cases to another hospital or ESC centre. | 3/17/2015 12:49 PM |
| 25 | In the interest of pet owners and their animals, almost all of whom would, in my view, prefer to have their OOH cases seen in their own practice rather than travel to a distant out-sourced place they have never been where the vet knows nothing of their animals's history and sometimes doesn't speak an acceptable level of English. | 3/16/2015 4:52 AM |
| 26 | This will lead to an increase in overheads (and by extension fees), or a drop in the quality of care through overworked staff. Or, it will lead to large numbers of current hospitals choosing not to enter into the scheme. The provision of OOH care by dedicated specialised EEC providers is of a higher standard than many in house schemes will provide. Patient welfare will suffer as a result. | 3/15/2015 3:14 AM |
| 27 | Hospitals are likely to managing more complex cases and so are likely to be involved in more in-depth OOH care | 3/13/2015 8:04 AM |
| 28 | Not sure if this will just put people off from raising standards. Quite hard to run a really good emergency clinic with fair and transparent pricing structure | 3/12/2015 6:09 AM |
| 29 | We have successfully used an OOH provider for several years and you can work well with them as a team. It would be very difficult to recruit staff willing to do traditional on call and smaller practices cannot manage a "separate" OOH business. It is hard enough managing staff anyway in a profession that is very stressful. How much of the schemes are supporting business owners.....what about their health & welfare? Also, and as there should be, the focus is primarily on the patients and clients but should there not be something about how they behave towards us as professionals and our staff? Everyone should be treated fairly and clients are not always good at this | 3/11/2015 12:53 AM |
| 30 | Clients expect continuity of care from VH | 3/9/2015 7:02 AM |
| 31 | I feel that a hospital practice should mean gold standard - and this means 24/7 service being available to the clients | 3/8/2015 3:55 AM |
| 32 | It should be from tomorrow. | 3/7/2015 1:07 PM |
| 33 | why? | 3/2/2015 4:13 AM |
| 34 | I think it is a good idea but some Hospitals will be unable - what will you have them do then? | 2/27/2015 12:43 AM |
| 35 | Absolutely - this must be a fundamental core issue for hospital accreditation! Also this should apply to farm and equine not just small animal. | 2/26/2015 1:46 PM |
| 36 | I always thought hospitals and to cover their own out of hours so I am surprised it is a new requirement. However in my opinion it is essential for animal welfare | 2/23/2015 11:03 AM |
| 37 | We are not a veterinary hospital, but think that this decision should be made in conjunction with the British Veterinary Hospitals Association. hospitals Association. | 2/23/2015 11:02 AM |
| 38 | It would be expected of a hospital | 2/23/2015 4:13 AM |
| 39 | I think this gives the best provision for a pet | 2/18/2015 1:52 PM |
| 40 | Not relevant two neighbouring hospitals should be able to pool resources | 2/18/2015 10:19 AM |
| 41 | I do not see why this should be a requirement as long as the hospital is transparent about their out of hours arrangements | 2/18/2015 10:14 AM |
| 42 | No necessity to be rigid . there are always exceptions and best left like that. if the standard is as required no further rule is needed | 2/18/2015 8:16 AM |
| 43 | I would support the concept that hospitals can only use other hospitals to provide ooh cover but I see no sound reason why it must be from the same premises | 2/18/2015 1:42 AM |

| | | |
|---|---|---|
| 44 | All practices taking animals in for operations should provide basic OOH care - should not move sick animals backwards and forwards | 2/17/2015 11:19 AM |
| 45 | If a practice has hospital status then the care is to a very high level so they should then provide that same level out of hours for their own clients as well as in normal working hours | 2/17/2015 7:42 AM |
| 46 | There is a lot of confusion about and certain practices appear to be supplying a 'full service' when they clearly are not | 2/17/2015 6:24 AM |
| 47 | Hospitals should have no excuse not to provide OOH. | 2/17/2015 6:06 AM |
| 48 | Consistency of care, in an ideal world all practices should be able to support their own out of hours. | 2/17/2015 5:42 AM |
| 49 | veterinary hospital are the highest standard, and so should provide 24hr care. this was one of the basic remits of a VH | 2/17/2015 5:34 AM |
| 50 | I don't see why hospitals should be allowed to take 5 years to sort out their out of hours if you are proposing that GP's do it straight away. I think the level of accreditation for hospitals is such that it would be unusual for them not to provide their own OOH cover anyway. | 2/17/2015 5:32 AM |
| 51 | The public rightly expect a 'hospital' to provide a 24 hour service | 2/16/2015 4:33 PM |
| 52 | To give a Hospital style service OOH provision shopuld be part of that service. Hospital status should be the pinnacle of standards and levels of care, this can only be achieved by providing full 24hour care | 2/16/2015 12:47 AM |
| 53 | if they are a hospital they should have 24 hour care | 2/12/2015 3:21 AM |
| 54 | A hospital should be able to care for its admitted/hospitalized patients without risking their stabilization or condition by trasnferring them to a nearer OOH/ECC practice. | 2/11/2015 6:21 PM |
| 55 | Public expectation of a hospital and investment required of those hospitals that do | 2/11/2015 10:45 AM |
| 56 | Current situation in place of transporting animals to OOH providers is major source of problems for the profession. | 2/10/2015 7:35 AM |

## Equine GP - Ambulatory

### Q23 Do you agree with this proposal?

Answered: 70 Skipped: 28




| Answer Choices | Responses | |
|---|---|---|
| Yes | **41.43%** | 29 |
| No | **2.86%** | 2 |
| Not sure | **14.29%** | 10 |
| Not applicable | **41.43%** | 29 |
| **Total** | | **70** |

## Equine GP – Ambulatory

### Q24 Do you have any additional comments on this proposal?

Answered: 11 Skipped: 87

| # | Responses | Date |
|---|---|---|
| 1 | Its very sensible. | 3/24/2015 7:03 AM |
| 2 | farm? | 3/23/2015 9:33 AM |
| 3 | The ambulatory standard must not be available to vets solely operating from vehicles. There must be at least and office where appointments can be made, equipment checked and cleaned, medicines stored | 3/23/2015 7:51 AM |
| 4 | Great idea - there is a need and the title is clear | 3/23/2015 6:47 AM |
| 5 | Staff capacity may prove an issue. Many 'one man bands' only have a wife/partner to answer the phone. | 3/20/2015 6:47 AM |
| 6 | Patients that would be better hospitalised will remain in their own yard, simply because the ambulatory practice will suffer financially if the case is referred to a practice with in-patient facilities. We would not contemplate an "ambulatory small animal level", why should equine be different. | 3/17/2015 12:51 PM |
| 7 | My equine colleagues would need to comment on this - I am completing this from the SA perspective of the practice | 3/11/2015 12:54 AM |
| 8 | Reading the 'ambulatory' section is comical. It has clearly been written by someone with no experience of equine practice. For example 'All team members have received and are familiar with protocols for examinations undertaken in the field. For example ophthalmological examinations may need to be carried out in a darkened area.'. In other news bear defecates in woods. | 3/7/2015 1:23 PM |
| 9 | Good idea - plenty of practices that have an ambulatory service but strive to achieve the same practice standards as hospitals. Fully support this proposal | 2/26/2015 1:47 PM |
| 10 | Equine ambulatory practices currently have no level of accreditaton and there are many very good ambulatory only practices. They should be recognised as such | 2/16/2015 12:48 AM |
| 11 | Consider opinion of those working in equine practices instead. | 2/11/2015 6:25 PM |

## IT System

### Q25 We would welcome any feedback in relation to the new IT system:

Answered: 39 Skipped: 59

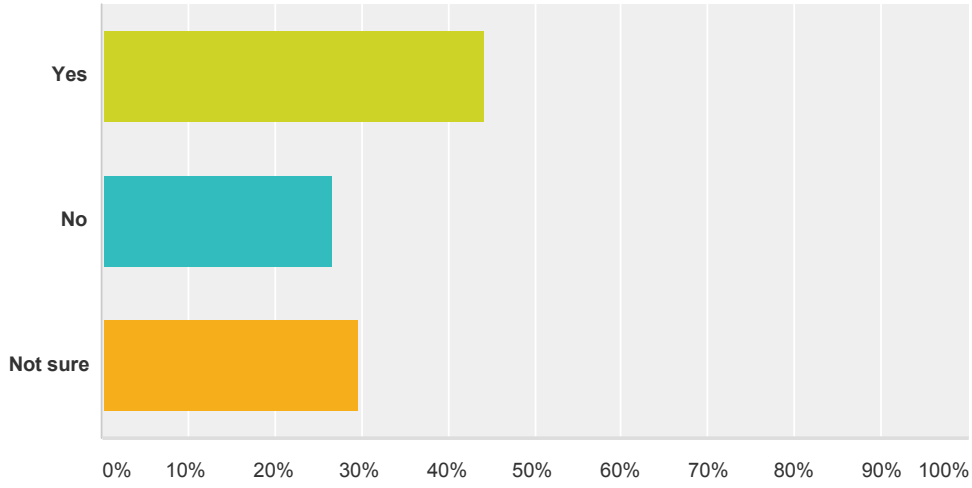
| # | Responses | Date |
|---|---|---|
| 1 | Sounds good as long as it doesn't take too long to upload stuff, and the information remains accessible only by the practice or RCVS. | 3/24/2015 9:16 AM |
| 2 | It sounds great - I look forward to trying it out in due course. | 3/24/2015 7:04 AM |
| 3 | already given | 3/23/2015 11:16 AM |
| 4 | If set up in a user-friendly manner, I think that this is an excellent idea. | 3/23/2015 10:29 AM |
| 5 | will it work? | 3/23/2015 9:36 AM |
| 6 | ok | 3/23/2015 9:34 AM |
| 7 | Needs to be basic & straighforward -could lend itself to the original tick system plus uploads | 3/23/2015 9:27 AM |
| 8 | An excellent idea, practices will almost certainly use it to generate reminders for many tasks in the business. | 3/23/2015 9:20 AM |
| 9 | IF it works as advertised it sounds quite good. | 3/23/2015 8:57 AM |
| 10 | Would be of use to smaller practices | 3/23/2015 8:47 AM |
| 11 | Need to see it first. Great idea, but please don't make it clunky like the NPL and PDR. Much quicker the fewer mouse clicks there are (allow multiple entries with tabs instead, and remember loads of us have <1Meg broadband or no broadband at all. Need to retain access to prev records (eg PDR only shows last 3 years so at beginning of each year, you can only see 2 years CPD - and it reverts to always showing that you haven't done enough even when you have! [This is misleading - pls put 4 years on]. Just needs some thought and feedback from several users and assessors before things go too far. Other essentials are log ins for the practice so several people can access it and easy summary printouts for progress (a nightmare on NPL) | 3/23/2015 6:56 AM |
| 12 | sounds good - just please make sure it works and is user friendly | 3/23/2015 6:18 AM |
| 13 | No Idea if this makes any difference to anything if the system iteslf is corrupt. | 3/22/2015 10:05 AM |
| 14 | Good idea. This further reduces the emphasis on box-ticking during the actual inspection. | 3/22/2015 3:32 AM |
| 15 | sounds great | 3/21/2015 12:50 PM |
| 16 | Would need to 'test drive' before reviewing but principle sounds good. | 3/20/2015 6:48 AM |
| 17 | Sounds excellent and I have had positive feedback from practices that I have described the system to, especially the facility to remind practices that a particular document requires renewal/updating | 3/20/2015 4:56 AM |
| 18 | This is a brilliant idea but needs to be easy to use | 3/20/2015 4:31 AM |
| 19 | Can see some value particularly as nurse training progress log works well. Keep it simple though! | 3/19/2015 12:40 AM |
| 20 | Good luck with the useability - trying to designs a complex system from the ground up for the various types of veterinary practice will probably produce a system as successful as the NHS IT system. Start small and gradually expand and develop a system that works. | 3/18/2015 8:37 AM |
| 21 | The RCVS PSS need not cover areas already covered by other legislation,eg H&S, waste disposal, PAT testing, employment contracts. This should not be within the remit of RCVS involvement | 3/18/2015 3:20 AM |
| 22 | this is a potentially excellent concept. let's hope it works well. The inspection would be much better if all documentation was dealt with in advance. maybe the actual inspection should only take place once the documentation is in place. | 3/17/2015 12:52 PM |
| 23 | As a (current) inspector I would want the IT for the new Assessors to be as simple as possible. | 3/16/2015 4:53 AM |
| 24 | Sounds like a great idea | 3/15/2015 3:15 AM |
| 25 | We believe this will be useful. We have had our files organised to parallel the PSS manuals so it should be very useful to us. We have indicated we would be happy to trial the system | 3/11/2015 12:55 AM |
| 26 | excellent investment | 3/9/2015 7:03 AM |

| | | |
|---|---|---|
| 27 | Knowing how inefficient some practices are at gathering the required documentation prior to their current inspections I predict that gathering this info prior to inspection may prove difficult and laborious in some cases. | 2/28/2015 1:41 AM |
| 28 | As long a sit works its a good idea. | 2/27/2015 12:44 AM |
| 29 | This may be a lot of work for a small practice with a limited staff. | 2/23/2015 11:05 AM |
| 30 | Sounds good so long as it actually works and does not cost the earth | 2/23/2015 11:04 AM |
| 31 | Seems sensible | 2/23/2015 4:14 AM |
| 32 | I hope it didn't cost too much and that it will work. Experience with the nurse computer system would suggest that it will likely be unsatisfactory and that there will be no money or interest in improving it | 2/18/2015 10:21 AM |
| 33 | may be easier but time to do all this just as long probably longer | 2/18/2015 8:17 AM |
| 34 | Anything like this to make life easier is always a bonus to both parties involved as saves time and paperwork | 2/17/2015 7:44 AM |
| 35 | The system must be simple and inexpensive!. It should by default work on all operating systems including Mac and Linux not just Microsoft. Default document upload should be PDF - not bespoke Microsoft documents. PAT testing seems crazy. We have hundreds of devices and extension leads etc and testing them is like painting the Forth Bridge - it depends when you initially buy the equipment when you test it and is not done on a particular day. Reminders for next pharmacy course due and occasional events maybe useful but unnecessary and will add to expense. Uploading relevant documents with a check list seems sensible | 2/17/2015 6:30 AM |
| 36 | Better than a lever arch file! | 2/17/2015 6:07 AM |
| 37 | an excellent idea for all these reasons | 2/17/2015 5:36 AM |
| 38 | As yet to try it but found computer system for nurse training to be easy to use | 2/17/2015 5:33 AM |
| 39 | Having an online chat available ofr any concern. | 2/11/2015 6:26 PM |

## Fees

### Q26 Taking into account the additional benefits of the revised Scheme, do you think the proposed price increase represents good value for money?

Answered: 68 Skipped: 30




| Answer Choices | Responses | |
|---|---|---|
| Yes | **44.12%** | 30 |
| No | **26.47%** | 18 |
| Not sure | **29.41%** | 20 |
| **Total** | | **68** |

## Fees

### Q27 Please give a reason for your answer:

Answered: 33 Skipped: 65

| # | Responses | Date |
|---|---|---|
| 1 | Is there a definitive increase in income linked to being accredited? | 3/23/2015 3:43 PM |
| 2 | Where a large practice has branches that are more than core, they should pay a higfher rate as this discfriminates against smaller or single site practices, who have to pay relatively more per vet. | 3/23/2015 11:17 AM |
| 3 | I do not own or manage a practice so am unaware of the current fees. The quoted figures sound reasonable. | 3/23/2015 10:32 AM |
| 4 | Too expensive for any benefit it will give to the practice | 3/23/2015 9:37 AM |
| 5 | i really don't see why i have to pay £350 for something i am doing anyway | 3/23/2015 9:34 AM |
| 6 | Need to see it working before can comment | 3/23/2015 9:28 AM |
| 7 | Not clear yet if the scheme is understandable to the public - if it is then support higher fees, if it is not then would question higher fees. Also would want it to lead to an improved quality of inspectorate with consistency | 3/23/2015 6:19 AM |
| 8 | Will depend on how many awards practices go for | 3/23/2015 5:54 AM |
| 9 | I have been chgarged for 3 visits in four years and given contorted explanations as to why. The standards themselves appear elastic, along with the costs. | 3/22/2015 10:07 AM |
| 10 | not sure of current prices | 3/21/2015 12:50 PM |
| 11 | I am not the person to ask re this. I am no longer a practice owner. | 3/20/2015 4:58 AM |
| 12 | As more of these processes are performed in advance submission to assessors surely the amount of time on site at a practice would be reduced? Therefore more inspections in a geographica area at the same time therefore cost saving to the RCVS? | 3/19/2015 12:42 AM |
| 13 | Convince me that I will see a real measurable change with this scheme for the proposed extra costs. | 3/18/2015 8:39 AM |
| 14 | The scheme at present has no marketable value. It is an increase of non productive costs to the practice. | 3/18/2015 3:21 AM |
| 15 | we just don't know whether the public will engage with the scheme and even if they do, it may well be that the less demanding awards become the ones that are achieved. | 3/17/2015 12:54 PM |
| 16 | Depends on how much time we have to put in to prepare for them first in order for it to fit the time scales proposed or it could cost a lot more in assessors time | 3/11/2015 12:56 AM |
| 17 | expensive | 3/2/2015 4:14 AM |
| 18 | The money has to come from somewhere - so ultimately it will be clients that pay for it and I am not sure they are informed enough to appreciate what exactly the benefits to them are, or if they would take that aboard. | 2/27/2015 12:45 AM |
| 19 | This may be too expensive for a small practice. It is an extra non productive expense at a time of economic recession. | 2/23/2015 11:08 AM |
| 20 | Potentially a practice could pay several £1000's per year. Where is the return on this? | 2/23/2015 11:06 AM |
| 21 | It seems unclear on costs. I think you'd be better setting a fee per award rather than on time - £50 per award (as an example). What isn't clear for a mixed practice - some areas have a lot of cross over, what happens if you want assessing in 3 areas, does it carry 3 fees or can the behaviours carry over. | 2/23/2015 4:15 AM |
| 22 | Currently you only have 57% of practices enrolled. Focus should be on attaining 100% before increasing the price | 2/18/2015 10:21 AM |
| 23 | I do not agree with the awards system - See previous responses | 2/18/2015 10:16 AM |
| 24 | I dont think the patients benefit | 2/18/2015 8:18 AM |
| 25 | I do not think it offers a meaningful benefit to either clients or practices and will actually complicate the system making it harder for clients to understand. I have concerns that the cost of awards would lead to only larger and corporate practices pursuing these awards and consequently using them in marketing which smaller practices may not feel able to do for financial rather than clinical reasons. | 2/18/2015 1:45 AM |
| 26 | Feel inspections should be just that and feel awards pointless | 2/17/2015 11:21 AM |
| 27 | If all the paperwork is in place could this not be done at the inspection | 2/17/2015 6:30 AM |

| | | |
|---|---|---|
| 28 | We would certainly try for additional awards at our hospital and possibly one of our larger branches so could work out very expensive. | 2/17/2015 6:09 AM |
| 29 | inspectors time for awards could prove to be very costly - if looking to achive several awards | 2/17/2015 5:47 AM |
| 30 | That is a considerable jump, especially for a group with 4-5 branches. | 2/17/2015 5:43 AM |
| 31 | It might be fairer to have some consideration for the size of the practice otherwise you will hit smaller practices hard and possibly disincentivise them | 2/17/2015 5:35 AM |
| 32 | I ignore the extend of paperwork and time consuming, therefore I wouldn't want to say whether the cost is reasonable, underestimated or abusive. | 2/11/2015 6:28 PM |
| 33 | As practice owner this feels like another professional fee that is likely to be forced upon me when there are already so many high fees of this type that we have to pay. | 2/10/2015 7:37 AM |

## General comments

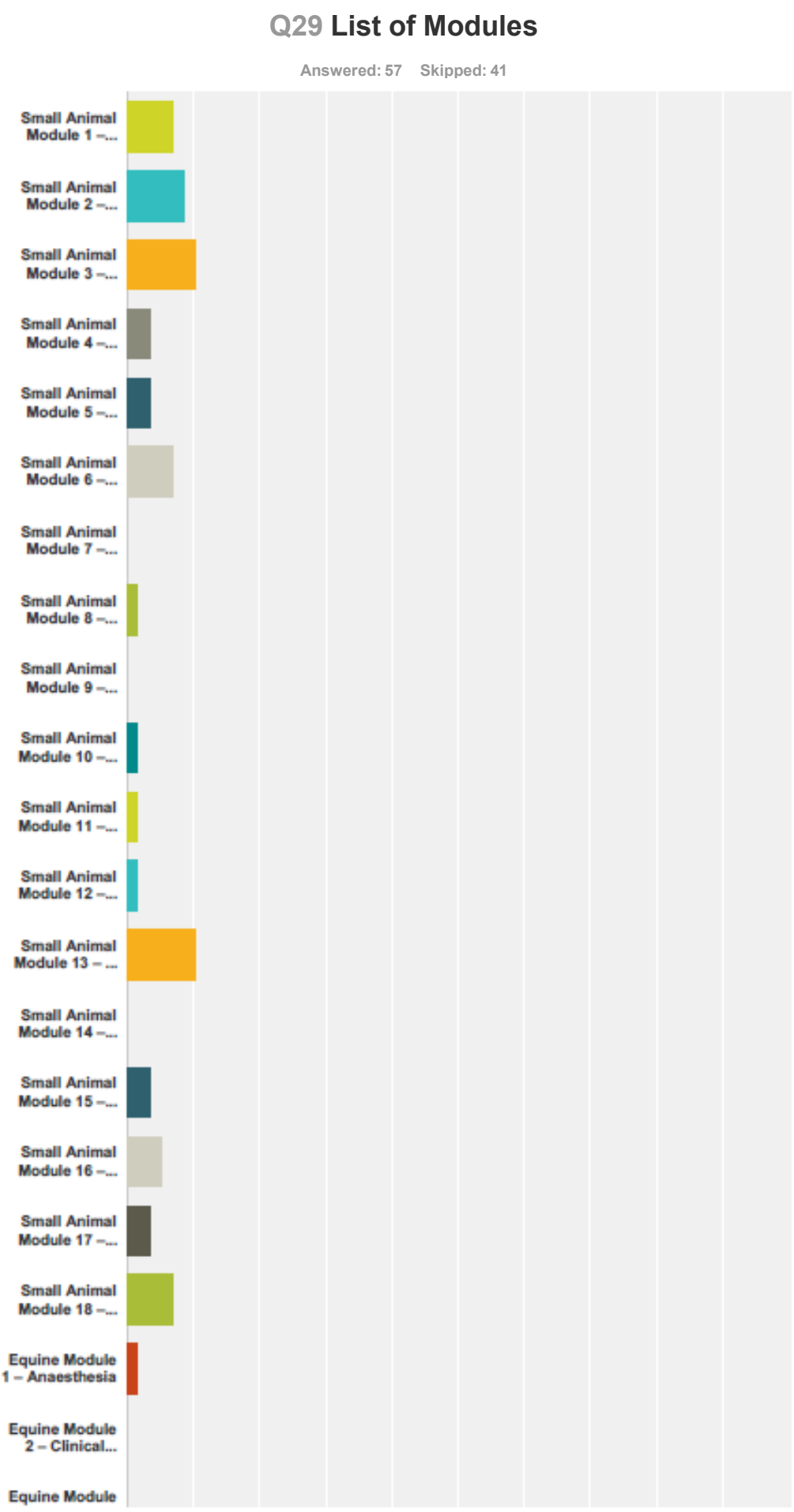
### Q28 If you have any general comments on the proposed revised Scheme, please add them below:

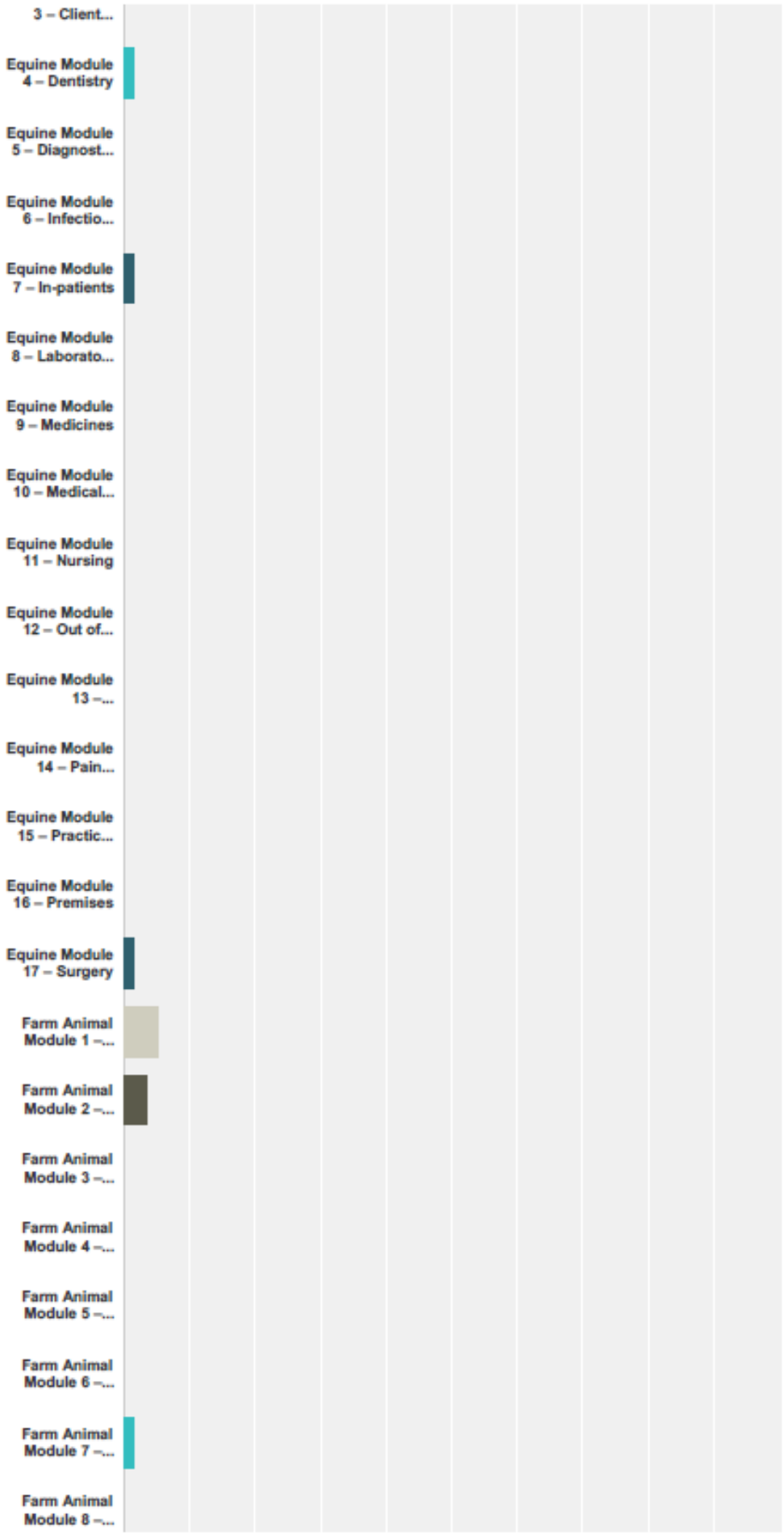
Answered: 28 Skipped: 70

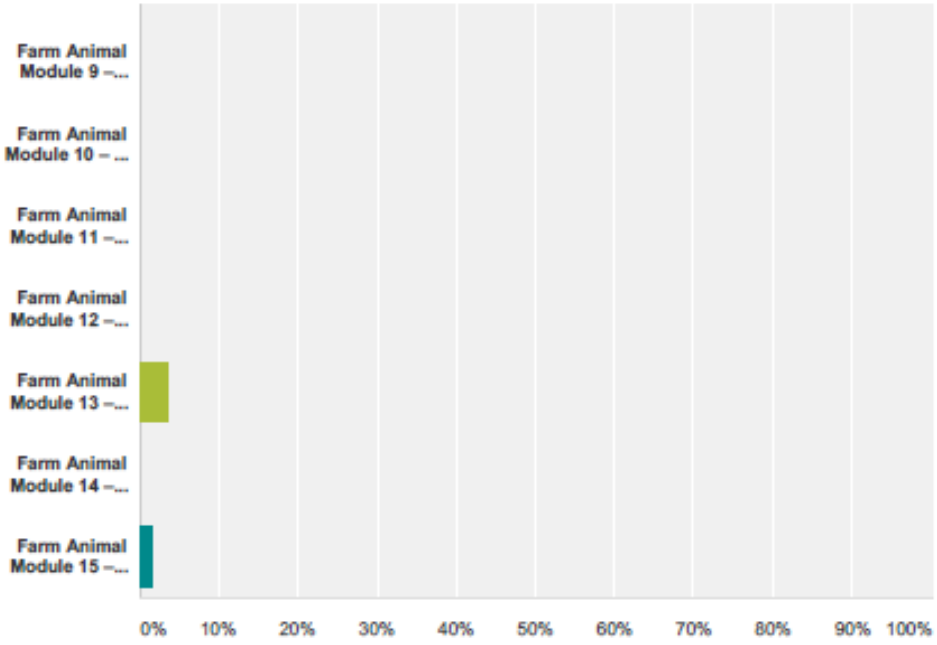
| # | Responses | Date |
|---|---|---|
| 1 | I don't think modules are a good idea; the public wont understand them | 3/23/2015 9:37 AM |
| 2 | Folk are familiar with the star system for hotels (objective assessment criteria) and fully understand that subjective experiences, e.g. a bored receptionist in a 5-star hotel, can alter their perception of the standard of service. A similar system applies with vet practices, but one cannot quantify this experience in a single day's assessment. The participation of the various vet bodies is noted, but I doubt if there is an insatiable appetite for hospitals to seek further ratings of their services. | 3/23/2015 9:24 AM |
| 3 | The proposals for the awards are complex and obviously represent a phenomenal amount of work by the members of PSG. We congratulate them on producing a practical framework for moving the PSS forwards in a way that is challenging but achievable for practices in the scheme. We are positive about the awards, but worry that some are not challenging enough or not specific enough to make assessment predictable yet. We are sure refinement with feedback from other practices and a pilot will result in a relevant framework for practices to improve. | 3/23/2015 7:16 AM |
| 4 | It seems very complex for the profession never mind the public. I was also hoping to see more on behaviours although appreciate this appears to be a work in progress | 3/23/2015 6:20 AM |
| 5 | Please make the veterinary profession proud of the standards be a return to trasparency and Animal welfare. | 3/22/2015 10:07 AM |
| 6 | I have worked in a practice accredited to the standard of veterinary hospital and this was a complete joke. The practice may have fulfilled these requirements on the day it was assessed but not in the years in between. I note that changes which will take place in the way the scheme is assessed, but I am still suspicious that practices will make a big effort at the time they are assessed but not in between. Supposedly on the old scheme there could be spot inspections but I never heard of that actually happening. I know the scheme is intended to be voluntary and not a police state, but I do think the system needs to be monitored in ways like this (i.e. unannounced visits) to ensure that it retains any integrity. This integrity is important not just for the general public but also, critically, for other members of the profession. I applied to work at the practice mentioned above partly because it had this status but was disappointed to find that this didn't really mean very much. Also, regarding assessment, the inspector of this practice mentioned above was a good friend of the owner of the practice and I hope that possible conflicts of interest like this will be monitored closely in future. | 3/22/2015 8:03 AM |
| 7 | If the only value of the scheme is to get a rating, then practices are missing the big benefit: this is a chance for an external 'adviser' to help each practice to improve. Practices shod be using the scheme to improve the quality of care they provide to staff, clients and patients. | 3/22/2015 3:34 AM |
| 8 | Everything sub-wise in the vet world is expensive. We are used to paying. At least this brings kudos, the RCVS registration is just money for old rope. | 3/20/2015 6:50 AM |
| 9 | I haven't seen what is coming in the survey but while reading through, I had the sense that the FA modules were the SA modules tweaked for FA practices rather than modules created from FA practice | 3/20/2015 5:02 AM |
| 10 | I think it is really valuable to focus on behaviours rather than just facilities - this should definitely improve patient care | 3/20/2015 4:32 AM |
| 11 | Award for maintenance of standards as seen on a spot check inspection. | 3/18/2015 3:24 AM |
| 12 | I am disappointed that the obvious inequality in effort between the modules has not been spotted and addressed. It is a clear weakness. I am also disappointed that some rather dated requirements (proof of ECG and ultrasound training) are still included. these specific training requirements were introduced many years ago when these modalities were relatively new to practice. They are now taught in clinical years at vet college. I am also disappointed that in all the modules the relative value of qualifications is incorrect. An old style certificate is now reduced to the equivalent of a single module of the new certificate in some sections. When the CertAVP was launched it was supposed to be equivalent to the old certificate. There was much consternation at the time that it was not as rigourous and yet now the cert AVP earns more points than the old certificate. The Diploma is only worth a few more points than a certAVP which is an equal travesty. a suggested points hierarchy would be 10 points per clinical module of a CertAVP 40 points for an old certificate 80 points for a Diploma. It should also be appropriate that every holder of qualifications should count. eg A practice with four certificate holders in a subject , clearly has a more resilient clinical strength than a practice with a single surgeon. | 3/17/2015 1:07 PM |

| | | |
|---|---|---|
| 13 | As a (current) inspector, will the new Assessors feel under pressure to get through the Award inspections asap as each half day costs the practice more? | 3/16/2015 4:55 AM |
| 14 | The scheme is good in principle but the change in requirement for OOH care is a backward step for the profession | 3/15/2015 3:17 AM |
| 15 | Sceptical at this stage as to how it will benefit us | 3/11/2015 12:56 AM |
| 16 | overall a genuine pathway for improvement for all practices | 3/9/2015 7:04 AM |
| 17 | All good. Hope it pulls in new members. | 3/3/2015 1:43 AM |
| 18 | Hugely impressed with the amount of thought and work that has gone into these proposals - and hopefully will rebut some of the criticisms of the old scheme. I am however doubtful whether this will bring a surge of new applicants to PSS. | 2/28/2015 1:43 AM |
| 19 | Generally an improvement | 2/23/2015 4:16 AM |
| 20 | As previous comment. These changes make the current situation with a large percentage of practices unwilling to join even less likely to do so. The objective was to reduce the tick box impression - these changes increase it. Thus exactly the opposite effect to that desired will be achieved. Unfortunately the scheme membership has not in my view been adequately involved in these changes and I do not feel that the majority of small practices will welcome them | 2/18/2015 10:24 AM |
| 21 | the scheme provides a standard but does NOT need to be compulsory . there are plenty of penalties for a practice if not in the scheme. more regulation does not help a lot of clients | 2/18/2015 8:19 AM |
| 22 | Cannot see why awards separate from overall scheme | 2/17/2015 11:21 AM |
| 23 | I believe the scheme shoul be compulsory for it be meaningful. As it is clients believe all practices offer the sams facilities | 2/17/2015 5:47 AM |
| 24 | My major concerns regards OOH service as per previous comments | 2/17/2015 5:35 AM |
| 25 | I think it is a great shame that there is no award for farm animal inpatient facilities. We are looking at spending a lot of time and money investing in excellent facilities to allow hospitalisation of farm animals. This could be a real area that could show different practices apart | 2/16/2015 4:35 PM |
| 26 | The awards scheme should not be confusing for the public. The profession can be difficult to understand the differing levels of qualification and standards within the profession. Time and money must be spent explaining the scheme to the public rather than self congratulating ourselves with further awards. | 2/16/2015 12:51 AM |
| 27 | Inform all the vets registered at the moment in the RCVS. So far, I just came across this survey by chance. | 2/11/2015 6:29 PM |
| 28 | it needs to be supported by direct to public marketing | 2/11/2015 10:46 AM |

## Module questions




3 – Client...
Equine Module 4 – Dentistry
Equine Module 5 – Diagnost...
Equine Module 6 – Infectio...
Equine Module 7 – In-patients
Equine Module 8 – Laborato...
Equine Module 9 – Medicines
Equine Module 10 – Medical...
Equine Module 11 – Nursing
Equine Module 12 – Out of...
Equine Module 13 –...
Equine Module 14 – Pain...
Equine Module 15 – Practic...
Equine Module 16 – Premises
Equine Module 17 – Surgery
Farm Animal Module 1 –...
Farm Animal Module 2 –...
Farm Animal Module 3 –...
Farm Animal Module 4 –...
Farm Animal Module 5 –...
Farm Animal Module 6 –...
Farm Animal Module 7 –...
Farm Animal Module 8 –...




| Answer Choices | Responses | |
|---|---|---|
| Small Animal Module 1 – Anaesthesia | **7.02%** | 4 |
| Small Animal Module 2 – Clinical Governance | **8.77%** | 5 |
| Small Animal Module 3 – Client Experience | **10.53%** | 6 |
| Small Animal Module 4 – Dentistry | **3.51%** | 2 |
| Small Animal Module 5 – Diagnostic Imaging | **3.51%** | 2 |
| Small Animal Module 6 – Emergency and Critical Care | **7.02%** | 4 |
| Small Animal Module 7 – Infection Control | **0.00%** | 0 |
| Small Animal Module 8 – In-patients | **1.75%** | 1 |
| Small Animal Module 9 – Laboratory and Post-Mortem | **0.00%** | 0 |
| Small Animal Module 10 – Medicines | **1.75%** | 1 |
| Small Animal Module 11 – Medical Records | **1.75%** | 1 |
| Small Animal Module 12 – Nursing | **1.75%** | 1 |
| Small Animal Module 13 – Out of hours | **10.53%** | 6 |
| Small Animal Module 14 – Out-patients | **0.00%** | 0 |
| Small Animal Module 15 – Pain Management | **3.51%** | 2 |
| Small Animal Module 16 – Practice Team | **5.26%** | 3 |
| Small Animal Module 17 – Premises | **3.51%** | 2 |
| Small Animal Module 18 – Surgery | **7.02%** | 4 |
| Equine Module 1 – Anaesthesia | **1.75%** | 1 |
| Equine Module 2 – Clinical Governance | **0.00%** | 0 |

| | | |
|---|---|---|
| Equine Module 3 – Client Experience | **0.00%** | 0 |
| Equine Module 4 – Dentistry | **1.75%** | 1 |
| Equine Module 5 – Diagnostic Imaging | **0.00%** | 0 |
| Equine Module 6 – Infection Control | **0.00%** | 0 |
| Equine Module 7 – In-patients | **1.75%** | 1 |
| Equine Module 8 – Laboratory and Post-Mortem | **0.00%** | 0 |
| Equine Module 9 – Medicines | **0.00%** | 0 |
| Equine Module 10 – Medical Records | **0.00%** | 0 |
| Equine Module 11 – Nursing | **0.00%** | 0 |
| Equine Module 12 – Out of hours | **0.00%** | 0 |
| Equine Module 13 – Out-patients (Ambulatory) | **0.00%** | 0 |
| Equine Module 14 – Pain Management | **0.00%** | 0 |
| Equine Module 15 – Practice Team | **0.00%** | 0 |
| Equine Module 16 – Premises | **0.00%** | 0 |
| Equine Module 17 – Surgery | **1.75%** | 1 |
| Farm Animal Module 1 – Anaesthesia | **5.26%** | 3 |
| Farm Animal Module 2 – Clinical Governance | **3.51%** | 2 |
| Farm Animal Module 3 – Client Experience | **0.00%** | 0 |
| Farm Animal Module 4 – Diagnostic Imaging | **0.00%** | 0 |
| Farm Animal Module 5 – Infection Control | **0.00%** | 0 |
| Farm Animal Module 6 – Laboratory and Post-Mortem | **0.00%** | 0 |
| Farm Animal Module 7 – Medicines | **1.75%** | 1 |
| Farm Animal Module 8 – Medical Records | **0.00%** | 0 |
| Farm Animal Module 9 – Nursing and Paraprofessionals | **0.00%** | 0 |
| Farm Animal Module 10 – Out of hours | **0.00%** | 0 |
| Farm Animal Module 11 – Out-patients | **0.00%** | 0 |
| Farm Animal Module 12 – Pain Management | **0.00%** | 0 |
| Farm Animal Module 13 – Practice Team | **3.51%** | 2 |
| Farm Animal Module 14 – Premises | **0.00%** | 0 |
| Farm Animal Module 15 – Surgery | **1.75%** | 1 |
| **Total** | | **57** |

## Small Animal Module 1 – Anaesthesia
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q30 If you have any feedback, please add it below:

Answered: 7 Skipped: 91

| # | Responses | Date |
|---|---|---|
| 1 | Re: Guidance notes GP 1.; what does daily check of anaesthetic equipment actually mean? How would an Assessor check that this is being done? | 3/16/2015 5:03 AM |
| 2 | Why does this have 80 points assigned to this module when others have 40? Is anaesthesia twice as important as anything else? Why does it have to be part of a certificate course for GP? What is meant by proper ventilation...is this referring to hospitals? Are GP practices going to be struggling to meet this? Are SVNs ok to monitor anaesthesia? Does training as a VS or VN mean that we have complied with adequate training in IPPV & CPR? | 3/11/2015 3:58 AM |
| 3 | I think for all species, it will be difficult for all audit types to be able to use published standards to undertake audit - there is very little evidence on certain conditions, and creating standards to aim for for the sake of it seems a bit pointless? | 3/9/2015 11:12 AM |
| 4 | GP SA 12. Would like to see added;' A concise chart of emergency drug doses must be kept with the rescucitation box'. VH 1. In a busy OOH situation where there is only one VN on duty it may not be possible for a recovering animal to receive undivided attention until fully recovered. | 2/28/2015 1:59 AM |
| 5 | You give similar weighting to a single CertAVP anaesthesia module as the whole old CertVA! Insulting | 2/23/2015 4:20 AM |
| 6 | The use of the word must when should is more appropriate. | 2/18/2015 10:34 AM |
| 7 | ie still a paper exericse as no change to original concept just some add ons | 2/18/2015 8:20 AM |

## Small Animal Module 1 – Anaesthesia
## Award points

### Q31 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 8 Skipped: 90

| # | Responses | Date |
|---|---|---|
| 1 | Award points are acceptable | 3/24/2015 7:05 AM |
| 2 | 2. not clear whether a module can be B or C? What about MSc or equivalents? 4. Are cleaning / disinfection records essential or not? Should we be adding to paperwork, or are we expecting this to be recorded say ion checklists? Could we instead expect an SOP to make it clear by where a mark is that it has been cleaned and disinfected? 6. H&S should not be in awards. Should be in PSS or not according to risk assessment. Lots of practices do not use keyfill at present but fill at end of day with good ventilation. 7. Don't understand the relevance of this. If wishing to include practices without a prep area, how does a separate induction area add to patient safety? 14. (plus experienced student nurses under supervision?) 15. Too woolly. What is 'adequate for the work undertaken?' Different practices will have very different views so this is meaningless. Points for these subunits are way too low. For example it shouldn't be possible to be outstanding in anaesthesia without multiparameter monitoring. Inspired agent monitoring is missing from the list. 16. and 17. should have hight point scores - they are vital In addition to the points already listed, we would expect for a practice to be good in anaesthesia, for auditing to be carried out and for capnography to be routinely used (staff will only become confident if it is routine) Only using monitoring on low risk cases doesn't help the unexpected. For a practice to be outstanding we would expect muscle relaxants to be used appropriately (yes they are used in GP); Constant rate Infusions to be used regularly for anaesthesia and pain relief, Local blocks to be used to reduce GA dose; blood pressure to be maintained using pressor agents, fluids and analgesia; CVP and urinary catheterisation to be used for appropriate monitoring (in relevant cases) | 3/23/2015 8:11 AM |
| 3 | Why are the award points for AP status different to surgery? Why no award points for anaesthesia specialist? | 3/23/2015 6:23 AM |
| 4 | I think IV catheters should be encouraged for all ASA categories, not just >2. | 3/22/2015 8:04 AM |
| 5 | Award point 5: cleaning of endotracheal tubes. Please can we have a mandatory requirement for a bottle brush-like piece of equipment to clean these tubes? ie small tubes for cats can easily block with mucus which can only be removed by this equipment. So simple, yet this could prevent a nasty anaesthesia moment. | 3/16/2015 5:03 AM |
| 6 | 1. Very woolly - does listening to a single webinar on anaesthesia suffice ? 7. This is mandatory for GP Sa - so hardly seems to merit award points. 19. Important - give more points. | 2/28/2015 1:59 AM |
| 7 | Point 2 & 3 - is this per practice or per site? What are ASA categories 2-5? | 2/23/2015 11:15 AM |
| 8 | To prove each of these points requires yet more documentation since verbal assurance will prove inadequate. | 2/18/2015 10:34 AM |

## Small Animal Module 2 – Clinical Governance
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q33 If you have any feedback, please add it below:

Answered: 8 Skipped: 90

| # | Responses | Date |
|---|---|---|
| 1 | Practices could be directed to specific projects e.g. Vetcompass, SAVSNET, or given further guidance on how to contribute data to undergraduate projects. Links to multi-centre studies currently looking to recruit primary care practice could also be provided. Vets working in practice may be interested in sharing data / contributing to research but be unaware of the various options. | 3/23/2015 10:44 AM |
| 2 | The auditing requirement seems to have been lost from VH guidance. Lots of hospitals are doing this so is this deliberate? | 3/23/2015 8:18 AM |
| 3 | I think that some work remains to be done to get practitioners to understand that governamce is about the practices themselves working to improve their own standards for their own benefit. There may be a frequent feeling that governance is more Big Brother rather than a kindly father. Efforts by VetCompass and Nottingham CEBVM are helping to show practices that governance goes hand in hand with improvement and can be very fulfilling for practitioners. | 3/22/2015 4:00 AM |
| 4 | Although CPD is important as are discussions amongst staff what is reasonable for a GP vs VH? | 3/11/2015 4:00 AM |
| 5 | A lot of GP vets still don't really understand what 'Clinical Governance' means - more publicity/webinars needed! | 2/28/2015 2:05 AM |
| 6 | In many practices clinical governance is performed informally on an ongoing basis, but is not necessarily documented, as it is hard to do whilst you are also trying to do your real work which is to make animals better. You seam to totally disregard that - why not simply ask the assistants themselves how often clinical cases are discussed and guidance given rather than requiring us to tick boxes all the time. | 2/27/2015 12:50 AM |
| 7 | Do these activities and behaviours carry over? Can we have meetings and journal clubs and take it in turns to talk about different species? Assume we don't need assessing 3 times if we go for small, farm and equine? | 2/23/2015 4:21 AM |
| 8 | Yet more documentation has to be kept - we are going to drown in paper. In a small practice every conversation will have to be recorded - this is irrational and not feasible. | 2/18/2015 10:39 AM |

## Small Animal Module 2 – Clinical Governance
## Award points

### Q34 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 8 Skipped: 90

| # | Responses | Date |
|---|---|---|
| 1 | Following the recent evidence based veterinary medicine day I think the contribution of data to research is hugely important and may represent the biggest long term contribution this scheme makes to improving the quality of veterinary care and animal welfare. | 3/23/2015 9:00 AM |
| 2 | 8. could add that referral reports are shared with the team for information and to aid case continuity? | 3/23/2015 8:18 AM |
| 3 | I am very impressed that the Clinical Governance section begins with an explanation that governance is a positive thing and should be embraced in order to improve standards of care: 'Clinical governance is a framework to enable the practice to deliver good quality care by reflecting on clinical cases, analysing and continually improving professional practice as a result, for the benefit of the animal patient and the client/owner.' The single requirement for General practices is that 'The practice must have a system in place for monitoring and discussing clinical cases, analysing and continually improving professional practice as a result.' Many practices already do this on an informal and ongoing basis most vets talk about their cases with colleagues anyhow. So this is really just setting these conversations into a systematised and formal structure in order to try to get a more evidence-based discussion going and to keep the conversations on track. To date, a major difficulty here has related to difficulties in retrieving records on multiple cases along with their outcomes and signalment for these conversations. The work going on at VetCompass at the RVC has built predictive coding systems that allows vets to record diagnoses rapidly and easily at the time of the events. this makes case retrieval fast and efficient: and overcomes this barrier. The categories within the Clinical Governance module seem to be well chosen and the arks allocated seem fair. It is now widely accepted by virtually every welfare, veterinary and scientific body that data gathering from primary-care veterinary practice is critical to improving clinical care and animal welfare http://www.rvc.ac.uk/vetcompass/support#tab-testimonials . Assigning 20 and 40 points respectively to points 11 and 12 such that practices that do cover neither of these areas cannot get an 'Outstanding' award seem totally logical. With the development of current data collection projects at a number of universities in the UK, there is no longer any excuse for practices not to become involved. VetCompass is currently working on systems that will clean and organise data collected from practices and make this available in an online format that will allow easy extraction of answers to clinical questions related to each practice's own data. A VetCompass coding system is being rolled out that will allow practices to set up their own clinical audit questions and then practitioners can answer these questions at the time of the event: this removes any onus for protracted extraction and analysis in the months after the event and allow practices to have real-time answers to clinical questions eg. relating to wound infections, use of critically-important antibiotics etc. Well done on putting these requirements into the Clinical Governance section. | 3/22/2015 4:00 AM |
| 4 | 8 - are these relevant to GP? Not all take referrals so do they lose the points? 12- does SAVSnet count as contributing to future publications | 3/11/2015 4:00 AM |
| 5 | There should be points awarded for a vet who has the CertAVP module in clinical governance. The other modules have awards for certificate holders, I feel it is unfair the CertAVP VetGP award is not included. Also, I would like to see credits given for Advanced Practitioner status in medicine or emergency care for example. | 3/8/2015 3:58 AM |
| 6 | 3.4.5 Give more points.11.12. - Not going to happen often ! | 2/28/2015 2:05 AM |
| 7 | Greater weighting on journal clubs than collecting data for future publication | 2/23/2015 11:17 AM |
| 8 | In a busy practice I doubt if there will be sufficient time for recording all the information required for must of these. Yet more tick boxes | 2/18/2015 10:39 AM |

## Small Animal Module 3 – Client Experience
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q36 If you have any feedback, please add it below:

Answered: 6 Skipped: 92

| # | Responses | Date |
|---|---|---|
| 1 | Good new section | 3/23/2015 8:51 AM |
| 2 | Include clients in the focus group | 3/20/2015 7:06 AM |
| 3 | Need more examples as to exactly what required? How is this going to be judged - most of it is just what we do but it seems we need to now write down everything as a "protocol" | 3/11/2015 1:33 AM |
| 4 | Should have reference to ease of access to the practice premises and adequate space for parking/turning/reversing lorries and trailers (not all equine owners are skilled drivers!!). I have seen equine clinics where access is down a narrow lane with no passing points ! | 3/3/2015 2:02 AM |
| 5 | Same question - can I carry over the appropriate points for different species? | 2/23/2015 4:22 AM |
| 6 | Once again this has little to do with actual client experience and much to do with documentation being present and ticked off | 2/18/2015 10:47 AM |

# Small Animal Module 3 – Client Experience
# Award points

## Q37 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 11 Skipped: 87

| # | Responses | Date |
|---|---|---|
| 1 | I think that the focus on end of life issues and communication CPD and training is very good. | 3/23/2015 9:05 AM |
| 2 | 6. noticeboards or equivalent. not all practices like noticeboards and many consider them clutter and unhygienic. We ned to be flexible here and refer to delivering info to client. The reasons could be more specific as most are for marketing which isnt the same thing as education. 9. points should not be equal. Feedback forms and NPS should have way higher point scores than Focus groups. Mystery shopping is good but may be regarded as promotion due to limited number of current providers. Asking for FREEHAND constructive feedback from clients on their experience and expectations (rather than scores) is more meaningful and more in the reach of many practices without paying out large sums of money. otherwise explain that practices can do their own mystery shopping to counteract any accusations of advertising. 10. Would like to be involved in putting this together / refining it 23 points could be higher | 3/23/2015 8:51 AM |
| 3 | This is very skewed towards general practice - I believe many referral hospitals, emergency clinics etc would want to (and should be able to) achieve this but it looks to be impossible as many of the points are awarded for things only done in daytime GP such as vaccination reminders | 3/23/2015 6:26 AM |
| 4 | As a company we have a big focus on client care and already have an NPS in place, however a lot of the points awarded would not be relevant to an ESC accredited practice and we would therefore not be able to achieve an outstanding award | 3/23/2015 6:10 AM |
| 5 | Looks good | 3/20/2015 7:06 AM |
| 6 | There are parts such as Investors in people etc that are heavily weighted which maybe should not be so. | 3/11/2015 1:33 AM |
| 7 | Give points for ease of access/good parking/turning/reversing space for FA clients bringing farmanimals to the veterinary premises. (some 'amateur' keepers may not be very proficient at reversing trailers etc! | 3/4/2015 3:18 AM |
| 8 | 3. i'm not sure what this actually means - and is such information readily available ? 23. Add points for good access to the practice premises for vehicles and easy parking/turning/reversing space for lorries and trailers. | 3/3/2015 2:02 AM |
| 9 | 11. How available is this? 14. I don't know what this means. 17. Unlikely 22. How available is this ? | 2/28/2015 2:11 AM |
| 10 | I feel thoroughly depressed by the whole exercise. I genuinely feel that I can no longer see the wood for the trees. As it happens we already do the vast majority of these clauses, but I am not sure that I can be bothered with trying to prove that we do. I would like it to be on record that the same comments apply to all remaining modules. I have the luxury of time to fill in questionnaires but this is so long and so dispiriting that even I cannot finish it properly. As far as I can tell the whole review has achieved nothing more than to make the previous system worse through exacerbation of the very problem it was trying to solve. Throughout the standards the emphasis is on working as a team - what has transpired is that a very small group of people are imposing ideas on the majority. | 2/18/2015 10:47 AM |
| 11 | Section 3:9 is too prescriptive. Firstly these are only some of the ways to monitor client feedback but not the only ways. Focus Groups and Mystery Shopping are methods of monitoring client feedback but are services sold to vets by third parties ( and are often expensive ) they are also of dubious value (having used some of them). Net Promotor Score is also a 'particular' business idea (registered trademark possibly?) promoted by a particular business. Whilst there are fans of it there are also many critics. It should not be necessary for vets to purchase services from certain providers in order to 'gain the points' for client services. Over the last 4 years or so we have developed our own in house system which monitors our client feedback and it works extremely efficently. The results of our system are visible on our practice website at westbarvets.co.uk/about-us/what-our-clients-say/ and do not require either mystery shopping focus groups or Net Promotor Score. What would be more appropriate would be that (i) The practice can demonstrate that it contacts clients to find out about their experience ( 10 points ) (ii) That the practice can demonstrate that clients respond to feedback requests (10 points) (iii) That the practice can demonstrate it takes action on the feedback received ( both positive and negative) (Iv) That the client feedback process is a constant process ( 10 points ) not just £700 once a year for a marketing company to send out feedback cards. I am very happy to talk to someone from PSS if they want to discuss client feedback further. | 2/17/2015 6:49 AM |

## Small Animal Module 4 – Dentistry
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q39 If you have any feedback, please add it below:

Answered: 5 Skipped: 93

| # | Responses | Date |
|---|---|---|
| 1 | vh 3 clarify that film and xray generator should be of dental type. Should expect to see a substantial proportion of dental procedures incl xrays (often underused or not used). If they are managing this on their main generator then fine. | 3/23/2015 9:00 AM |
| 2 | Not relevant to practices at referral level that dont offer dentistry - unnecessary emphasis on CPD - what about CPD in other areas????? | 3/12/2015 6:11 AM |
| 3 | Some guidance on what is meant by a dental cpd esp for nurses - are diets ok? Also it appears that referral practice is all under the same helm...not all practices will have certAVP or equivalent but it doesn't mean that we are bad at dentals. Why does it have to be an equivalent module of a certificate course. There are plenty of good dental cpd courses available. More detail required | 3/11/2015 1:38 AM |
| 4 | Core 3. And face masks (very important - inhalation of enamel dust is said to be carcinogenic - inhalation of general oral 'crud' is not nice! Also must ensure suitable PPE (esp head gear/footwear ) for owners/others helping with the procedure - especially on home visits. | 3/3/2015 2:10 AM |
| 5 | VH 3. Dental radiography. It is an undeniable fact that currently some VHs have limited or poor quality ability to perform dental radiography and in practice seldom do it. The requirements should add 'And must demonstrate that effective dental radiography is conducted routinely.' | 2/28/2015 2:17 AM |

## Small Animal Module 4 – Dentistry
## Award points

### Q40 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 5 Skipped: 93

| # | Responses | Date |
|---|---|---|
| 1 | 3. these statements are common to many modules - member must also pass on their knowledge. FOR EACH MODULE: should there be a team leader who 'champions' the module? This person should have responsibility for: ensuring the stds are adhered to, ensuring constiual improvement; auditing the behaviour of staff rel to the standards; inducting new staff and ensuring everyone is trained and kept up to date. This would be reasonably easy to assess and provides a point of contact for each part of the assessment. Missing from the dental module: Local blocks Team members confident with surgical extraction Should outstanding include restorative dentistry? | 3/23/2015 9:00 AM |
| 2 | There is no mention of how to maintain sharpness of elevators, I am sure vereinary dentits would agree that this is critical to extraction technique. As an inspector under the current scheme I still see too many blunt elevators. | 3/16/2015 5:08 AM |
| 3 | Why dental ethics and not ethiocs in other modules? | 3/11/2015 1:38 AM |
| 4 | award points for demonstrating good cleansing/disinfection of equipment between patients - e[p on home visits. Award points for having a protocol in place if requested to provide sedation only for work done by an EDT (a fairly common occurence). | 3/3/2015 2:10 AM |
| 5 | 5. See above. Need to say that diagnostic quality dental x rays are produced routinely ( eg for all cats having extractions). | 2/28/2015 2:17 AM |

## Small Animal Module 5 – Diagnostic Imaging
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q42 If you have any feedback, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | Elements of this seems to discriminate against GP - we are not going to have mri/scintigraphy or slit lamps or perform angiography...lots of points therefore unavailable in day to day practice | 3/11/2015 4:02 AM |
| 2 | GP 5 ultrasound should now be compulsory at GP level. | 3/9/2015 7:14 AM |
| 3 | G2. I don't think the practice is going to keep records of every individual ultrasound p.d. done on a 1000 cow dairy farm! | 3/4/2015 3:18 AM |

## Small Animal Module 5 – Diagnostic Imaging
## Award points

### Q43 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 7 Skipped: 91

| # | Responses | Date |
|---|---|---|
| 1 | 1. Diagnostic images should be easily searchable by patient name and by date. There is no advantage to them being attached to the records as long as they are easy to access and display. Some images are huge eg U/S and endsocopy videos and DICOM files are pretty large so a dedicated PACS system should be added and should attract more points. 8. Should be split out so that Ultrasound and Endoscopy are separate from radiography. Radiography use is falling as ultrasound and endoscopy are rising. Ultras ound in particular is often preferred for some emergency diagnoses. It should not be possible to be good at diagnostics without endoscopy and ultrasound. Display should be as DICOM high respolution images, not just jpg, which may be OK for clients but not for diagnostic purposes. Additional points should be available for DICOM high res viewing monitors such as BARCO [too many practices diagnose on small 'quality control' screens which do not display the films full size]. A large no of points should be awarded for practices where everyone using digital radiography understands and can demonstrate how they can assess they have achieved an optimally exposed radiograph. the system for this varies with each digital system but lack of understanding may be one of the main reasons for the fall in radiograph quality with digital systems (reported by BVA). All users should be proficient in recognising digital 'film' faults. 6. the wording of this clause in each module should be similar Where are FAST scans and rapid thoracic scan protocols? Outstanding practices should be able to routinely image adrenals and the pancreatic area to detect pancreatitis. 10. and 11. some equine has crept in SA - are we going to ask for MRI and CT??? | 3/23/2015 9:15 AM |
| 2 | 5 why cpd in last 2 years when other modules are last 4years? | 3/11/2015 4:02 AM |
| 3 | award 11 should be EQUINE not small animal | 3/9/2015 7:14 AM |
| 4 | Give points for use of consent forms including pregnancy disclaimer if owner/staff hold animals when x-rayed at farm premises. Award points if the practice always takes a helper to hold animals. Award points if can demonstrate practice has equipment to mark out controlled area when X-rays are taken on farm. | 3/4/2015 3:18 AM |
| 5 | Award point for use of consent forms for owners/helpers holding horses for radiography on home visits (inc pregnancy disclaimer). Award points for use of individual x ray badges for anyone holding a horse for radiography on a home visit. Award points for never using owners/helpers to hold horses for radiography. Award points for demonstrating that materials are carried and always used to define the controlled area on home visits. 5. Include use of bones/skeletal models as training aids. | 3/3/2015 2:19 AM |
| 6 | 10 & 11 - these apply to equines not SA ? | 2/28/2015 2:21 AM |
| 7 | It should be assessed if a practice has CT as well as MRI or scintigraphy this is a much more applicable advanced modality for large GP hospitals | 2/11/2015 10:48 AM |

## Small Animal Module 6 – Emergency and Critical Care Requirements of Emergency Service Clinics

### Q45 If you have any feedback, please add it below:

Answered: 7 Skipped: 91

| # | Responses | Date |
|---|---|---|
| 1 | 3. not consistent with other modules - but could be - possibly the responsibility of the module 'champion' to agree with the team? 8 see earlier note regarding ECC - it should be possible to be good at least without a vet on site as long as an RVN is there and vet within say 10-15 min? Once patient is there vet should be there. This ties in with human situation re paramedics / doctors. Back up should be readily available as cases may take up all one vet;s time. This can be from remote location but must be close eg 10-20 min away max 14 Need to add that incubator facilities for small and very young patients should be provided - not just neonates. may be needed for ICU and GA recovery. Similar guidance 19. back up may be needed and must be available This badly needs defining - what endoscopes???????? | 3/23/2015 9:31 AM |
| 2 | I am not sure whether the intensive care of critically ill patients should be part of an emergency clinics requirements. | 3/23/2015 9:09 AM |
| 3 | Point 9 - can you consider mention that additional member of staff should be RVN Point 25 - microscope and white cell counter much more important than haematology machine; in fact most ECC specialists would teach to priortise smears over haem machines as haem machines are not so good for the kind of problems seen in ECC patients such as toxic neutrophils, red cell morphological changes. Think this would be a step backward in terms of standards Point 19 - I think it is unrealistic to have team members devoted solely to anaesthetic recoveries and this requirement will tend to take away the professional judgements of both VS and VN who should be able to balance patients needs. Suggest reword as "Anaesthetised patients should be closely monitored until full recover with appropriate documentation of monitoring including justification of monitoring level chosen" I believe this would more accurately reflect the behaviours the PSS states it is looking for ie professional judgement as opposed to "telling" professionals to do something which on occasion may be unnecessary. | 3/23/2015 6:36 AM |
| 4 | Point 9 - the other other on duty staff member should be an RVN Point 25 - more important to have a microscope, blood smear training and a white blood cell counter | 3/23/2015 6:04 AM |
| 5 | 8/9 one member of staff should be awake at all times | 3/9/2015 7:10 AM |
| 6 | 3. CPD - should specify that a high % (? 75%) of CPD must relate to ECC. 12. This is not easy to do in the real world. 19. Difficult in a busy ESC when there is only one VN on duty. | 2/28/2015 2:28 AM |
| 7 | It should be compulsory that any ECC service provides 2 vets: 1 in site, and 1 on call, to be able to attend emergencies if required. | 2/11/2015 6:33 PM |

## Small Animal Module 6 – Emergency and Critical Care
## Award points

### Q46 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 9 Skipped: 89

| # | Responses | Date |
|---|---|---|
| 1 | 3. should all the hours mean 24 hours? Should we ask for ECC appropriate hospitalisation records? Must be capability for emergency surgery - vets and nurses must be appropriately experienced if working on their own without help 10 min away. Capability for cooling as well as heating eg large dogs in summer | 3/23/2015 9:31 AM |
| 2 | A few points why no mention of having an AP or specialist involved as with other modules? | 3/23/2015 6:36 AM |
| 3 | Suggest include oversight by AP or specialist as giving extra points as in the surgery award. Section 5 rather than having all drugs in stock feel some should be easily accesible (within a short car drive) especially those which can be difficult to get hold of or have short shelf lives otherwise will continually go out of date | 3/23/2015 6:04 AM |
| 4 | To be a small animal hospital you should need to demostrate facilities suited to the species the public will present. If you only have cat and dog facilities you should be a cat and dog hospital, not a small animal hospital etc . Receiving an OOH case on false advertising and failing to give a minor species the treatment expected is a potential breach of COC 1.1 Yety a Tier 2 can pretend to treat birds and wildlife and reptiles and yes - even rabbits and pass an inspectors visit - bonkers! | 3/22/2015 10:11 AM |
| 5 | Much is missing. should include all pain module client care 9-16,18,19. in patient 1-3,7,9-12 and surgery module 1-20 | 3/9/2015 7:10 AM |
| 6 | There should be an award for RVNs with additional qualifications in ECC. amd also for advanced vet practitioners. Home visits out of hours should be included as a requirement. | 3/8/2015 3:59 AM |
| 7 | 2. I think this should be more that 30%. 8. Should this not be mandatory for ESC workers? | 2/28/2015 2:28 AM |
| 8 | I-m learning now that there are "award points" | 2/11/2015 6:33 PM |
| 9 | I feel this is an important area and the increased ephasisi on out of hours , emergency and critical care should be commended . it is often an area that affects patient welfare , the public and the profession the most | 2/11/2015 10:49 AM |

## Small Animal Module 7 – Infection Control
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q48 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Potentially discriminatory against practices in old buildings. To install dedicated sinks in every ward would be costly & there may be no space. Consider the aerosol created. Also hand gels have been shown to be effective. You can work around not having a sink in these areas. We have had to make changes in our wards in the past which seem to be just for the sake of asking us to do something - the one I found most irritating was putting in a more aesthetically pleasing floor covering when we had a perfectly adequate floor. None of our clients understood this request! | 3/11/2015 1:42 AM |
| 2 | 4. Add 'Used needles must never be re-capped , but placed directly into the sharps container' (this is mandatory in the NHS). | 2/28/2015 2:34 AM |

## Small Animal Module 7 – Infection Control
## Award points

### Q49 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 4 Skipped: 94

| # | Responses | Date |
|---|---|---|
| 1 | 9&10 are duplicated | 3/4/2015 3:18 AM |
| 2 | 3. Don't think I've ever seen this ! 5. This should be mandatory at GP level ? | 2/28/2015 2:34 AM |
| 3 | Not that convinced that the web links in point 9 are actually any good. | 2/23/2015 11:25 AM |
| 4 | Use of antimicrobials and records of culture and sensitivity and lists of amounts of certain types i.e fluroqiinolones prescribed - to incase awareness of over prescribing the asseoer could advise appropriately on over prescribing or inappropriate use | 2/11/2015 10:50 AM |

## Small Animal Module 8 – In-patients
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q51 If you have any feedback, please add it below:

Answered: 4 Skipped: 94

| # | Responses | Date |
|---|---|---|
| 1 | Item 3 Core. Not all core premises have a large kennel for a large breed dog and such patients are usually referred to the main premises where they are better coped with. Does the size of dog have to be specified perhaps or should the wording suggest that referral is acceptable? Item 2 VH Important the the person on the premises is directly responsible for nursing care and not just living there and actually off duty | 3/20/2015 5:15 AM |
| 2 | Core 12. And advise that GP vets are not pathologists. | 3/4/2015 3:17 AM |
| 3 | GP 5. trot uup/lunging areas m,ust eb escape proof - as must access to them form the stables. (I have seen awful high-risk facilities where the potential to escape onto a busy road is very real). VH The whole facility must be escape proof, with gates and good fencing. VH There used to be a requirement for an RVN (Eq) - has this been removed - and also req. for a VS with a Cert in surgery etc ?? | 3/3/2015 2:37 AM |
| 4 | Gp 6. This used to specify 'crystalloid and colloid' VH 7. ? Doesn't make sense .VH 13. I've never seen a humidifier. | 2/28/2015 2:40 AM |

## Small Animal Module 8 – In-patients
## Award points

### Q52 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 6 Skipped: 92

| # | Responses | Date |
|---|---|---|
| 1 | 9. must include infusion pumps and syringe drivers (surely by now? They are not expensive 15. Because of RVN shortage even with excellent fully staffed practice, it may not be possible to replace that RVN and an experienced student may have to take their place for a while - prudent to recognise this possibility rather than the clause being ignored. This should not be a permanent measure however. With 24 hour clinics Working Time Directive may make it more difficult for existing staff to cover for sickness of absence within law. 16. Awake at all time that their is a patient under their care? | 3/23/2015 9:37 AM |
| 2 | Award point 2: what is 'correct handover'? | 3/16/2015 5:37 AM |
| 3 | 16 - staff awake overnight...was this stipulated in ECC or did it just say on site? | 3/11/2015 4:04 AM |
| 4 | 18. i don't know what this means. | 3/3/2015 2:37 AM |
| 5 | 2. Give this more points. | 2/28/2015 2:40 AM |
| 6 | 16. Person 'awake all night' when any patient in. Can we have some further info on this? It's not uncommon to keep something in that doesn't need round the clock treatment. How about a wording where a person is on site and awake all night if the vet in charge deems that level of care necessary? | 2/23/2015 4:24 AM |

## Small Animal Module 9 – Laboratory and Post-Mortem
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q54 If you have any feedback, please add it below:

Answered: 6 Skipped: 92

| # | Responses | Date |
|---|---|---|
| 1 | Suggest rename lab and clin path and remove post mortems altogether from the awards as not frequently performed. Or can just retain 14. | 3/23/2015 9:40 AM |
| 2 | Core item 11 Statutory requirements. Such as? Item 25, does this just duplicate item 9? | 3/20/2015 5:20 AM |
| 3 | Some elements are not common in GP practice - points therefore not available. Additional paperwork evidencing training required - what depth of evidence will be required? | 3/11/2015 4:06 AM |
| 4 | GP 10. Also need to make clear that GP vets are not pathologists ! GP3. Does an MRCVS count for this ? | 3/3/2015 2:42 AM |
| 5 | Core 2 Is this not self-evident / 10. Should include 'And the level of skill of the person undertaking the PM' (GP cvets are not pathologists! 9& 25 - Duplicated ? VH 6. is an MRCVS adequate for this? | 2/28/2015 2:50 AM |
| 6 | How are you counting different analysers? We have an I-stat machine - that does blood gasses, basic biochemistry, some haematology and electrolytes. Can I count it as 4 machines? It's not clear the way it is currently written. | 2/23/2015 4:26 AM |

## Small Animal Module 9 – Laboratory and Post-Mortem
## Award points

### Q55 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 5 Skipped: 93

| # | Responses | Date |
|---|---|---|
| 1 | 12-13 too many points to lose if a practice prefers to send all post mortems for professional pathologist PM. It is rare to PM a case in SA practice these days and advised to generally use a pathologist. The cost is not prohibitive. I would suggest losing post mortems from this section altogether and sticking to clin path Retain point 14. | 3/23/2015 9:40 AM |
| 2 | Item 1 What does it mean by 'nationally accredited provider? Where would the assessor find this, do laboratories appear on a list? Item 9 It is not altogether clear whether the examination of the FNA is to be done at the practice or always referred to an outside pathologist | 3/20/2015 5:20 AM |
| 3 | 3 - presumably use of outside labs is fine? 8. how do you define adequately trained? | 3/11/2015 4:06 AM |
| 4 | 17. Not always possible as client may refuse permission. | 3/3/2015 2:42 AM |
| 5 | 2. How would you know that this is always the case ?3. Give more points. 8. MRCVS OK ? 13 !!!!Surely self evident ? | 2/28/2015 2:50 AM |

## Small Animal Module 10 – Medicines
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q57 If you have any feedback, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | Many previoius ambiguities have been sorted but Core item 3 can be confusing. Are POM-Vs to be out of sight in the consult room AND in reception or just inaccessible from reception but perhaps in view behind the reception? | 3/20/2015 5:26 AM |
| 2 | CVore 16. Need to make refernce to meds on open shelves in consulting rooms. 18. Need more detailed advice on how to do the weekly audit - e.g. making allowance for wastage/ how do you measure how much of a product is left in a bottle ??? 32.. Please clarify if the anthelmintic policy requirements aree ust for FA/Eq (i.e. grazing animals) or also include SA . | 2/28/2015 3:01 AM |
| 3 | Not sure how important a SQP is in small animal practice? How about anyone dispensing is suitably trained? | 2/23/2015 4:29 AM |

# Small Animal Module 10 – Medicines
# Award points

## Q58 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 8 Skipped: 90

| # | Responses | Date |
|---|---|---|
| 1 | 7. SQP Why is this a benefit? Would not include in awards An outstanding practice would show evidence of staff training and understanding of advanced therapeutics: Choice of meds and use; interactions Inpatient sheets should have clear meds administration guidelines and clear records that meds have been given at correct times. Meds should be able to be obtained quickly Sufficient stock to have everything to hand Efficient repeat rx system for clients and clear authorisation by vet in charge of the case, not just a look at the notes. Good client information sheets about their pets meds Data sheets given with every dispense med incl unlicensed (BSAVA or similar sheets used) | 3/23/2015 9:46 AM |
| 2 | The antimicrobial and endo and ecto parasiticide protocols are great. | 3/23/2015 9:14 AM |
| 3 | I feel that it will not be difficult for many existing practices that I visit to get good and outstanding points. So not 'aspirational' but, since Medicines are being heavily scrutinised, that is not a surprise | 3/20/2015 5:26 AM |
| 4 | Award points for demonstrating that information is given to clients about any possible complications./side effects relating to Cascade products - as required by VMD. (not easy for FA/equine clients as no equivalent of the BSAVA client information sheets exist). | 3/4/2015 3:17 AM |
| 5 | Award points for demonstrating that temperature sensitive medicines are stored properly in cars and there is a temperature monitoring system in place which is recorded regularly (Most practice will say they do this - but in reality very few do- at least in my experience!). Award points for demonstrating that Cascade consent forms are used routinely (very seldom done in Eq/FA practice in my experience)and that clients are given information about possible side effects etc. (difficult for Eq clients - SA practices have access to BSAVA info sheets - nothing similar exists for Eq/FA Cascade meds - something should be done to get these made available in my opinion. 2. Also . Award points for providing written instructions to clients if they are left injectable medicines to administer themselves - inc. disposal of sharps etc. 4.Also Award points for having appropriate in-car facilities for disposal of hazardous waste after using cytotoxics (e.g. sarcoid creme) on home visits. also award points for having an SOP in place detailing how eq passports will be checked prior to prescribing medicines and also availability of BEVA forms for emergency prescribing in absence of a passport. | 3/3/2015 3:23 AM |
| 6 | give more points to 2,6,10,13. 14. Is this good practice ? | 2/28/2015 3:01 AM |
| 7 | Why does the practice need to employ an SQP? | 2/23/2015 11:28 AM |
| 8 | 11. Internet retailer must be reg under AIR scheme. You lose the points if you don't trade on the internet. You lose the points if you trade online, but are not registered. The only way to get the points is to trade online AND be registered. Could we not have this worth 0 points with a 10 point deduction if trading online and not registered? | 2/23/2015 4:29 AM |

## Small Animal Module 11 – Medical Records
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q60 If you have any feedback, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | Clarification needed - we have a different PMS to our equine center but we don't need to see equine records and they do not need SA records. | 3/11/2015 1:44 AM |
| 2 | Core 4. Should there be an obligation for signed consent form for major surgical procedures. | 3/4/2015 3:17 AM |
| 3 | GP 4. Does this mean consent forms must be uploaded onto computerised clientt records. (Not many practices do this). | 2/28/2015 3:07 AM |

## Small Animal Module 11 – Medical Records
## Award points

### Q61 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 4 Skipped: 94

| # | Responses | Date |
|---|---|---|
| 1 | Bit thin this section. Suggest: Records regularly audited for quality Normal vet noted on record for case continuity 7. Weight and body score or similar recorded each visit Possible to search records by text or by cateory eg list all meds, all consults etc? | 3/23/2015 9:50 AM |
| 2 | Implementation of VeNom coding ad allowing these to be searchable, auditable and sharable are all vital and should be worth more points. | 3/23/2015 9:17 AM |
| 3 | More info required about integration of venom. Definition of regular in adding weights? Annual or more frequent? | 3/11/2015 1:44 AM |
| 4 | 1. Should this not be mandatory for all practices in PSS ? 7. Give more points. | 2/28/2015 3:07 AM |

## Small Animal Module 12 – Nursing
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q63 If you have any feedback, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | Seems to be an ever increasing amount of hospital sheets required...not liked by staff as takes them away from actually caring for the patient although we recognise the importance of records is it all going just a bit too far? | 3/11/2015 1:46 AM |
| 2 | VH 1 - It was formerly obligatory to have an RVN Eq - has this changed ? | 3/3/2015 3:25 AM |
| 3 | 1. Is the very act of being qualified as a VN not sufficient here ? | 2/28/2015 3:10 AM |

## Small Animal Module 12 – Nursing
## Award points

### Q64 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | 7. Nurse clinics should be held by RVNs only, and with additional training. 8. ...and shares her knowledge with the team Add RVNs should be clearly identified to clients | 3/23/2015 9:53 AM |
| 2 | Why do RVNs need to have additional qualifications in GP practice? Is this discriminating against GP practice as most of these nurses will be working in referral/hospital centres? | 3/11/2015 1:46 AM |
| 3 | points should be given for RVNs with additional qualifications eg BSAVA awards or Diploma holders | 3/8/2015 4:00 AM |

## Small Animal Module 13 – Out of hours
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q66 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Practices should inform all clients of their out-of-hours (OOH) arrangements. Practices should specifically state whether they do their own OOH or use a third party and how far away it is from the practice. | 3/18/2015 8:50 AM |
| 2 | Allow for specialised ESC to provide OOH care for any level of practice as long as they meet relevant standards. Remove the requirement for hospitals to have in house OOH cover within 5 years | 3/15/2015 3:20 AM |

## Small Animal Module 13 – Out of hours
## Award points

### Q67 If you have any feedback about the individual ‘Award points’ clauses, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | Muddled If a prcatice covers its own OOH then animals are not transferred. That should have 30 points then if transfer will be necessary this should offer fewer points. these can only be offset by using a 'value-added practice to send them too. A practice should not appear less good by not having a vet or nurse awake when there are no patients in 5. Should end - not permitted | 3/23/2015 9:56 AM |
| 2 | I think it is good that the routine transfer of patients for overnight care is discouraged, whilst recognising sometime it is required. | 3/23/2015 9:20 AM |
| 3 | Again referral centres included under the same umbrella as GP practices - what happens to the 10 points if you do not have referral cases - is it unavailable? | 3/11/2015 1:47 AM |

## Small Animal Module 14 – Out-patients
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q69 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Core 8,. Inc ensure owners/helpers also use PPE (esp hard hat and appropriate footwear). | 3/3/2015 3:36 AM |
| 2 | Core 6. Weight charts are not appropriate as they are very inaccurate,. Small scales are cheap and readily available to weigh mini-patients. GP - 2. The Poisons contact tel no must be prominently displayed. Don't see any reference to wash stations and impervious/easily cleaned consulting table ? | 2/28/2015 3:20 AM |

## Small Animal Module 14 – Out-patients
## Award points

### Q70 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | no CPD required/rewarded in small animal medicine. Other modules require further cpd eg diagmostic imaging/anaesthesia/dentistry but no mention of awards for medicine CPD/further qualifications | 3/9/2015 7:13 AM |
| 2 | 1. award points for use of digital X ray systems which allows viewing of radiographs in the field without need to return to base to develop films. 10,. Add 'and firearms'. | 3/3/2015 3:36 AM |
| 3 | 1 & 5 - add 'Dental' | 2/28/2015 3:20 AM |

## Small Animal Module 15 – Pain Management
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q72 If you have any feedback, please add it below:

Answered: 5 Skipped: 93

| # | Responses | Date |
|---|---|---|
| 1 | Good section | 3/23/2015 11:58 AM |
| 2 | There must be evidence for the provision of a multimodal approach to analgesia. This should be a core tsndard goal. | 3/23/2015 9:26 AM |
| 3 | How much evidence is required - seems to be that we are going to need lots of forms to provide evidence of training etc | 3/11/2015 3:48 AM |
| 4 | Core 1 - Need to elaborate on methods of pain scoring and provide evidence that this is actually done ? | 2/28/2015 3:22 AM |
| 5 | not enough detail. should include peri-operative pai control,chronic& acute pain management | 2/17/2015 5:47 AM |

## Small Animal Module 15 – Pain Management
## Award points

### Q73 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | 6. Interventions SHOULD include local and /or regional anaesthesia 10. We should be clear here that we are not referring to homeopathy! What is an appropriate protocol? Need more guidance for assessments. Stress reduction, immobilisation / massage / physio should certainly be in the list as well as rehabilitation activity. In addition: Maybe add 24 hour access to advice for pain relief for post op cases - clear info for owners. Should have points for: Team members should have specific skills in performing : Local anaesthetic blocks (esp for dentistry, ortho ops etc) CRI - regularly used and protocols agreed and handy for reference- needs syringe drivers Schedule 2 Controlled Drug analgesics should be available and used where indicated. (ie reliance should not just be on non Sch 2 drugs). Alternatively this could be placed in the Surgery and ECC modules. | 3/23/2015 11:58 AM |
| 2 | How are you expecting us to evidence delivery in clear and sympathetic manner? | 3/11/2015 3:48 AM |

## Small Animal Module 16 – Practice Team
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q75 If you have any feedback, please add it below:

Answered: 5 Skipped: 93

| # | Responses | Date |
|---|---|---|
| 1 | Core item 23 Emergency lighting This is a new requirement, I think. This is non-existent in many core clinics so expect some 'flak' | 3/20/2015 5:32 AM |
| 2 | Again appears to be lots of paperwork involved to show evidence of what is done already | 3/11/2015 3:54 AM |
| 3 | 6. is this a 'job description'. need to review annually. 8. please add 'CPD records must eb submitted on the official RCVS form or on-line record '. 23. This is not often seen at Core and GP level practices ? | 3/3/2015 3:43 AM |
| 4 | This area seems to have been expanded - and will involve a lot more talking to the whole team if it is to be done to the level specified here. Core 1. Add 'including locums'. 6. Is this the same as a 'Job description' If so it needs to specify 'These must be reviewed annually' (very important in my opinion as for example a VN job may often change dramatically over the years. 8. CPD records MUST MUST MUST (!) be submitted on official RCVS record sheets or on line (not on heaps of scrappy papers showing attendance at meetings - grrrr - my pet hate!!!). 10 Not sure how you assess this on the day. 20. ditto . 23 Does this really apply to Ciore standards - certainly this is not often to be found except in VHs. | 2/28/2015 3:39 AM |
| 5 | I found it worrying that the inspector was really interested in our contracts but did not bother to ask any of my employees how I treat them - surely this is more important? In a similar vein things like labels and consent forms are scrutinised but nobody actually asked any clients what the quality of our service is and whether we explain the use of medicine to them etc. The list goes on, and the main reason we have dropped out is that is seemed that you can be an appalling practice but as long as you have the correct paperwork you will pass with flying colours (probably because you are not very busy and have a lot of time to write protocols)whilst another practice that really works hard to make sure they provide a good service and look after their staff will get pulled up on technicalities and boxticking. For instance AH wise we are proud to provide our own even though it is difficult to get staff to do it and actually costs us quite a lot, but then we get pulled up because we don't have a designated nurse available every night. For some reason it is not acceptable to phone all the nurses and find an available one - something which has NEVER not been possible. We have worked this way for 30 years and it has been fine, and we continue to provide a good service. The alternative would be to switch to a provider, but we don't believe they provide a good service, so what are we do do? Drop out of the PSS was the only option as the costs of paying a nurse to be on call every night is prohibitive. We continue to provide a good service that is why we are a succesful practice, but we are free from all the time and costs involved in complying with a system that actually brought us no perceivable benefits whatsoever. Sorry - rant over. | 2/27/2015 1:04 AM |

## Small Animal Module 16 – Practice Team Award points

### Q76 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | The focus on staff development is very enocourgaing. | 3/22/2015 8:04 AM |
| 2 | 6. i don't know what this means. | 3/3/2015 3:43 AM |
| 3 | 5. no idea what this means ! 6 Mandatory PLEASE! 17 Mandatory at GP level? 25/26/27 Are these readily available ? | 2/28/2015 3:39 AM |

## Small Animal Module 17 – Premises
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q78 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | GP Item 4 I cannot imagine what the required SOP will look like. There is either access or there isn't... | 3/20/2015 5:34 AM |
| 2 | VH 2. 'Stick on coving'. This is still frequently found in older hospitals - and generally seems to have been allowed. If it is in good condition I believe it is generally fit for purpose. A rigid implementation of this rule may be very costly indeed for some of these older VHs! | 2/28/2015 4:43 AM |

## Small Animal Module 17 – Premises
## Award points

### Q79 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | 5. What is a professional standard? Suggest adding (as many practices have differing standards of care of their premises for different areas, particularly staff areas and waste holding): All areas of the practice including clinical, non-clinical, residential and storage areas are maintained and cleaned to the same high standard so that the presentation of the practice is uniformly good (or outstanding - by points difference) in ALL areas. This should be a big points scorer as it reflects the culture and systems of the practice, whatever the building. ie no obvious defects, worn, dirty or stained areas. This then moves the requirements forward from the previous 'differing expectations for clinical and non clinical , public/private areas' Add? Regular maintenance and hygiene audits should be performed with action plans resulting and acted upon. Repairs are reported on and carried out in a timely fashion (should be an effective reporting and action system for remedying problems. | 3/23/2015 12:25 PM |
| 2 | 1. Isn't temp regulation of the work-place covered by relevant H&S legislation? | 2/28/2015 4:43 AM |

## Small Animal Module 18 – Surgery
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q81 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | VH ? no reference to need for an operating table and also ameans to remove an animal from the table in event of power cut. | 3/3/2015 4:14 AM |
| 2 | If you have a surgery advanced practitioner you get +30 points. If you have a specialist you get +30 points. You give the same weighting to being an AP or a specialist. Unless you give the specialist the 30 points PLUS the 30 for being a specialist. I suggest you offer +30 for AP and +60 for specialist. | 2/23/2015 4:33 AM |

## Small Animal Module 18 – Surgery
## Award points

### Q82 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 4 Skipped: 94

| # | Responses | Date |
|---|---|---|
| 1 | 1. Add the theatre must be damp dusted before each operating session. 3 NO NOTICES PLEASE - they are wall litter, unhygienic, ignored and we have only just lost them from PSS thank goodness! Change to all team members are clear about required attire and comply with the rules (which are NOT ion the wall) 4. No notices please! See above - similar wording 6. scrubbing up facilities must be in a separate room, not just screened 11. It is REQUIRED that clippers are cleaned and disinfected between each patient (surely) 18. Electrocautery or electrosurgery? - presume we mean diathermy / harmonic scalpel here? Would be useful tio signpost appropriate training. Team members must understand the technology and the risks to themselves from surgical smoke and to the patient from burns if patient plates are used. 20. Why give bair huggers as an example (trade name), Could use thermostatically controlled thermal pads (NOT heat pads), warm air or warm water devices, and insulating materials. 24. Do you mean no multi-use reels, or just a mix. if the latter no point in having the standard as everyone will comply with a few single use packs. Evidence base? (we use only single use packs but that's unusual from what I see) 28. Are we saying ethylene oxide is a point scoring item them, but only if monitoring is happening? 36. If there is a visiting specialist or cert holder / advanced practitioner, it is vital that to allow points, they must interact with the team and pass on their knowledge or assist with audits / reviews etc Otherwise they are no different to ext referral. | 3/23/2015 12:16 PM |
| 2 | It seems inexplicable that having an AP on site carries the same number of points as having a specialist | 3/23/2015 6:24 AM |
| 3 | some of these award categories seem too simplistic - eg 4,10,13,15,17 - You would have to be a pretty poor practice not to be comlying with these sorts of things ! 24 add 'exclusively'. 26. give this more points. | 2/28/2015 4:53 AM |
| 4 | 22 & 28 - where lasers and ethylene oxide used, used properly. Can we not also have these worth 0 points with a deduction for lack of training in proper use? Seems unfair to lump someone who is not using lasers/ethylene oxide with those that are, but not following H&S rules. -10 points would be fair. | 2/23/2015 4:33 AM |

## Equine Module 1 – Anaesthesia
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q84 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | GP ..2. This is a bit of a specialist procedure and not often done at GP level. VH - No mention of a need for an operating table? | 3/5/2015 2:23 AM |
| 2 | Core 3&5 seem duplictaed ? GP2. Direct arterial BP measurement is a bit of a specialist procedures and seldom to be seen in GP level practices. | 3/3/2015 1:53 AM |

## Equine Module 1 – Anaesthesia
## Award points

### Q85 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | 19. i feel you would be a pretty poor practice not to do this ! | 3/3/2015 1:53 AM |

## Equine Module 2 – Clinical Governance
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q87 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 2 – Clinical Governance
## Award points

### Q88 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 3 – Client Experience
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q90 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 3 – Client Experience
## Award points

### Q91 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Award points for provision of good parking/turning/reversing area for clients bringing horses to the clinic -(not all horse owners are proficient at driving lorries/trailers). Alo easy access to the clinic (I have known an equine practcie which was accessed up a long narrow lane with no passing places - not easy for lorries/trailers and not a good client experience! 23. ADD 'and scheduled visit times are running late'. | 3/5/2015 2:30 AM |

## Equine Module 4 – Dentistry
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q93 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Core 3. Add 'and PPE e.g. hard hats and appropriate footwear, is used by owners/helpers when dentistry is done on home visits. Add - 'and face masks' - (Dental enamel dust is said to be carcinogenic - and inhaling dental 'crud' is never good!) | 3/5/2015 2:34 AM |
| 2 | It looks great -no further comments to make on module. | 2/26/2015 1:49 PM |

## Equine Module 4 – Dentistry
## Award points

### Q94 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Spot on - no further comments. Easily achievable for those practices already practicing high standards dentistry - and good targets to aim for those practices not currently at that level | 2/26/2015 1:49 PM |
| 2 | 3. Paraprofessionals must do CPD on teeth. If only vets do teeth and no paraprofessionals employed then you lose 30 points! Should also be 0 points with a deduction for not doing so. Unfair weighting. | 2/23/2015 4:35 AM |

## Equine Module 5 – Diagnostic Imaging
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q96 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 5 – Diagnostic Imaging
## Award points

### Q97 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Add awards for use of consent forms including pregnancy disclaimer for owners/helpers who are involved in holding horses for radiography on home visits. Add points if owner/helper is never involved and practice takes out staff member to help. 5. Add availablity of bones/skeletal specimens to reference materials. 18. I don't know what this is. | 3/5/2015 3:20 AM |

## Equine Module 6 – Infection Control
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q99 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Core - Add a need for a protocol for disinfection of equipment such as endoscopes/clippers/scanner heads between patients when on home visits | 3/5/2015 3:20 AM |
| 2 | VH 1. There should be some reference to disposal of bedding/waste from the isolation box - n.b. this may constitute 'Hazardous waste'. | 3/3/2015 2:27 AM |

## Equine Module 6 – Infection Control
## Award points

### Q100 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Award points for demonstrating how equipment such as endoscopes/clippers/scanners are cleaned/disinfected between patients - particularly on home visits. | 3/3/2015 2:27 AM |

## Equine Module 7 – In-patients
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q102 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | GP 5 _ Add 'these areas and access to them from the stables must also be secure and escape proof' VH - Add -'The whole facility must be well fenced, gated and totally escape proof'. | 3/5/2015 3:20 AM |
| 2 | Same point for small animal surgery - an advanced practitioner gets +30 points, as does a specialist. I suggest the specialist should hold more weighting so be worth +60 | 2/23/2015 4:42 AM |

## Equine Module 7 – In-patients
## Award points

### Q103 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | 4. Single use suture packs. Do they just have to be available and used sometimes - or are cassette suture materials completely banned? What about for skin sutures or suturing in IV catheters? | 2/23/2015 4:42 AM |

## Equine Module 8 – Laboratory and Post-Mortem
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q105 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | GP 3 . Does an MRCVS qualification count here ? | 3/5/2015 3:20 AM |

## Equine Module 8 – Laboratory and Post-Mortem
## Award points

### Q106 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 9 – Medicines
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q108 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 9 – Medicines
## Award points

### Q109 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Add awards for consistent use of Cascade consent forms (Not often done in equine practice!) and as per VMD requirements 'Owners must be informed of potential problems/side effects with Cascade products'. This is not easy in Eq/FA practice as there is no equivalent of the BSAVA Client Information sheets available for SA use. Add points for availabilty of BEVA emergency dispensing forms for animals without a passport at time of examination. | 3/5/2015 3:21 AM |

## Equine Module 10 – Medical Records
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q111 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | core records should include vaccination batch numbers | 3/9/2015 7:16 AM |

## Equine Module 10 – Medical Records
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q112 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 11 – Nursing
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q114 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | VH 1. There used to be a requirement for an RVN Eq for VH status ? | 3/5/2015 3:22 AM |

## Equine Module 11 – Nursing
## Award points

### Q115 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 12 – Out of hours
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q117 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 12 – Out of hours
## Award points

### Q118 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | 3. If the practice doesn't take referral cases then they instantly lose 30 points and can only achieve 'good' status at best - even if providing great service for their own clients. This needs addressing. | 2/23/2015 4:37 AM |

## Equine Module 13 – Out-patients (Ambulatory)
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q120 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | GP 8 Add ' and must ensure use of appropriate PPE (eg hard hats, footwear) by owners/helpers on home | 3/5/2015 3:29 AM |

## Equine Module 13 – Out-patients (Ambulatory)
## Award points

### Q121 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | 6 can not have scales for ambulatory work. similarly point 20 | 3/9/2015 7:17 AM |
| 2 | 10. Add ' including controlled drugs'. Add points for having appropriate facility in the car to carry a firearm if appropriate. | 3/5/2015 3:29 AM |

## Equine Module 14 – Pain Management
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q123 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 14 – Pain Management
## Award points

### Q124 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 15 – Practice Team
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q126 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | 6. is this a 'Job description '? Needs to be reviewed annually. 8. CPD records must be submitted on the official RCVS record card or on-line (not a bundle of papers relating to attendance at courses etc !). 23. core - This is seldom found in Core/GP premises ? 35 Add ' and demonstrate how firearms are securely transported in vehicles' VH there used to be a requirement for an RVN Eq and Cert Holders in surgery etc. Has this gone ? | 3/5/2015 3:39 AM |

## Equine Module 15 – Practice Team
## Award points

### Q127 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | 6. I don't know what this means | 3/5/2015 3:39 AM |

## Equine Module 16 – Premises
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q129 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 16 – Premises
## Award points

### Q130 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Add awrads for ease of parking/reversing/turning lorries and trailers =- and ease of access to the premises (I have known an eq Vh which was only accessed down a long narrow road with no turning points). (n.b I did mention also this also in Client Experience) | 3/5/2015 3:42 AM |

## Equine Module 17 – Surgery
## Requirements of Core Standards / General Practice / Veterinary Hospital

### Q132 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Equine Module 17 – Surgery
## Award points

### Q133 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | no mention of certificate or diploma holders for surgery | 3/9/2015 7:18 AM |
| 2 | 4. Add 'exclusively'. 7.I think you would be fairly bad not to be doing this !! | 3/5/2015 3:45 AM |

## Farm Animal Module 1 – Anaesthesia
## Requirements of Core Standards / General Practice

### Q135 If you have any feedback, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | irelevent to me | 3/23/2015 9:37 AM |
| 2 | Need to take into account practices which have in patient facilities | 3/23/2015 9:15 AM |
| 3 | GP 1 & 2 seem similar and could be combined ? | 3/4/2015 3:20 AM |

## Farm Animal Module 2 – Clinical Governance
## Requirements of Core Standards / General Practice

### Q137 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Module 2 Clinical Governance – Core standards 1. “For practices to be clinically effective they need access to the best available evidence in order to discuss and draw up protocols and monitor how effective they are by clinical audit and significant event reviews” I think this should say “For practices to be clinically effective they need to use clinical audit and significant event reviews to monitor their clinical practice and ensure good quality clinical care is delivered and continually improved upon. The best available evidence should be used to support this process” The evidence is not available to draw up evidence based protocols to then audit against for all veterinary topics. Practices may wish to use their own in house-protocols, but that does not mean it is the best way to do something. They could however, create their own protocols or guidelines (using the best evidence available) and audit against it as just one way of doing clinical audit – this process still encourages evaluation of the service and consideration of the clinical care being delivered. (www.vetaudit.co.uk needs updating. Could you link the RCVS Code of Conduct to the RCVS Knowledge clinical audit toolkit instead now?) Where is the practical guide on the bsava.com website? This just takes me to the home page and I can’t find any details on clinical governance/effectiveness/audit – needs the link to the actual details. I also don’t think there is any information on these topics on the BCVA website (or not for non-members). Perhaps put the specific links to the RCVS knowledge clinical governance/clinical audit pages? Or perhaps Viner’s In Practice article ‘Using audit to improve clinical effectiveness’, and Pam Mosedale’s 1998 In Practice clinical audit article. General Practice 1. “The practice must have a system in place for monitoring and discussing clinical cases, analysing and continually improving professional practice as a result” I almost feel like this should be a core standard? I think most practices already do this, and actually if they were “accessing the best available evidence in order to discuss and draw up protocols and monitor how effective they are by clinical audit and significant event reviews”, they would already being doing this? I think accessing and using the evidence is more difficult than just looking at what they do and trying to improve it. I think for Core Standards practices should be able to show that they monitor and discuss clinical cases and use clinical audit, or significant event audits to improve professional practice as a result. This could involve discussing a particular condition and how everybody treats it or if they would like to develop practice guidelines, or discussing something that has gone wrong (significant event audit) and the assessor would expect to see evidence of these meetings and discussions. I think for General Practice assessors should expect to see names of specific papers or websites used to discuss these things, more detailed clinical audits and significant event audits carried out, and more detailed records to reflect these things? | 3/10/2015 8:30 AM |
| 2 | There is no recognition here that the way that farm animal practice works is very different to the way that other types of practice works? Particularly when the guidance about clinical governance is mostly from small animal practice? | 3/9/2015 11:10 AM |

## Farm Animal Module 2 – Clinical Governance
## Award points

### Q138 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Point 1. I think monthly clinical meetings is a lot. Bearing in mind many practices struggle to have a monthly practice meeting. I think every other month as a minimum would be more realistic - less often I think would make people do them properly, rather than putting something together quickly for the sake of ticking the 'monthly' box. Point 4. Will you want evidence of this? Maybe a signature from the locum to say they have been provided with the protocols? Point 6. Should there be guidance on how often you would like this? And evidence of what and when it was done – eg presentation given to other vets at lunch time meeting/email of CPD notes sent to all vets Point 7. I think this should be 20 points – they take a lot of effort! Point 11. I'm not sure how easy this would be to do in practice? Point 11 & 12 – if you're not 'contributing data' then you can't be 'outstanding' due to the points allocated, is this the way it is intended? | 3/10/2015 8:30 AM |
| 2 | 11. The practice is contributing data towards professional benchmarking or clinical data collection. I think it is unlikely that practices will be able to contribute to undergraduate projects, or other projects, on a regular basis - there is currently not a system in place for farm animal studies in relation to benchmarking, so I think this will be difficult for people to meet? 12. The practice is contributing data for future potential publication. Again I think there won't always be multicentre studies going on that the practice can contribute to. By having this point in the list, you will potentially force practices to undertake research for the sake of it, as opposed to for it being for a useful reason? | 3/9/2015 11:10 AM |

## Farm Animal Module 3 – Client Experience
## Requirements of Core Standards / General Practice

### Q140 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | How does the farm animal module, address all species eg pigs and poultry as this is currently unclear | 3/23/2015 9:18 AM |
| 2 | Do some of the behaviours carry over into small animal and equine? For example could a practice meeting with a journal club be counted for all 3 areas? | 2/23/2015 4:17 AM |

## Farm Animal Module 3 – Client Experience
## Award points

### Q141 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Add points for ease of vehicle access/turning/reversing for clients bringing farm animals to the clinic (not all 'amateur' livestock keepers may be proficient at reversing trailers etc!). | 3/5/2015 4:32 AM |

## Farm Animal Module 4 – Diagnostic Imaging
## Requirements of Core Standards / General Practice

### Q143 If you have any feedback, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | It is currently unclear where some further diagnostics currently sets - eg bull testing etc | 3/23/2015 9:17 AM |
| 2 | GP 4. I don't think the practice will keep detailed individual records for Ultrasound P.D.s on a 1000 cow herd ! | 3/5/2015 4:36 AM |

## Farm Animal Module 4 – Diagnostic Imaging
## Award points

### Q144 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Add points for use of consent forms and pregnancy disclaimer if owner/helper assists with radiography on the farm. Add points if the practice takes its own help. Add points for demonstrating use of materials to delineate the controlled area on farm visits (similar to eq requirements). | 3/5/2015 4:36 AM |

## Farm Animal Module 5 – Infection Control Requirements of Core Standards / General Practice

### Q146 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 5 – Infection Control
## Award points

### Q147 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Award 2 - add -' and disinfection of equipment e.g. scanner heads, clippers, between visits. | 3/5/2015 4:39 AM |

## Farm Animal Module 6 – Laboratory and Post-Mortem Requirements of Core Standards / General Practice

### Q149 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 6 – Laboratory and Post-Mortem
## Award points

### Q150 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 7 – Medicines
## Requirements of Core Standards / General Practice

### Q152 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | stock audit of cars should be included | 3/9/2015 7:18 AM |

## Farm Animal Module 7 – Medicines
## Award points

### Q153 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 2 Skipped: 96

| # | Responses | Date |
|---|---|---|
| 1 | Not sure why you get points for having an SQP. Surely a vet has to sign off on most medicines anyway. | 3/24/2015 9:17 AM |
| 2 | add points for demonstrating that Cascade consent forms are actually done consistently (many say they do this, but in reality very few FA vets do so!). Also demonstrate that owners are given information on possible side effects/problems with Cascade products (this is not easy for Eq and FA vets as there are no equivalents of the BSAVA Client Information sheets). Add points for demonstrating that temp sensitive products carried in the car have their temp measured daily (again something that many FA/Eq vets may say they do - but very few actually do in practice. | 3/5/2015 4:48 AM |

## Farm Animal Module 8 – Medical Records
## Requirements of Core Standards / General Practice

### Q155 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 8 – Medical Records
## Award points

### Q156 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 9 – Nursing and Paraprofessionals
## Requirements of Core Standards / General Practice

### Q158 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 10 – Out of hours
## Requirements of Core Standards / General Practice

### Q160 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 11 – Out-patients
## Requirements of Core Standards / General Practice

### Q162 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 11 – Out-patients
## Award points

### Q163 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 12 – Pain Management
## Requirements of Core Standards / General Practice

### Q165 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 12 – Pain Management
## Award points

### Q166 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 13 – Practice Team
## Requirements of Core Standards / General Practice

### Q168 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Core 8. please add 'CPD records must be submitted on the official RCVS Record Cards or on-line (not on scraps of paper!). | 3/5/2015 5:01 AM |

## Farm Animal Module 13 – Practice Team
## Award points

### Q169 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 3 Skipped: 95

| # | Responses | Date |
|---|---|---|
| 1 | Is there scope for giving better demarcation to vets that have had further qualifications. | 3/23/2015 9:21 AM |
| 2 | no mention of points for certificate holders | 3/9/2015 7:19 AM |
| 3 | 5 I don't know what this means | 3/5/2015 5:01 AM |

## Farm Animal Module 14 – Premises Requirements of Core Standards / General Practice

### Q171 If you have any feedback, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | How is a practice that has hospitalisation facilities viewed in comparison to one that doesn't? | 3/23/2015 9:19 AM |

## Farm Animal Module 14 – Premises
## Award points

### Q172 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | Add points for ease of parking /turning/reversing trailers etc at the clinic (Have mentioned this previously under Client Experience). | 3/5/2015 5:03 AM |

## Farm Animal Module 15 – Surgery
## Requirements of Core Standards / General Practice

### Q174 If you have any feedback, please add it below:

Answered: 0 Skipped: 98

| # | Responses | Date |
|---|---|---|
| | There are no responses. | |

## Farm Animal Module 15 – Surgery
## Award points

### Q175 If you have any feedback about the individual 'Award points' clauses, please add it below:

Answered: 1 Skipped: 97

| # | Responses | Date |
|---|---|---|
| 1 | 7. Ethylene oxide - if the practice doesn't use then they lose the 10 points. If the practice does use and has no training they lose 10 points. The only way you get the points is to use it AND have training. Could this have 0 points and -10 if not used safely? | 2/23/2015 4:19 AM |

**Annex E**

# DRAFT Updated PSS Rules

The RCVS Practice Standards Scheme ("the Scheme") has been in effect since 1 January 2005. It provides a mechanism for accreditation for different types of veterinary practices

## What Standards apply?

1. The Standards to be met are set out in the *RCVS Practice Standards Modules Documents.There is a separate document for each species type*. Full details of this are available on the RCVS website http://www.rcvs.org.uk/practice-standards-scheme/. For any additional information please contact Practice Standards, RCVS, Belgravia House, 62-64 Horseferry Road, London, SW1P 2AF. Tel 020 7202 0767 / 020 7202 0753; Email pss@rcvs.org.uk or tweet @RCVS_UK

2. Practices may apply for accreditation in the following categories:

| | |
|---|---|
| **Core Standards** | These standards are relevant to all veterinary practices and reflect mainly legal requirements which must be met in running a veterinary practice, together with guidance as set out in the *RCVS Code to Professional Conduct.* |
| **General Practice** | Small Animal, Equine and Farm Animal. For Small Animal and Equine practices the standards reflect the requirements of a primary care practice which aims to facilitate the achievement of high standards of clinical care, and encompasses many of the facilities required for veterinary nurse[e1] Training Practice (TP) standards.<br><br>For Farm Animal General Practices, the standards reflect both the requirements of a primary care practice which promotes the achievement of high standards of clinical care, and also a proactive approach to management, through the use of health planning, client training and communication. |
| **Equine Ambulatory GP** | This recognises there are equine practices that provide a GP level service, albeit they do not have stabling facilities or premises where horses are treated. |

| | |
|---|---|
| **Emergency Service Clinic** | For Small Animal Emergency Service Clinics, the standards reflect the requirements of a designated out-of-hours provider. A Small Animal Emergency Service Clinic must fulfill the requirements for a Small Animal General Practice as well as specific ESC standards. |
| **Hospital Veterinary / Hospital** | Small Animal and Equine. For Small Animal and Equine Veterinary Hospitals, the standards reflect the requirements of a General Practice (above) allied with additional facilities and protocols for the investigation and treatment of more complex cases. |

3. General Practice and Veterinary Hospital accreditation are cumulative and represent the additional standards in order to achieve accreditation at the different levels. (For General Practice accreditation Core Standards are mandatory. For Veterinary Hospital accreditation, Core Standards and General Practice standards are mandatory.)

4. The Scheme requires that all practice premises open to members of the public to bring animals for veterinary treatment and care must be inspected and comply with, at least, Core Standards for all species treated. The visit will include inspecting a representative selection of practice vehicles.

5. At Core Standards, requirements are if undertaken at the premises. If for example the premises does not undertake surgery the 'Surgery' module would not be applicable.

   Different premises within a practice may apply for different categories of accreditation (e.g. a main premises could be a Small Animal Veterinary Hospital ; with its branch an Equine General Practice). Also one premises may apply for multiple accreditations (e.g. as an Equine Veterinary Hospital and a Small Animal General Practice).

   A full list of the modules can be found in the PSS handbook.

**Awards**

6. Voluntary awards are available for each practice premises which are over and above the base accreditations of Core, General Practice and Veterinary Hospital. Requirements are set out in the Awards section of each module.

7. Practices can choose if they want to be inspected for none, for some, or for all of the Awards.

8. Awards are available at either 'Good' or 'Outstanding'. Awards have been specifically tailored to

take into account the differences between Small Animal, Equine and Farm Animal practices. A full list of the awards available can be found in the PSS handbook.

### Veterinary nursing Training Practices (TPs)

9. General Practice accreditation includes many of the requirements under the TP Scheme. It should be noted however that additional resources are also required in order to meet TP criteria and that inspection of these resources and the training capabilities of a practice will[e2] be carried out by the relevant veterinary nursing approved Centre. The current list of Centres (with contact numbers) is available on the RCVS website http://awardingbody.rcvs.org.uk/centres/what-is-an-rcvs-centre/ or via the Veterinary Nursing Department vetnursing@rcvs.org.uk

## How does the Scheme work?

### Who is eligible to join?

10. Eligible organisations are those running veterinary practices from premises that are open to members of the public to bring animals for veterinary treatment and care, or where the veterinary treatment and care of animals is provided to members of the public via ambulatory services. All premises within the organisation must achieve accreditation, following inspection by an RCVS Assessor. All species of work undertaken at a premises must be accredited to at least Core Standards.

### PSS IT System

11. The Practice Standards Scheme is adminstered from a bespoke IT System which takes practices through the inspection process. Practices are obliged to use this system in order to gain accrediation and the optional Awards. Practices are required to upload pre-inspection documents which will be checked by their allocated assessor before a date for the visit is agreed.

### Who makes the application?

12. The application to join must be made by the legal entity running the veterinary practice (e.g. partnership, company or sole trader).

13. The practice must also provide details of the person responsible for coordinating Practice Standards at the practice if this is different to the Veterinary Surgeon who has overall responsibilty at the practice. Where the individual with authority to sign on behalf of the legal entity is not a MRCVS, the practice must state the name of the veterinary surgeon nominated to have overall reponsibility for veterinary matters in the practice, and must sign the application. Each premises or premises group must nominate a veterinary surgeon who will have responsibility for that group and will be present during the visit.

### Main and Branch Practice Premises

14. A practice must have one Principal Practice Premises. It may then have one or more Main Practice Premises associated with the Principal Practice Premises and also have any number of Branch Practice Premises associated with either the Principal or Main Practice Premises. Where a practice has administration offices at a separate location to its other practice premises please

notify the RCVS PSS Team. . When deterimining if a practice premises is a ‘Branch’ the Practice Standards Scheme will take into account factors such as shared staff, shared clinical governance, shared clerical services, shared out-of-hours and geographical location.

**The inspection**

15. Practices will be inspected, at least every four years for their acccrediation and optional Awards. Any practice premises may be subject to ‘spot checks’ in the interim. These may be without prior warning and could include premises that are under the ambit of the Scheme which have not yet been accredited.

16. Where a practice acquires any additional premises, the practice may choose to have these premises inspected immediately (in which case an inspection fee, to cover costs, will be levied), or may ask for inspection of the premises to take place at the practice’s next 4 yearly inspection. Pending accreditation, the additional premises may not use the logo of the Scheme, or otherwise be promoted as an accredited premises. Where a practice has already received accreditation and, prior to its 4 yearly inspection falling due, wishes to apply for accreditation for another category/species, an inspection fee will be payable.

17. Where possible, the routine and initial inspection of a Principal or Main Practice Premises and its branches will be completed within one day. The RCVS reserves the right to levy an additional fee in the event that more than one day is required.

18. Practices can request to have an award inspection at any time and will be charged based upon assessor time, which will be charged in half-day blocks plus travel. Awards requested during years 1-3 of the routine inspection cycle will expire after four years or the practice may chose to have them inspected at the next routine inspection. Awards requested in year 4 of the routine inspection cycle, may be extended until the next but one routine inspection (up to five years).

19. In the course of their visit, Assessors will expect to speak to a cross section of team members involved in the normal activities of an operational day. The purpose of such discussions is so that the Assessor can be satisfied that practice policies are not only in place but are understood by relevant staff and are applied in the day to day operaton of the practice, and to encourage better practice. The Assessor will also wish to discuss levels of expertise and training for roles undertaken. The Assessor will record the number of veterinary surgeons, veterinary nurses and other members of staff spoken to in the course of an inspection.

20. Practices will be required to confirm annually that they remain in compliance with the standards of their accreditation and Awards.

21. Practices will be required to notify any material change in circumstances which affects accreditation to the RCVS Practice Standards Scheme for example new species treated, major building works orrefurbishment, or key personel leaving.

**Use of accreditation titles/Awards/logos/promotions**

22. The titles 'Hospital' and 'Veterinary Hospital' on their own, or as part of any practice signage or practice advertising, may only be used by practices accredited as Veterinary Hospitals.

23. A practice shall only use the logo to promote practice premises accredited under the Scheme.

24. No amendment, alteration or addition may be made to the logo as supplied to members when used in promotional or other documents or materials generated by the practice or on its behalf.

25. A practice cannot promote a module on its own e.g. 'Oustanding in Surgery'.

26. The term 'Good' and 'Outstanding' can only be used in conjunction with the Award name eg 'Good in Inpatient Service'

27. A practice may be asked to cease any promotion considered to be inconsistent with the Scheme.

**Registration of Premises under the Veterinary Medicines Regulations**

28. The supply of veterinary medicinal products must be from premises registered with the RCVS as Veterinary Practice Premises.

29. Practices will be asked annually to confirm that the details of the main and branch premises held by the RCVS under the Scheme are correct and, as appropriate, agree that premises are included in the statutory Register of Veterinary Practice Premises. (See paragraph 25 below re fees.)

30. Practice Premises that are not eligible for accreditation under the Scheme may need to be registered as 'Veterinary Practice Premises' (and pay the statutory fee) under the Veterinary Medicines Regulations.

31. Further details of the requirements under the Veterinary Medicines Regulations can be found via the links to the RCVS and VMD websites below;
http://www.rcvs.org.uk/registration/register-of-veterinary-practice-premises/
http://www.vmd.defra.gov.uk/vet/vpp.aspx

32. When a practice open new premises they must register them with the RCVS and pay the applicable fee. See the Register of Veterinary Practice Premises area on the website for further information.

33. When a premises is closed down or sold practices must notify the Registration Department at the RCVS in writing registration@rcvs.org.uk

## Fees

### Application Fee

34. An application/joining fee is payable for any Principal or Main Practice Premises and its Branch Practice Premises. This is a non-refundable fee payable to cover initial inspection costs. The initial inspection must take place within x months of the RCVS receiving the initial application. If the inspection does not take place by x the practice will need to re-apply to join the Scheme and pay the application fee again.

35. Where inspection of a Principal or Main Practice Premises and its Branch Practice Premises cannot be concluded within one day, the RCVS reserves the right to levy an additional fee. If relevant, this may include an overnight fee.

36. In the event a premises requires a re-inspection an additional fee will apply.

### Annual Fees

37. An annual fee is payable for every Principal or Main Practice Premises and each Branch Practice Premises.

38. The annual fee is due each year for the period 1st April to 31st March. Invoices will be issued to indicate when the fee is due to be paid. Direct Debit forms are available from the RCVS Finance Department.

39. Fees are reviewed anually. Details are available on the RCVS website. The annual fee for each PSS premises accredited includes the fee due under the Veterinary Medicines Regulation for those premises which have been registered.

40. Non-payment of annual fees following one warning notification, will result in accreditation being withdrawn. Any application for re-instatement should be made to the RCVS, together with payment of the joining fee. The RCVS reserves the right to require re-inspection of the practice and the cost of re-inspection will be charged to the practice.

41. A practice may notify the RCVS at any time that it wishes to withdraw from the application process or membership of the Scheme. No refund of fees already paid will be made.

42. The RCVS reserves the right to charge a cancellation fee where an inspection is cancelled by the practice less than 7 days before the inspection date agreed by the practice. Following withdrawal the RCVS will notify the Veterinary Medicines Directorate regarding medicines inspection.

### Award Fees

43. Practices who apply for Awards inspections will be charged in half day blocks plus travel.

44. All fees must be paid before accrediation and/or Awards are granted and the premises entry on Find a Vet is updated to display the accrediations and/or Awards achieved

## The Assessors

**Who are the Assessors?**

45. The criteria for appointment as an Assessor are as follows:

    a. To be at least five years qualified as an MRCVS;
    b. To be in full or part-time veterinary practice (or to have been so within the previous three years);
    c. To have been approved by the RCVS as having suitable experience for inspections to be undertaken.

46. Assessors will be appointed for an initial term of 5 years, and thereafter may on application be appointed for further term(s) of 5 years[A3].

47. There shall be no restriction either geographically or with regard to the number of occasions on which an individual Assessor is chosen to inspect practices.

48. Assessors will be expected to attend at least one training day annually. Failure to do so, without valid cause, may result in status as an Assessor being suspended or withdrawn.

49. In order to assure quality and consistancy in inspections, Assessors will from time to time be subject to review by the Lead Assessor or another member of the Review Group who will monitor them in the course of an inspection visit. A copy of the report will be provided to the Assessor which will advise the Assessor of any follow-up recommendations.

**The Lead Assessor**

There will be a Lead Assessor appointed by the RCVS whose role will include the provision of support and guidance to the Assessors. The Lead Assessor will consider all recommendations from the Assessors following inspections. He/she may approve such recommendations or refer them to the Review Group for decision. All decisions of the Lead Assessor will be recorded.

## Composition and role of the RCVS Practice Standards Group (PSG)

50. The PSG comprises eleven members, one to be nominated by each of the British Veterinary Association (BVA); the British Small Animal Veterinary Association (BSAVA); the British Veterinary Hospital Association (BVHA); the British Equine Veterinary Association (BEVA); the British Cattle Veterinary Association (BCVA); RCVSwho shall be the Chairman of the Group); the Society of Practising Veterinary Surgeons (SPVS); the Veterinary Practice Management Association (VPMA); the British Association of Veterinary Emergency Clinics ( BAVEC);VeterinaryNurses Council; British Veterinary Nursing Association (BVNA) and a lay person.

51. The Chairman may co-opt individuals to the PSG on an ad-hoc basis. Such individuals will have no voting rights.

52. The PSG shall be responsible for the ongoing development of the Scheme and the Standards and shall report to RCVS Council through Standards Committee (and through the Operational Board in respect of budgets and fees).

**Composition and role of the Review Group**

53. The composition of the Review Group will be decided by the Practice Standards Group . It will comprise five members including the Lead Assessor.

54. A member of Standards Committee may not also be appointed as a member of the Review Group.

55. The Review Group will review any decision disputed by an applicant as set out in the Appeals Procedure.

56. The Review Group may direct that specific Standards are targetted as a result of (i) a practice's previous non-compliance; (ii) areas of common non-compliance identified through feedback from Assessors; (iii) areas of non-compliance identified through the RCVS complaints procedure.

57. The Review Group may direct that specific RCVS or other relevant advice is discussed during an inspection to encourage compliance with professional responsibilities.

58. All decisions of the Review Group shall be recorded together with reasons for such decisions.

59. The Review Group may recommend to Standards Committee possible changes to the Scheme.

**Role of the RCVS Standards Committee in the context of the RCVS Practice Standards Scheme**

60. To recommend to RCVS Council changes to the Scheme requiring authorisation by RCVS Council, following consideration by the PSG.

61. To act as an appeal body in relation to individual applications to the Scheme and complaints against individual practices, so far as they relate to complaints within the Scheme.

62. In considering any matter related to the Scheme, a quorum of Standards Committee shall be four members.

## Providing evidence post inspection

**‘**The requested Evidence to confirm compliance should be uploaded to the the PSS IT system by the practice as soon as possible within the stipulated period of either 2, 4, 12 or 24 weeks from the date of receiving the outcome of the report Within 5days of the evidence being uploaded to the PSS IT System, the Assessor assessor will (review the evidence e and notify the PSS Team of their comments . Where the assessor Assessoris not satisfied that the evidence provided is sufficient, the PSS Team will notify the practice of the his/her comments within 5 working days
AssessorIn some cases a re-inspection of the premises may be required. This may, for example, be due to the original visit highlighing a large number of issues or if the practice needs to undergo refurbishment/structural changes in order to comply with the Scheme requirements.

63. A re-inspection fee will be levied to cover the costs of the visit.

## Appeals procedure

**Disputing a decision of the Lead Assessor**

64. In the event that a practice disputes a decision of the Lead Assessor, it should notify the RCVS in writing of the grounds of their dispute and submit any additional material it wishes considered within 21 days. This, together with all relevant documents, shall be submitted to the Review Group for a decision, which shall be notified to the practice within 21 days.

65. In the event that a practice disputes a decision of the Review Group, and wishes to lodge an appeal, it should notify the RCVS in writing of its intention to appeal, within 21 days of the date of the letter from the RCVS notifying it of the decision.

66. Upon receipt of notification of intention to appeal, the practice shall be supplied with any additional reasons for the decision recorded that have not already been provided.

67. If the practice wishes to pursue the appeal then it should submit in writing full details of the grounds of the appeal to the RCVS, together with any supporting documentary/photographic material it wishes to be considered. (This must be done within 21 days of receipt of any additional reasons for the decision.)

68. The assessor who carried out the inspection shall be given the opportunity to comment upon the grounds of appeal and supporting material, and any comments received shall be supplied to the practice for further comment thereon. (All comments from the assessor or the practice must be submitted within 21 days of receipt of the date of the letter from the RCVS inviting comment.)

69. As soon as practicable, the grounds of appeal, supporting material, Assessor’s comments and practice’s comments, together with copies of the original decisions and all correspondence, shall be submitted to the Review Group, which shall review the application and either:

    a. confirm the earlier decision and refer the matter to the next available meeting of the Standards Committee;

    **or**

    b. issue an amended decision.

70. The result of the review by the Review Group, and a copy of its decision, shall be notified to the practice within 14 days.

71. In the event that the practice disputes the amended decision it shall notify the RCVS and the matter shall be referred to the next available meeting of Standards Committee.

72. The decision of Standards Committee as to whether or not to accredit a practice under the Scheme and the appropriate level of accreditation and any conditions to be imposed shall be final.

73. Following consideration by either the Review Group or the Standards Committee, if conditions require to be fulfilled, a Certificate of Standards will not be issued until the Assessor has confirmed the practice has complied with all conditions.

## Complaints

74. If a complaint is received alleging a practice has not complied with the Standards of the Scheme, the Review Group will consider it after the practice has had the opportunity to comment on the complaint.

75. If in the course of an inspection an Assessor has concerns relating to a possible breach, he reserves the right to bring the matter to the attention of the Review Group or, where concerns relate to issues of professional conduct, to the Professional Conduct Department.

76. Practices agree to respond to all requests for information and complaints relating to the Scheme.

## Data protection

77. All information on a practice obtained or recorded in connection with the Scheme will be accessible to the RCVS as a whole, and, in particular, may be used by the Professional Conduct Department responding to complaints relating to the professional conduct of a veterinary surgeon or, in accordance with the Data Protection Act 1998, may be passed to relevant enforcement agencies, e.g. the Health and Safety Executive or Veterinary Medicines Directorate.

## Miscellaneous

78. If any matter arises regarding the operation of the Scheme that is not provided for under the Rules, it shall be decided upon by the Review Group.

79. Although the Health and Safety requirements (and other legal requirements) may be extensive, and as far as possible up to date, fulfillment of these at inspection does not constitute a guarantee that each and every Health and Safety requirement (or other legal requirement) has been met, and does not obviate the necessity for each practice to check with the Health and Safety Executive (or other relevant authority) regarding their individual requirements.

**Feedback and improvements**

80. The College welcomes feedback on the application/inspection process. Practices are therefore required to complete the online feedback form following inspection which can be found on the RCVS website: http://www.rcvs.org.uk/practice-standards-scheme/information-for-existing-members/inspection-feedback/

**Transitional Arrangements for existing members**

81. Practices will automatically migrate to the new Scheme at their current accreditation level, for example, General Practice – Small Animal.

82. Routine inspection dates will not change under the new Scheme and practices do not need to delay or bring forward their routine inspection in order to be inspected for Awards.

83. Practices may apply to be inspected for optional Awards at anytime