Royal College of Physicians

Pulmonary Rehabilitation Services Accreditation Scheme

Pulmonary rehabilitation services accreditation scheme

Accreditation standards and guidance for the public

Published September 2020

Contents

Introduction

This document has been designed to assist pulmonary rehabilitation (PR) services in all sectors to prepare for their Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) assessment. It defines the standards and evidence required to achieve PRSAS accreditation.

The standards have been established with the PR community and are based on the **British Thoracic Society's (BTS) quality standards** and the **British Standard Institute's (BSI)** specification for accreditation of clinical services, and take into account the **NHS England and Improvement PR Service Guidance**.

Eligibility criteria for assessment

To request an assessment all criteria in the accreditation standards must be fully evidenced.

Assessment eligibility	
All evidence uploaded against the accreditation standards is correct, up to date and relevant	☐
Your service has at least 12 months' of funding for continued service	☐
Your service is participating in the national pulmonary rehabilitation (PR) audit that is part of the National Asthma and COPD Audit Programme (services in England and Wales only)	☐
Your service's annual subscription is up to date and there are no outstanding invoices	☐
A representative of your service has attended a PRSAS accreditation training session	☐
Patient Identifiable Data (PID) I confirm that I have not uploaded any Patient Identifiable Information or data in the assessment evidence	☐
Clinical effectiveness	
If using the 6-minute walking test as an outcome measure, the course is 30 metres in length	☐
All patients complete a practice walk test a maximum of 4 weeks before completing a walk test during the initial assessment	☐
Service profile	
All contact details for staff at your service have been verified as correct (Assessment dashboard → Service user accounts)	☐
All registration details are correct and up to date, including your service name, your organisation and details of your organisation leads (Assessment dashboard → Service information)	☐
Assessment requirements	
Your service will have a PR class running on the day of the site assessment	☐
Your service lead, a clinical director or equivalent, and patients will be available and present on the day of the site assessment to talk to the assessment team	☐
Services that run PR classes on multiple sites	
All site details are correct on the website (Assessment dashboard → Service information) A site is a location where PR classes take place	☐
All policies are shared across all sites within your service	☐
All audits are conducted and presented as a service	☐
All accreditation standards are met at all sites within your service	☐

Domain 1 – Leadership, strategy and management

Standard	Example guidance
1.1 The ethos, culture and team approach of the service is defined and published.	> This might be in a mission, vision and values statement that links to the organisation's values and objectives.
1.2 The service has a leadership team that is visible, approachable and communicates regularly with staff members.	> The roles and responsibilities of individuals in the leadership team should be clearly defined. The service should be delivered by experienced and specialist healthcare professionals – it is expected that the service will have physiotherapist and/or nursing input in collaboration with a broader multidisciplinary team.
1.3 The service has a leadership team that is responsible for operational planning and service development.	> The operational planning/service development process must consider: – the needs of the local population, including geographical and clinical profiling – disease burden – national and local requirements – value for money – promotion of the service – review of demand and capacity of the service.
1.4 There are escalation procedures for staff members.	> This must include: – the sharing of information and raising general concerns – challenging questionable and/or poor clinical practice – breaches of code of conduct and accountability; raising concerns of an ethical nature – disrespectful, discriminatory, abusive behaviour or harassment – provision of information and support for staff members raising concerns to clarify that there is no blame for adverse consequences – staff awareness of service/organisational policy on 'bullying and harassment'.
1.5 The service promotes the health and wellbeing of staff members.	
1.6 The service leadership team carry out a PR staff survey and provide opportunities for informal feedback.	> There are systems in place to ensure that staff are able to feedback in confidence.

Domain 1 – Leadership, strategy and management

Standard	Example guidance
1.7 There is promotion of the service to referrers and potential patients.	> The service promotion must describe: – the scope of the service provided (including who the service aims to provide treatment/care to and whether research or training is undertaken) – the range of services offered and expected clinical outcomes – service organisation including the team members involved in delivering the service, frequency of clinics and opening times, their location(s), including satellite services, how to contact the service for help and advice, including out of hours – facilities available, including access for users with specific needs – expected timescales for the patient pathway, including initial assessment, start of PR, length of programme and discharge assessment – information regarding volunteers participating in the PR programme, if applicable to service – any links with other services/stakeholders, including how referral pathways are managed, eg information about other services in patient pack or referral agreements/ pathway documents.

Domain 2 – Systems to support service delivery

Standard	Example guidance
2.1 The service has defined roles and responsibilities for facilities, equipment and IT management, in accordance with the operational plan.	
2.2 The service carries out an assessment of the clinical space, facilities and equipment required to deliver the service.	> As a minimum, the equipment available onsite must include: – aerobic equipment – weights and resistance equipment – oximeters, BP monitor, weight scales, height chart – stopwatches (for assessments and exercise sessions, one for each patient) – music player, two bright cones, tape measure (10 metre for incremental shuttle walk test (ISWT) or 30 metre for 6-minute walking test (6MWT)) – chairs – telephone access – emergency equipment – laptop/projector/flipcharts/white boards and supplementary written material for educational sessions.

Domain 2 – Systems to support service delivery

Standard	Example guidance
2.3 The service uses IT systems which are designed to facilitate the collection, management and monitoring of data to support service delivery.	> The service must identify information standards and IT systems relevant to the specific needs of the service. > If purchasing or implementing new IT systems; how they relate, communicate and interact with other IT systems within the service shall be assessed.
2.4 The service has a procedure for the storage of data, which includes the requirements for back-up, retention, archiving and any encryption.	> It is expected that the policy should include the transportation of data off site.
2.5 The service has a process for document management and control.	> The process for the control of documents requires that: – documents are kept up to date, secure and, where necessary, confidential – information that is obsolete is removed from use and archived.

Domain 3 – Person-centred treatment and/or care

Standard	Example guidance
3.1 Patients and carers are involved in the development of the service.	> Information about how a shared common purpose is established with patient/carer groups.
3.2 There are procedures to respect and protect patients/carers and their belongings.	> The procedures should be developed to safeguard the rights, privacy, dignity, confidentiality and security of patients/carers at all times, especially during subjective parts of initial and discharge assessments.
3.3 The service communicates to the patient their responsibilities.	
3.4 The service reviews and acts on did not attend (DNA) rates.	
3.5 The service monitors waiting times and completion rates and keeps patients informed if journey times are expected to exceed locally set targets.	
3.6 The service monitors and reviews inappropriate referrals.	
3.7 The service has a procedure for managing patient transitions within the service, out of the service, to self-management or to other services.	> Evidence of links and referral pathways to community-based opportunities. > The service identifies, makes patients aware of and encourages access to, local and national patient support groups and provides access to information to support patients to manage their condition.

Domain 3 – Person-centred treatment and/or care

Standard	Example guidance
3.8 The service documents person-centred treatment/care plans, based on the needs of the individual.	> These are fundamental aspects of care for any patient, including: – relationships with key staff – communication – ensuring comfort, alleviating pain – promoting independence.
3.9 The service enables patients and carers to feed back on their experience of the service confidentially.	> These procedures should include at a minimum feedback on: – quality and safety of treatment and/or care provided – involvement of patients in their treatment/care – quality and clarity of information provided – dignity, respect and compassion – all aspects of the patient pathway including referral and assessment.
3.10 The service records and investigates concerns, complaints and feedback.	> The service has processes in place to ensure complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon.

Domain 4 – Risk and safety

Standard	Example guidance
4.1 The service has risk management procedures.	
4.2 The service records risks in a risk register.	
4.3 The service has a procedure for how incidents, adverse events and near misses are reported, investigated and used to inform changes to service delivery.	
4.4 The service undertakes and records a clinical risk assessment of individual patients.	> The clinical risk assessment must include: – the risk of harm to the servicer user and others – the patient's changing risks – deteriorating health and wellbeing – challenging behaviour – medical emergencies – medication management.

Domain 5 – Clinical effectiveness

Standard	Example guidance
5.1 The service measures and manages clinical outcomes.	
5.2 The service provides a comprehensive programme of education.	
5.3 The service participates in local and national audit/assessment programmes.	
5.4 The service reviews all relevant guidelines, quality standards and benchmarking data.	
5.5 The service keeps a register of all research undertaken in the clinical service, including ethics approval, where relevant.	> The service should review participation rates in research projects where relevant.

Domain 6 – Staffing a clinical service

Standard	Example guidance
6.1 The service undertakes a review of the workforce.	> The review should include any planned appointments to support new work and skillmix of the team.
6.2 There is a service-specific induction programme, which new staff members and those with a change in role are required to complete.	> Staff should attend further **BTS PR courses** as they become available.
6.3 The service has an appraisal process for staff members.	
6.4 The service has training plans in place for staff members.	> Team members should receive mandatory training procedures to safeguard patients and to protect the health and safety of patients and staff members.
6.5 The service implements a process to assess staff members as competent before using techniques and specialist equipment.	
6.6 The service has documented procedures in place for staff members who have responsibility for students, trainees and observers.	

Domain 7 – Improvement, innovation, and transformation

Standard	Example guidance
7.1 The service develops a quality improvement (QI) plan based on clinical quality metrics and patient/carer feedback.	> Where clinical metrics and/or patient/carer data demonstrate positive results, the QI plan should focus on ways to maintain the results and continue to improve.
7.2 The service provides staff members with the support, training and protected time to undertake improvement initiatives.	
7.3 The service develops an innovation programme.	> Innovation could include: – research to develop new ways of working – recommendations by national or regional bodies – the adoption of technology, facilities and equipment to improve quality/value.

Version history:

V1	July 2018	
V2	July 2019	Editorial changes to wording and change of numbering. Some standards condensed owing to repetition.
V3	March 2020	Update to some evidence requirements and streamlining of standards.
V4	September 2020	Editorial changed to wording of some standards.

Further information

For further information on PRSAS visit
www.prsas.org

Follow us on Twitter
@PRaccreditation

If you have any queries about the work of the PRSAS, please email us at
pulmrehab@rcplondon.ac.uk

Royal College of Physicians

Pulmonary Rehabilitation
Services Accreditation Scheme