I am part of Quality Network team visiting Brockfield House next week. I wonder whether you would be able to forward me electronic copies of the below policy/procedures in advance:

- RMPG09 Security - Risk Management – Procedure
- CLP41 Seclusion, Segregation & Restricted Access Policy (previously Seclusion Policy)
- CLPG41 Seclusion, Segregation & Restricted Access Procedure (previously Seclusion Procedure)
- RM05 Prevention and Management of Violence and Aggression - Policy
- RMPG05 Prevention and Management of Violence and Aggression – Procedure
- CG9 Preceptorship Clinical Guideline
- CG10 Named Nurse Clinical Guideline
- CP54 Mobile Phone - Policy
- CPG54 Mobile Phone – Procedure
- CP60 Information Sharing & Consent Policy
- CPG60 Information Sharing & Consent Procedure
- HR21 Induction/Mandatory Training - Policy
- HRPG21 Induction/Mandatory Training – Procedure
- CG8 Formal Observation Clinical Guideline
- HRPG36a Employee Wellbeing - Procedure (previously one procedure)
- CP24 Equality & Diversity – Policy
- CLP30 CPA - Policy
- CLPG30 CPA and Non-CPA Handbook
- CLP14 CPR - Policy
- CLPG14 CPR – Procedure
- CPG59(b) Confidentiality Procedure
- HRPG27a Conduct – Procedure
- CPG36 Communicating Patient Safety Incidents ‘Being Open’ – Procedure
- CG20 Clinical Handover Clinical Guideline
- CG28 Clinical Risk Assessment and Management Clinical Guideline

Response:
Please see attached.

However please note that RMPG09 Security procedure has been withheld. Due to its sensitive content the Trust believes this may be a security risk if this information was in the public domain.
ENGAGEMENT AND SUPPORTIVE OBSERVATION POLICY

POLICY REFERENCE NUMBER  CG8
VERSION NUMBER  1
REPLACES SEPT DOCUMENT  CG8 Clinical Guidelines For Engagement And Supportive Observation
REPLACES NEP DOCUMENT
KEY CHANGES FROM PREVIOUS VERSION  SEPT - a greater focus on supportive observation/engagement principles.
AUTHOR  Practice Development Lead Nurse and
CONSULTATION GROUPS
• Team Leads/Ward Managers/Sisters
• Trustwide (MH/LD) Operational Service Leads-Managers
• Compliance Team
• Risk Team
• Mobius Team
• Workforce Development and Training Clinical Governance & Quality Subcommittee

IMPLEMENTATION DATE  30 March 2018
AMENDMENT DATE(S)  6 March 2018
LAST REVIEW DATE  December 2017
NEXT REVIEW DATE  June 2020
APPROVAL BY CLINICAL GOVERNANCE & QUALITY COMMITTEE  February 18
RATIFICATION BY QUALITY COMMITTEE  March 2018
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POLICY SUMMARY
The principles contained within this policy and the associated documents will ensure that engagement and observation are supportive to the patient, carried out professionally and respectfully in order to ensure the safety of the patient, clinical team and visitors.

There is emphasis upon engaging and developing a supportive and therapeutic relationship with the patient based upon mutual respect and trust.

The therapeutic relationship between the patient and the professional is considered a fundamental element to effective engagement and observation; therefore observation must take place on the basis of proactive engagement and dialogue with the patient consenting, as long as that individual is capable. Staff involved in engaging and observing any patient must be clearly aware of their role and responsibilities in maintaining safety and wellbeing of patients, themselves and others.

To ensure recognised national terminology is used throughout this document the “patient” is used to refer a patient, resident, client or service user.

The Trust monitors the implementation of and compliance with this policy in the following ways;
A Trust wide audit will be undertaken at the minimum of every three years. Service Directors/Leads will nominate clinical leads to undertake the compliance audit who will be supported by the clinical audit department.

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<tr>
<th>Services</th>
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<td>CHS</td>
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</table>

The Director responsible for monitoring and reviewing this policy is
Executive Director of Nursing
Engagement and Supportive Observation Policy

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2.0 DUTIES
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6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION
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APPENDIX 1 – ENGAGEMENT AND SUPPORTIVE OBSERVATION CARE PLAN FORM
APPENDIX 2 - CORE COMPETENCIES
APPENDIX 3 - RECORD FOR LEVELS 2, 3 AND 4
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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ENGAGEMENT AND SUPPORTIVE OBSERVATION POLICY

Assurance Statement

1.0 INTRODUCTION

This policy and associated procedure and appendices takes into account current guidance on Duty of Care, patient engagement and supportive observation issued by the National Institute of Clinical Excellence (NICE 2005; NICE Guidance NG10 2015), the Standing Nursing and Midwifery Advisory Committee (SNMAC 1999) Practice Guidance: Safe and Supportive Observation of Patients at Risk, June 1999 and the Patient Safety Observatory at the National Patient Safety Agency (NPSA) and the Mental Health Act Code of Practice (2015) – Chapter 26

Observation/engagement is important as a supportive mechanism, for the purpose of engaging positively with the patient. It should not be seen as inflexible and rigid but spending time with patients, whether engaged in activity, discussion or simply being with them may allow close assessment and monitoring of behaviour and mental state.

Supportive observation/engagement should be an integral part of the care plan, to ensure the safe and sensitive monitoring of the patient’s behaviour and mental well-being. It should enable a rapid response to change, whilst at the same time fostering therapeutic relationships between the member of staff and the patient.

The use of increased observation levels should never be regarded as routine practice, but must be based on assessed and current need. Enhanced observations should be recognised as a restrictive practice and may be perceived by patients as a coercive intervention. It should therefore only be implemented after positive engagement with the patient has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patients’ dignity and privacy whilst maintaining the safety of the patient and those around them.

The general principles issued by the NICE guidance (NG10 May 2015) recommend that staff should be aware of the location of all patients for whom they are responsible, but not all patients need to be kept within sight. At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the patient. As part of the assessment, the nurse should evaluate the impact of the patient’s mental state on the risk of violence and aggression, and record any risk in the notes.

Decisions about what level of observation a patient requires will be based and supported by documented evidence of assessed current need.
There may be occasions when it is appropriate to combine observation levels over a 24-hour period, for example, defined observation (level 2) and within eyesight (level 3). This is likely to occur when an increased risk is associated with a particular event or time-frame for the patient, i.e. meal times, during visiting, handover periods.

There will be occasions where a patient is assessed as needing a high level of supportive observation for a protracted period e.g. patients with severe dementia, delirium, mixed presentations at risk of falls etc. where it may be deemed appropriate to review observation weekly as opposed to daily. This review may take the form of a safety huddle (where in use). The aim of safety huddle is to review all patients on high level observations, adopting a positive risk taking approach and taking into account factors such as patient’s medication, level of agitation and acceptance of personal care with input from physio and OT to assess patients’ need for special observations.

Any reduction in the level of engagement or observation should ideally be a team decision but to ensure patients are not left on an increased level too long it is recommended that teams plan ahead [particularly at weekends] clarifying the circumstances that would enable a reduction in observation level.

If the risk of falls has been identified, consideration should be given to the use of falls sensor equipment in the event of a reduction in levels of observation.

For seclusion and restricted access please refer to Seclusion and Long Term Segregation Policy and Procedure.

The decision on prescribing, increasing and decreasing levels of engagement and supportive observation must take into account:

- The patient’s current mental state.
- Any prescribed and non-prescribed medications and their effects.
- The current assessment or risk and previous risk assessments where appropriate.
- The views of the patient, as far as possible. (NICE: NG10 May 2015).

The outcome of risk assessments and the decision to place a patient on any level of observation must be clearly recorded in the patient’s records.

**Appendix 1**, the Engagement and Supportive Observation Care Plan form must be completed and signed.

### 2.0 Duties

**Trust Board of Directors** – are responsible for overseeing the reduction of restrictive practice within its services, recognising enhanced observations should only be used for the least amount of time clinically required. They have a responsibility for ensuring there is an appropriate and adequate infrastructure to support the observation and engagement of patients and that patients are safeguarded and their equality and human rights is not compromised.
Executive Director of Nursing – is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance with this Policy and procedure, which promotes supportive observations, engagement of patients and safeguards against unnecessary use of restrictive practice.

Service/Associate Directors – have operational responsibility for clinical divisions’ compliance with this Procedure and will ensure mechanisms in place within each service for:

- Identifying and deploying resources within the clinical division to safely deliver this Policy and Procedure.
- Ensuring all clinical staff with responsibility for prescribing and carrying out observation/engagement receive orientation to the content of this Procedure.
- Monitoring the clinical division’s compliance and consistent application of the Procedure.
- Ensuring that all patients subject to prolonged periods of constant observations are reviewed after 14 days and then at least once per calendar month by clinicians independent of the patient’s care.

Responsible Clinician – has a legal and professional responsibility for the care and treatment of the service patients. As part of that responsibility they must have a thorough knowledge of the patients in their care, input to patients’ current care plans and observational requirements and provide advice when uncertainty arises regarding level of observation required.

Matrons – are accountable to the Service Director for providing assurance that their respective wards’ are compliant with the requirements of the Policy and Procedure.

Ward Managers – have overall accountability for the management of their ward and must ensure:
- They understand their role in initiating and reviewing supportive observations.
- Care plans are in place and appropriately identify the required level of observation.
- Documented risk review accompanies the decisions made to change the levels of observation.
- Deployment of the available resources to safely deliver this Procedure on their wards.
- Identification, responding and where necessary escalating any areas of non-compliance with this Procedure on their wards.
- That Peer review occurs when patients are subject to constant observations for longer than 14 days.

Multidisciplinary Care Team – have a responsibility to understand their role in initiating and reviewing supportive observations. They must balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed by the Multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation.
The teams must consider how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive and how observation can be carried out in a way that respects the individual’s privacy as far as practicable and minimises any distress. In particular care plans should outline how an individual’s dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc., as detailed in later a robust care plan based on identified risk should be in place at times usually associated with the need for privacy.

When enhanced observations are used for longer than 14 days, the team should use the skills of the entire team to support patient’s recovery.

**Nurse in Charge** – is responsible for identifying the staff (by their profession and grade) who are best placed to carry out enhanced observation and under what circumstances. This selection should take account of the individual’s characteristics and circumstances (including factors such as experience, ethnicity, sexual identity, age and gender). They should ensure staff allocated to undertake increased observations have been assessed as competent to do so.

The Nurse in Charge should also be checking observations are undertaken in line with the prescribed observation level, and in accordance with the agreed care plan. Competency is checked with staff using **Appendix 2**; records are kept by ward manager/team leader and reviewed yearly. Review could also be done through supervision.

**All Registered inpatient clinical staff have a responsibility to:**

- Understand their role in initiating, carrying out and reviewing supportive observations/engagement
- Carry out that role in line with the Procedure
- Complete the care plan for their named patient.
- Inform each patient of the level of observation they are subject to and the reasons for this.
- Review the level of observation based on recorded clinical need and risk review.
- Ensure the care plan is implemented.
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
- Complete all the required documentation.
- Fully familiarise themselves with the policy and procedure.

**Non-registered inpatient clinical staff have a responsibility to:**

- Understand their role in carrying out supportive observations
- Carry out observations in line with the observation level prescribed
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
- Be familiar with, and implement, the patient’s care plan.
- Complete the required documentation accurately and contemporaneously.
- Report any relevant information that would assist the effective review of the patient’s needs.
3.0 DEFINITIONS

This policy and procedure have been developed as follows:

- Clinical observations provide opportunity to build therapeutic relationships
- Engaging with a person whilst carrying out observations can have a positive effect on levels of distress
- Assessment, engagement and intervention should be used to recognise, prevent and therapeutically manage: disturbed or violent behaviour; risk to self; risk of neglect; and abscondment
- The current level and the reason for the observation must be clearly recorded in the patient's clinical notes
- Observations cover the 24 hour period, which means going into patient’s bedrooms when the person is sleeping/resting to check on their physical and mental well-being and to ensure there is no loss of vital signs
- At times, it may be necessary to search the patient and their belongings whilst having due regard for the patients legal rights and in accordance with the Trust’s Searching Patient’s/Visitor’s Property Policy/Procedure
- In some circumstances it may be necessary to temporarily remove belongings that could be used to inflict harm to self and other
- All observations will be recorded on the appropriate Observation Recording Form

4.0 PRINCIPLES

The purpose of this policy is to make clear the standards expected of clinical staff for the engagement and supportive observation of patients, and to provide them with direction and guidance for making decisions about observation levels including reviews, carrying out observations, correct completion of documentation and their training requirements.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

A Trust wide audit will be undertaken at the minimum of every three years. Service Directors/Leads will nominate clinical leads to undertake the compliance audit who will be supported by the clinical audit department.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION


CG8 – Engagement and Supportive Observation Policy


Dennis, S. SUPPORTIVE Observation in acute in-patient setting: Mental Health Care vol.21, Sept.1998

Department of Health Safety First ‘February 2001


Seclusion & Long Term Segregation Policy - CLP41.


NICE guidelines [NG10] Published date: May 2015


Standing Nursing and Midwifery Advisory Committee (SNMAC) Practice Guidance: Safe and Supportive Observation of Patients at Risk, June 1999

The Scottish Office Home and Health Department clinical research advisory group (CRAG) CRAG/SCOTMEG. Nursing observation of acutely ill psychiatric patients in hospital. Edinburgh: HMSO, 1995

Observation and Engagement Policy: Anne Leithch, Southern Health NHS, April 2015


Metal Health Act 1983 as amended by the Mental Health Act 2007 and Revised Code of Practice

7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

Seclusion and Long Term Segregation Policy and Procedure

Clinical Risk Assessment, Management and Safety Policy and Procedure

Care Programme Approach (CPA) & Non-CPA (Standard Care) Policy

Prevention and Management of Violence and Aggression at Work Policy, Procedure and Guidelines

A Joint Policy Relating to Section 136 Mental Health Act 1983 as amended by the Mental Health Act 2007

Incident Reporting Policy and Procedure

Searching Patient’s/Visitor’s Property Policy/Procedure

Unified Health and Social Care Written Record Policy

Management of Patients Who Self Harm Policy and Patient Safety Environmental Standards

In-Patient Leave Procedure and Policy

Privacy and Dignity – Safeguarding Good Practice

Guidance and Protocol on the Management of Staffing Levels

Training need analysis

Trust Auditable standards and monitoring arrangements
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ENGAGEMENT AND SUPPORTIVE OBSERVATION CARE PLAN FORM

(Please use black ink only)

Ward:

Named Nurse:

Patient Name:
Patient Date of Birth:
NHS Number:

Observation Levels Required including Clinical Reason, Date and Time started:

Patient's own view (or Patient's representative) of observation level:

Following completion of a risk assessment any special Instructions for example: risk areas, identified times of possible increased risk (times of day or night)

Medical Staff  Nursing Staff
Print Name:  Print Name:
Signature:  Signature:
Details of Discontinuation or any Change including Clinical Reason, Date and Time:

Medical Staff  Nursing Staff
Print Name:  Print Name:
Signature:  Signature:
The engagement of formal observation is in itself a skilled activity and requires the clinician (registered and unregistered) to be familiar with/competent in a number of areas. The development of competencies may be achieved by attending in-house training programmes, shadowing, and preceptorship.

The assessment of a clinician’s competency to undertake inpatient engagement of formal observation is the responsibility of the clinician’s line manager and should be monitored via performance review, during managerial supervision, direct observation and supervised practice if necessary.

New staff should only be allocated engagement of formal observation duties when they are deemed competent and it is the responsibility of the manager to assess this.

**Clinicians undertaking the engagement of formal observations must be familiar with / competent in the following:**

<table>
<thead>
<tr>
<th>Competency</th>
<th>Achieved: Signature of supervising manager</th>
<th>Date</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>Staff member is familiar with/competent in risk assessment and takes into account both physical and mental health aspects.</td>
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<tr>
<td>2</td>
<td>Staff member demonstrates awareness of management and engagement of patients at risk of harming self or others, and of physical and/or mental deterioration</td>
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<tr>
<td>3</td>
<td>Staff member is aware of factors associated with self-harm/harm to others and physical and mental deterioration</td>
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<td>4</td>
<td>Indication for engagement of formal observations</td>
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<td>Description</td>
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<td>5</td>
<td>Demonstrates a clear understanding of the respective engagement of formal observation levels.</td>
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<td>6</td>
<td>Demonstrates a professional attitude towards engagement of formal observation</td>
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<td>7</td>
<td>Demonstrates an awareness of the therapeutic opportunities of engagement of formal observations</td>
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<td>8</td>
<td>Demonstrates awareness of roles and responsibilities of the engagement of formal observing clinician</td>
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<td>9</td>
<td>Demonstrates awareness of the roles and responsibilities of the MDT in relation to engagement of formal observation and the review process.</td>
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<td>10</td>
<td>Demonstrates the ability to maintain a safe and conducive environment</td>
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<td>11</td>
<td>Demonstrates the ability to record engagement of formal observation</td>
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<td>12</td>
<td>Demonstrates the ability to engage the patient in their own care</td>
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<td>13</td>
<td>Demonstrates awareness of high risk periods and how to manage the risk</td>
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Staff member has also completed the Trust online (OLM) Engagement and Supportive Observation training.

Date completed ......................................................
Name of supervising manager .........................................................

Signature ..................................................................................................
Name of staff member ............................................................................

Signature ..................................................................................................

Date: ..................................................
Time: .............................................
ENGAGEMENT AND SUPPORTIVE OBSERVATION RECORD FOR LEVELS 2, 3 AND 4

Patient’s Name: ........................................... Male/Female (Please delete as appropriate)  NHS or Paris Number: ..............................
Ward ..............................................................

Reason for Observation or Reason for Change in Level

Examples of presentation at night can be shown as: (LS: Patient on the left side) (RS: Patient on the right side) (ST: flat on the stomach) (BK: flat on the back). Some examples for rationales for enhanced observation: Self-Harm, Absconding, Falling, Aggression, Physical Care, and Mental Well-being. Examples of this include: dis-inhibited (rude or offensive) behaviours, wandering, severely depressed, severely anxious/agitated, elated, sleep disturbance, poor motivation, medical condition. Also including, returned from leave, as patients can be deemed more at risk on their return.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Level of Formal Observation (Please circle as appropriate)</th>
<th>Engagement and Formal Observation Report (whereabouts of the patient, their activity, presentation etc. must be recorded)</th>
<th>Interventions/Actions taken during this period of formal observation</th>
<th>Name of Observer</th>
<th>Signature of Observer</th>
<th>Gender of Observer</th>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>Example: Jane nursed in the day area. Presented as restless and agitated.</td>
<td>N.B Record effectiveness of interventions etc.</td>
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<td>Example: Given PRN as per PMAC. Agitation reduced. Doctor informed. Asked to review medication.</td>
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*Hard copies are to be retained with care plan and integrated into patient’s records. THIS DOES NOT REPLACE REGULAR ENTRIES INTO PATIENT’S DAILY RECORDS*
This record is to be used to check HOURLY the whereabouts of every patient on the ward/unit on General Formal Observation level 1 and Zoned Observations. Each patient must be checked every hour throughout the 24 hour period including checking for signs of life. A designated staff member is to ensure this is completed. A key code is to be used as follows:

- **Sleeping Area** = SA,
- **Dining Area** = DA,
- **TV Lounges** = TVL,
- **Bathroom** = B,
- **O/L** = On Leave,
- **G/L** = Ground Leave,
- **O** = Outside Garden,
- **Gy** = Gym,
- **C/L** = Compound Leave,
- **Therapy Room or Activity Room** = TR or AR,
- **Clinic Room** = CR.

Enhanced to higher level of formal observation.

This record is to be maintained and filed on a monthly basis. Any patient unaccounted for must be immediately reported to the nurse in charge.

<table>
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<tr>
<th>TIME</th>
<th>Observer's Name</th>
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**COMMUNAL AREAS CHECKED EVERY 10 MINS**

| Observers Signature |
ENGAGEMENT AND SUPPORTIVE OBSERVATION RECORD FOR LEVEL 1 (GENERAL OBSERVATION)

WARD .......................................................... DATE ........................................

This record is to be used to check HOURLY the whereabouts of every patient on the ward/unit on General Formal Observation level 1 and Zoned Observations. Each patient must be checked every hour throughout the 24 hour period including checking for signs of life. A designated staff member is to ensure this is completed. A key code is to be used as follows:

Sleeping Area = SA, Dining Area = DA, TV Lounges = TVL, Bathroom = B, O/L= On Leave, G/L= Ground Leave, O = Outside Garden, Gy = Gym, C/L= Compound Leave, Therapy Room or Activity Room = TR or AR, Clinic Room = CR. Enhanced to higher level of formal observation.

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COMMUNAL AREAS CHECKED EVERY 10 MINS

Observers Signature

Hard copies are to be retained with care plan and integrated into patient’s records. THIS DOES NOT REPLACE REGULAR ENTRIES INTO PATIENT’S DAILY RECORDS
ENGAGEMENT AND SUPPORTIVE OBSERVATION TRUSTWIDE PROCEDURE

PROCEDURE REFERENCE NUMBER: CGPG8
VERSION NUMBER: 1
REPLACES SEPT DOCUMENT CG8 Clinical Guidelines For Engagement And Supportive Observation
REPLACES NEP DOCUMENT
KEY CHANGES FROM PREVIOUS VERSION SEPT - a greater focus on supportive observation/engagement principles.
AUTHOR: [Redacted], Practice Development Lead Nurse and [Redacted]
CONSULTATION GROUPS:
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- Compliance Team
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- Mobius Team
- Workforce Development and Training
- Clinical Governance & Quality Sub-committee

IMPLEMENTATION DATE: 20 March 2018
AMENDMENT DATE(S): 6 March 2018
LAST REVIEW DATE: December 2017
NEXT REVIEW DATE: June 2020
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE: February 2018
APPROVAL BY QUALITY COMMITTEE: March 2018

PROCEDURE SUMMARY
The principles contained within this procedure and the associated documents will ensure that engagement and observation are supportive to the patient, carried out professionally and respectfully in order to ensure the safety of the patient, clinical team and visitors.

There is emphasis upon engaging and developing a supportive and therapeutic relationship with the patient based upon mutual respect and trust.

The therapeutic relationship between the patient and the professional is considered a fundamental element to effective engagement and observation; therefore observation must take place on the basis of proactive engagement and dialogue with the patient consenting, as long as that individual is capable. Staff involved in engaging and observing any patient must be clearly aware of their role and responsibilities in maintaining safety and wellbeing of patients, themselves and others.

To ensure recognised national terminology is used throughout this document the “patient” is used to refer a patient, resident, client or service user.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
A Trust wide audit will be undertaken at the minimum of every three years. Service Directors/Leads will nominate clinical leads to undertake the compliance audit who will be supported by the clinical audit department.

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The Director responsible for monitoring and reviewing this procedure is Executive Director of Nursing
ENGAGEMENT AND SUPPORTIVE OBSERVATION TRUSTWIDE PROCEDURE

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ENGAGEMENT AND SUPPORTIVE OBSERVATION TRUSTWIDE PROCEDURE

1.0 INTRODUCTION

This procedure takes into account current guidance on Duty of Care, patient engagement and supportive observation issued by the National Institute of Clinical Excellence (NICE 2005; NICE Guidance NG10 2015), the Standing Nursing and Midwifery Advisory Committee (SNMAC 1999) Practice Guidance: Safe and Supportive Observation of Patients at Risk, June 1999 and the Patient Safety Observatory at the National Patient Safety Agency (NPSA) and the Mental Health Act Code of Practice (2015) – Chapter 26

Observation/engagement is important as a supportive mechanism, for the purpose of engaging positively with the patient. It should not be seen as inflexible and rigid but spending time with patients, whether engaged in activity, discussion or simply being with them may allow close assessment and monitoring of behaviour and mental state.

Supportive observation/engagement should be an integral part of the care plan, to ensure the safe and sensitive monitoring of the patient’s behaviour and mental well-being. It should enable a rapid response to change, whilst at the same time fostering therapeutic relationships between the member of staff and the patient.

The use of increased observation levels should never be regarded as routine practice, but must be based on assessed and current need. Enhanced observations should be recognised as a restrictive practice and may be perceived by patients as a coercive intervention. It should therefore only be implemented after positive engagement with the patient has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patients’ dignity and privacy whilst maintaining the safety of the patient and those around them.

The general principles issued by the NICE guidance (NG10 May 2015) recommend that staff should be aware of the location of all patients for whom they are responsible, but not all patients need to be kept within sight. At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the patient. As part of the assessment, the nurse should evaluate the impact of the patient’s mental state on the risk of violence and aggression, and record any risk in the notes.

Decisions about what level of observation a patient requires will be based and supported by documented evidence of assessed current need.
There may be occasions when it is appropriate to combine observation levels over a 24-hour period, for example, defined observation (level 2) and within eyesight (level 3). This is likely to occur when an increased risk is associated with a particular event or time-frame for the patient, i.e. meal times, during visiting, handover periods.

There will be occasions where a patient is assessed as needing a high level of supportive observation for a protracted period e.g. patients with severe dementia, delirium, mixed presentations at risk of falls etc. where it may be deemed appropriate to review observation weekly as opposed to daily. This review may take the form of a safety huddle (where in use). The aim of safety huddle is to review all patients on high level observations, adopting a positive risk taking approach and taking into account factors such as patient’s medication, level of agitation and acceptance of personal care with input from physio and OT to assess patients’ need for special observations.

Any reduction in the level of engagement or observation should ideally be a team decision but to ensure patients are not left on an increased level too long it is recommended that teams plan ahead [particularly at weekends] clarifying the circumstances that would enable a reduction in observation level.

If the risk of falls has been identified, consideration should be given to the use of falls sensor equipment in the event of a reduction in levels of observation.

For seclusion and restricted access please refer to Seclusion and Long Term Segregation Policy and Procedure.

The decision on prescribing, increasing and decreasing levels of engagement and supportive observation must take into account:

- The patient’s current mental state.
- Any prescribed and non-prescribed medications and their effects.
- The current assessment or risk and previous risk assessments where appropriate.
- The views of the patient, as far as possible. (NICE: NG10 May 2015).

The outcome of risk assessments and the decision to place a patient on any level of observation must be clearly recorded in the patient’s records. Appendix 1, the Engagement and Supportive Observation Care Plan form must be completed and signed.

### 2.0 PURPOSE / SCOPE

To provide an agreed Trust-wide structure for engagement and supportive observation to all inpatients.

This is a Trust wide procedure and applies to all staff working in the Trust’s clinical divisions who have a responsibility for prescribing and/or undertaking supportive observations (including temporary, permanent, bank and agency staff).
3.0 ROLES AND RESPONSIBILITIES

Trust Board of Directors – are responsible for overseeing the reduction of restrictive practice within its services, recognising enhanced observations should only be used for the least amount of time clinically required. They have a responsibility for ensuring there is an appropriate and adequate infrastructure to support the observation and engagement of patients and that patients are safeguarded and their equality and human rights is not compromised.

Executive Director of Nursing – is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance with this Procedure, which promotes supportive observations, engagement of patients and safeguards against unnecessary use of restrictive practice.

Service/Associate Directors – have operational responsibility for clinical divisions’ compliance with this Procedure and will ensure mechanisms in place within each service for:

- Identifying and deploying resources within the clinical division to safely deliver this Policy and Procedure.
- Ensuring all clinical staff with responsibility for prescribing and carrying out observation/engagement receive orientation to the content of this Procedure.
- Monitoring the clinical division’s compliance and consistent application of the Procedure.
- Ensuring that all patients subject to prolonged periods of constant observations are reviewed after 14 days and then at least once per calendar month by clinicians independent of the patient’s care.

Responsible Clinician – has a legal and professional responsibility for the care and treatment of the service patients. As part of that responsibility they must have a thorough knowledge of the patients in their care, input to patients’ current care plans and observational requirements and provide advice when uncertainty arises regarding level of observation required.

Matrons – are accountable to the Service Director for providing assurance that their respective wards’ are compliant with the requirements of the Policy and Procedure.

Ward Managers – have overall accountability for the management of their ward and must ensure:

- They understand their role in initiating and reviewing supportive observations.
- Care plans are in place and appropriately identify the required level of observation.
- Documented risk review accompanies the decisions made to change the levels of observation.
- Deployment of the available resources to safely deliver this Procedure on their wards.
- Identification, responding and where necessary escalating any areas of non-compliance with this Procedure on their wards.
That Peer review occurs when patients are subject to constant observations for longer than 14 days.

Multidisciplinary Care Team – have a responsibility to understand their role in initiating and reviewing supportive observations. They must balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed by the Multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation.

The teams must consider how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive and how observation can be carried out in a way that respects the individual’s privacy as far as practicable and minimises any distress. In particular care plans should outline how an individual’s dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc., as detailed in later a robust care plan based on identified risk should be in place at times usually associated with the need for privacy.

When enhanced observations are used for longer than 14 days, the team should use the skills of the entire team to support patient’s recovery.

Nurse in Charge – is responsible for identifying the staff (by their profession and grade) who are best placed to carry out enhanced observation and under what circumstances. This selection should take account of the individual’s characteristics and circumstances (including factors such as experience, ethnicity, sexual identity, age and gender). They should ensure staff allocated to undertake increased observations have been assessed as competent to do so.

The Nurse in Charge should also be checking observations are undertaken in line with the prescribed observation level, and in accordance with the agreed care plan. Competency is checked with staff using Appendix 2, records kept by ward manager/team leader and reviewed yearly. Review could also be done through supervision.

All Registered inpatient clinical staff have a responsibility to:

- Understand their role in initiating, carrying out and reviewing supportive observations/engagement
- Carry out that role in line with the Procedure
- Complete the care plan for their named patient.
- Inform each patient of the level of observation they are subject to and the reasons for this.
- Review the level of observation based on recorded clinical need and risk review.
- Ensure the care plan is implemented.
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
- Complete all the required documentation.
• Fully familiarise themselves with the policy and procedure.

Non-registered inpatient clinical staff have a responsibility to:

• Understand their role in carrying out supportive observations
• Carry out observations in line with the observation level prescribed
• Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
• Be familiar with, and implement, the patient’s care plan.
• Complete the required documentation accurately and contemporaneously.
• Report any relevant information that would assist the effective review of the patient’s needs.

4.0 DESCRIPTIONS OF THE LEVELS OF ENGAGEMENT AND SUPPORTIVE OBSERVATION

ENGAGEMENT:
There is a need for nursing interventions to be based on engagement with the patient, not just on observation (Barker and Cutliffe 1997, Jones et al 2000). The engagement process is a way of establishing a clinically based working relationship that should be supportive, explorative and reassuring towards patients who may feel alienated isolated threatened and fearful (Barker 1998, 2000, Barker and Buchanan-Barker 2004).

Engagement is a way of assessing mental state, behaviour, mood and risk. Consideration should be given to the use of activity, discussion and distraction processes, with recognition of sometimes the need for silence and as much privacy as is safely achievable.

Practical Engagement:
• Activities of Daily Living — assisting individuals to maintain self-care, maintaining some responsibility and dignity. Assisting with bed making, tidying room and doing personal laundry. As appropriate; writing letters, making telephone calls.
• Social Interaction — (Respect patient’s right for silence!). If patient wishes to talk, talk and introduce general conversation topics. Explore their previous or current hobbies or interests.
• Coping strategies - Ask the patient what would be helpful to them at that moment in time, what has helped in the past and what could you help them with to try now: distraction, breathing, relaxation, walking.
• Therapy – support access to on-ward occupational therapy activities,
• Walking – walking around the ward, garden or around the grounds.
• Active diversion (The Tidal Model) – is a technique that is used to support the patient to understand their distress/agitation/anxiety etc. Therefore during the engagement with the patient identify what activity may help (and suggest to try ‘as it may not work for them!’) e.g. going for a walk, drawing, watch TV, conversation, gym, pool, squeezing objects, listening to music.
Engaging with patients that are very symptomatic and non-responsive is more difficult, however we can often still engage through the senses, connecting them to the world and to our care.

- Engage alongside the patient within the ward environment (walking through the garden, walking to the dining room, walking to the bathroom):
- Engage in activities that elicit **sensory-motor feedback** and assist with orientation
- Mechanisms for **Calming** – going to a space that is less noisy and busy.
- Mechanisms for **Soothing** – music, sensory ‘toys’, weighted blanket.
- Mechanisms for **distracting attention** – music, sucking sweets, popping bubble wrap, colouring-in.
- Mechanisms for **grounding** – focusing on the sensory inputs of the here and now through physical body or describing in detail something that can be seen, heard, felt etc.
- Engage the patient in a **physical activity** (5 min) to either reduce arousal or activate.
- Engage the patient in a **personal care activity** (5 min) sensory, nutritional, self-awareness.
- Engage the patient in a **self-care task** (5 min) washing, dressing, make-up, hair.
- Engage the patient in a **food/drink based task** (5 min)
- Engage the patient in a **sensory activity** (5 min) such as self-massage, relaxation, soft music.

**OBSERVATION:**

Supportive observation calls for empathy and engagement combined with readiness to act. It provides an opportunity for staff to interact with the patient in a therapeutic way. Supportive observation can increase understanding of the feelings and motivations of the patient to act in a particular way. It can also offer the patient support and guidance in how to deal with those feelings and thoughts.

There are a number of reasons why a patient may need to be nursed on engagement of supportive observations such as defined or higher, including –

- Intent to harm self/others
- Personal safety
- Social/sexual vulnerability
- Self-neglect
- Risk of falling/wandering
- Risk of absconding
- To support agreed objectives in care plan, e.g. support with identified triggers/dietary intake/supervised visits
- Poor adherence to or non-compliance with treatment programmes/medication regimes
- Physical illness
- Unknown patient recently admitted
- Following a seclusion episode
- To provide an atmosphere where therapeutic risks can be taken
• Marked changes in behaviour/presentation
• Recent loss/bereavement
• Hallucinations- suggesting harm to self or others
• Paranoid ideas- where the patient believes that others pose a threat
• Reaction to medication

NB. This list is not exhaustive.

**Level 1 – Low Level Intermittent**

This is the minimum level of observation for all patients in inpatient areas. Staff should know the location of all patients in their area, but patients need not be kept in sight. This is for patients assessed as being low-risk to themselves or others. The frequency of engagement and supportive observation is once every 30–60 minutes. This is prescribed using Appendix 1 of the engagement and supportive observation form.

During each shift, members of the clinical team must engage with each patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records. The engagement process is a way of establishing a clinical relationship that should be supportive, explorative and reassuring towards patients. In turn this allows for the development of meaningful care plans and risk assessments carried out in collaboration with the patient and taking into account the views of the patient.

The whereabouts’ of all in-patients must be known at all times. All in-patients on level 1 or Zoned supportive observations must be subject to hourly checks throughout the 24 hr period; this must be recorded on Appendix 4 of the engagement and supportive observation form. Appendix 3 of the engagement and supportive observation form must be completed for all patients on level 2, 3 and 4.

Any patients unaccounted for must be reported immediately to the nurse in charge.

Mental health nurses in in-patient settings have 24 hour responsibility therefore after each nursing verbal handover outgoing and incoming nurses must walk around the ward and account for the well-being and whereabouts of each patient including reflection upon mental state and condition. The nurse in charge has ultimate responsibility for ensuring this is undertaken.

Documentation of interactions and level of engagement of supportive observation (including rational for observation level) must be recorded in the patient’s notes and electronic records on a shift by shift basis. Entries should be in line with and refer to assessed care plans. Service requirements may require more entries.

**Level 2 – High Level Intermittent Observation.**

The patient’s location and safety must be visibly checked at intervals that may range from every five minutes to a maximum of every thirty minutes with at least four checks within every one hour period at irregular intervals. The patient must not be able to predict the pattern or to anticipate the time of the next checks. This is for
patients who pose a potential but not immediate risk of becoming violent or aggressive or absconding or patients who have previously been at risk of harm to self or others, but who are in the process of recovery, require intermittent engagement of supportive observation.

This is prescribed using Appendix 1 of the engagement and supportive observation form. Exact times of Level 2 supportive observations undertaken must be specified within the patient’s record/care plan using Appendix 3 of the engagement and observation form which should be kept in patient’s notes once completed.

Whilst a patient is prescribed intermittent engagement of supportive observation they must be periodically checked ensuring throughout that a positive therapeutic engagement takes place. During each shift, the allocated observer(s) must engage with the patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records.

This level of observation must be reviewed daily. Changes should be recorded in case notes.

**Level 3 Continuous**
This means a nominated staff member will be allocated to each individual being managed on this level of observation and the patient must be kept within continuous eyesight or at arm’s length at all times. This is for patients who could, at any time, make an attempt to harm themselves or others, or where a patient is perceived as being vulnerable. The responsible clinician and relevant members of the multidisciplinary team should be informed at the earliest opportunity when this level of observation is used. This is prescribed using Appendix 1 of the engagement and supportive observation form. Hourly notes should be written and signed on the engagement of supportive observation record sheet (Appendix 3) during the designated period of observation. The record sheet must be passed on to the nurse/clinician taking over the observation which should be kept in patient’s notes once completed.

During continuous observation it may well be necessary to search the patient and their belongings, whilst having due regard for the patient’s privacy and dignity, legal rights and cultural and gender sensitivities.

During each shift, the allocated observer(s) must engage with the patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records.

Staff observing a patient on level 3 should never leave the patient before the next nurse/clinician on the rota arrives. A verbal handover should take place; if practicable the patient should be made aware of the changeover.
Level 4 Within Arm’s Length
This means a nominated staff member will be allocated to observe the patient in close proximity (i.e. within arm’s length). This is for patients who pose the highest level of risk of harm towards themselves or potentially to others, and it has been determined that this level of risk can only be managed by close proximity of the patient with staff, again more than nurse may be required to implement this level of observation safely.

Multi professional continuous observation:
Usually used when a patient is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

This level of engagement of supportive observation is prescribed using Appendix 1 of the engagement and supportive observation form. During each shift, the allocated observer(s) must engage with the patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records.

This must involve maintaining arm’s length contact at all times, including when the patient is asleep or using the toilet. The clinician/s should be in sufficiently-close proximity to ensure immediate intervention (arm’s length).

This type of engagement of supportive observation should only be used in exceptional circumstances for the management of extremely challenging behaviour.

Issues of privacy and dignity, consideration of gender issues, religious requirements and environmental dangers should be discussed and incorporated into the patient’s engagement and supportive observation care plan.

A proactive approach is required which includes agreed optimum observation periods by any one nurse/clinician.

With this intense level of engagement of supportive observation, no one nurse/clinician should be allocated to observe a particular patient for more than 1 hour at a time the Nurse in Charge should allocate a rota at the commencement of shift.

In exceptional circumstances, such as when the patient has to be escorted to attend an appointment elsewhere, this may be increased.

Hourly notes should be written and signed on the engagement of supportive observation record sheet (Appendix 3) during the designated period of observation. The record sheet must be passed on to the nurse/clinician taking over the observation.

At the end of each shift, the allocated nurse/clinician for that shift is responsible and must enter a summary of the content into the patient’s daily records.

The possibility of self-harm by patients under supportive observation must never be underestimated as it is unlikely that closer observation will eliminate the desire for a
patient to do so. In fact, patients who habitually self-harm are likely to experience an increase in frustration during periods of reduced opportunity to self-harm.

All completed engagement of supportive observations at this level must be recorded hourly using Appendix 3. These records are to be kept within the patient’s notes and electronic record.

Staff observing a patient on level 4 should never leave the patient before the next nurse/clinician on the rota arrives. A verbal handover should take place; if practicable the patient should be made aware of the changeover.

**ZONAL ENGAGEMENT AND SUPPORTIVE OBSERVATIONS FOR LEVEL 3 AND BELOW**

This is an approach a ward or clinical area may take to enhance observation of a particular group of patients within a specific ward or environment, e.g. a dementia ward. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the patient group. Individual needs assessment will inform individual care plans and individual observation levels as detailed in this procedure. A staff member may be assigned to observe and engage with individuals using specified zones within the ward area.

This is prescribed and recorded using Appendix 1. A risk assessment must be completed followed by an Individual management plan which must be agreed and reviewed on a daily basis by the ward team and in-patient Responsible Consultant.

Staff must maintain a constant presence in communal zones and incorporated this approach with patient’s management plan.

Where higher levels of vigilance and monitoring are standard, daily community meetings can be introduced where patients collaborated with staff in planning meaningful activities and a ‘therapeutic day’ (including recreational, therapeutic and physical activities).

The increase in the level of patient engagement with activities would be marked; whilst activities had been on offer before zonal nursing, this approach will free nursing staff to take part in supporting these activities and the consequent engagement by patients would be significantly higher.

Staff observing patients on level 3 should never leave the patient before the next nurse/clinician on the rota arrives. A verbal handover should take place; if practicable the patient should be made aware of the changeover.

**COMBINING ENGAGEMENT OF SUPPORTIVE OBSERVATION LEVELS**

There may be occasions when it is appropriate to combine engagement of supportive observation levels over a 24-hour period.

Combining engagement of supportive observation levels should be considered when assessing patient whilst asleep or at night. For example, Level 2 and Level 3 of engagement of supportive observation is likely to occur when an increased risk is
associated with a particular event or time-frame for the patient, i.e. meal times, during visiting, handover periods, e.g. two patients who are on level 3 of observation could be overserved by one person in one room i.e. during meal times. Other staff must maintain constant presence in case they are needed.

A combination of engagement of supportive observation levels may also be appropriate when ‘stepping down’ for a patient who has been on a long period of intensive observations.

As with all levels of observation, the decision to combine levels must be based on patient’s risk assessment and the rationale behind the decision recorded clearly in the patient’s records.

The patient’s care plan must be clear as to the combination of observations and clearly communicated to all staff involved in the care of the patient and, as appropriate, the patient, family or significant others.

This level of engagement of supportive observation is prescribed and recorded using Appendix 1.

**SAFETY HUDDLE**

This is an additional multi-disciplinary team (MDT) review meeting of patients on level of observations due to safety concerns, predominately for falls risk patients on the older adult wards presenting with advanced dementia, delirium or mixed presentation in a confused state, agitated, have a lack of safety awareness and will often try to mobilise without supervision, walking aid, thus increasing falls risk.

The aim of the safety huddle is to discuss fall prevention strategies i.e. medication review, high/low bed, fall sensors for patients at risk of falls or that are repeat fallers. It is a multi-disciplinary team (MDT) decision to review supportive observations and to ensure that if observation levels are reduced i.e. at night time that falls prevention equipment is used.

The safety huddle is led by a senior clinician and the MDT staff (consultant, ward sister/nurse in charge, occupational therapist, physiotherapist, pharmacist and other relevant staff such as the ward activity coordinator and patient’s named nurse) is invited to attend.

The reduction in the level of engagement of observation should ideally be a team decision but to ensure patients are not left on an increased level too long it is recommended that teams plan ahead [particularly at weekends] clarifying the circumstances that would enable a reduction in observation level.

Safety huddle could also be for patients at risk of choking, any safeguarding issues, violence and aggression or any risk behaviour that raises concerns about a patient’s safety.
PROTECTED ENGAGEMENT TIME (PET)
For older adult inpatients, protected engagement time (PET) is established at least once daily, for between 1 - 2 hours in the morning or afternoon, not including night time.

During PET the ward is closed to visitors and professionals from outside the ward (with some exceptions depending on how ward staff choose to implement it).

Ward staff do not make phone calls or administrative duties but actively approach patients who were reluctant to engage with the planned programme previously and offer person-centred alternatives.

ENGAGEMENT OF SUPPORTIVE OBSERVATION AND SMOKING
EPUT is a smoke-free organisation and, as such, smoking is not permitted on any part of the Trust site including buildings, entrance/exits, car parks, pavements/walkways and residences. Staff are not permitted to buy cigarettes for patients, hold lighters/matches for patients or escort patients out to smoke. The Trust has agreed its policy in relation to vaping. All members of staff have a role to play in implementing and complying with the Trust Smoke free policy and procedure and are expected to be familiar with its content.

ENGAGEMENT OF SUPPORTIVE OBSERVATION WITHIN 136 SUITES
Whilst in a 136 suite individuals should be continuously engaged and observed; level 3 minimum. Following assessment should the individual then be admitted to inpatient ward either formally or informally an assessment as to level of supportive observation required should be carried out by the admitting ward, taking in to account the patients presentation and assessed risk/risks

ENGAGEMENT OF SUPPORTIVE OBSERVATION IN GENERAL HOSPITAL
The need for continuous psychiatric engagement and supportive observation must be agreed between the psychiatric ward and the receiving ward. This will depend on the patient’s risk assessment at the time and can be adjusted accordingly.

SPECIAL CONSIDERATIONS
½ hour engagement of supportive observations should be considered for patients on level 1 (general observation) who are physically unwell.

ESCORT AND ENGAGEMENT OF SUPPORTIVE OBSERVATION
Both the receiving and the sending wards will assess the requirements for engagement and supportive observation and establish and record the requirement for escorting/observation in the respective patient’s ward records. EPUT will provide the appropriate escorting/observing nurse when a high level of observations (level 3 and above) are required and recorded in line with this policy and procedure.
SOME PRACTICAL GUIDANCE:

(a) Staff need to be aware of their own thoughts, feelings and attitudes about observations to ensure that they can convey the supportive and therapeutic role of intervention to the individual.

(b) When making decisions about observation levels, the following should be taken into account – the patient’s current mental state, their view (as far as possible), their gender and religious requirements, as well as the environment itself.

(c) Any identified needs/requirements must be reflected within the patient’s Engagement of Supportive Observation care plan.

(d) Respect a patient’s wishes within safety boundaries, and the level of observation in force.

(e) Informed consent, as with any intervention, should be sought when prescribing supportive observation. If there is doubt as to the patient’s ability to consent, a Mental Capacity Assessment must be undertaken.

(f) If an informal patient is considered to require a period of enhanced engagement of supportive observations, a review of their legal status by the clinical team should take place immediately and a record made in the notes/records of the review and outcome.

(g) The prescribing of level 3 engagement of supportive observation and above to reduce the risk of absconding should only be considered where there are associate risks of harm to self or others, or the absconding behaviour cannot be managed in a less restrictive way, such as escorted leave.

(h) It is not normal practice, given the associated risks, to grant overnight leave to patients on level 2 and above supportive observation, unless the rationale for supportive observation is unit specific e.g. enhanced supportive observation due to vulnerability whilst on the unit, or it is assessed as therapeutically beneficial; e.g. to facilitate a young person spending time with their family. Prior to granting overnight leave for a patient on enhanced engagement of supportive observations the understanding and the agreement of the family/carer must be sought and a care plan in place which specifies that the family/carer has agreed and is aware of the risks. This care plan must stipulate the actions to be taken should the patient self-harm, abscond or deteriorate mentally during the period of leave. Careful consideration must be given to the therapeutic benefits and the identified/potential risks when granting day/short periods of leave to patients nursed on level 2 (defined). Patients nursed on engagement of supportive observation levels (3 and above) should only be granted escorted leave following a risk assessment. The assessment must consider the higher level of environmental and other risks present outside the ward environment and staffing level and observation levels adjusted accordingly. Any discussion regarding leave must be documented; this is to include both the rationale for granting or refusing escorted leave.

(i) Staff should balance the potentially distressing effects on the patient of increased levels of supportive observation, particularly for prolonged periods of time, against the risk of self-injury.
(j) Regular engagement of supportive observation of each patient should be maintained throughout the night shift.

(k) Ensure that electronic falls equipment has been assessed and is used appropriately.

(l) Engaging patients in activities can be very therapeutic and occupational therapists / activity coordinators can assist with this where possible.

(m) Nurse management systems should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible.

(n) 1:1 session with named nurse allows the patient to discuss concerns and frustrations.

(o) The engaging and supportive observing nurse/clinician should not observe one particular patient for more than 1 hour at a time without a break from supportive observation duties, unless there are exceptional circumstances, i.e. escorting the patient.

(p) Consideration should be given to the environment in which the observation is to take place. Where possible, any tools or instruments that can be used to either self-harm or harm others should be removed. It may be necessary to search a patient’s belongings (refer to Trust policy on Searching Patients and Their Property Policy.) If this is deemed necessary, this should be conducted sensitively and with due regard to legal rights.

(q) Observations through glass is only acceptable when checking a patient’s general whereabouts and the patient can be seen fully and is moving around (refer to Trust policy and procedure on the use of seclusion and long term segregation for additional guidance for seclusion).

(r) It is not acceptable to assume that a patient is sleeping from a visual check through a window; the observer must confirm this by a direct engagement of supportive observation including confirming breathing sounds.

(s) If, in order to hear audible breathing sounds, there is a risk that the patient would be disturbed and that this would be detrimental to the patient, the patient’s breathing may be confirmed by the clear raising and lowering of the chest/abdomen which would be an indicator of breathing.

(t) Consideration must be given to communicating with/providing information in an alternative format where necessary, e.g. via an interpreter, audio tape, large print, accessible language.

(u) Engagement of supportive observation levels should be regularly reviewed and the agreed decisions recorded.

(v) As with all details, a patient’s notes/records of engagement of supportive observation must be kept confidential, unless the patient has given permission for or requests otherwise.

**Particular vigilance should be exercised during ‘high risk’ times. These include:**

(a) Immediately upon admission and during staff handovers

(b) During the early stages of recovery

(c) During the early stages of a course of ECT

(d) Following patient’s use of non-prescribed drugs or alcohol
(e) During periods of physical illness e.g. urinary tract infection
(f) Following return from leave
(g) Following a visit from relatives/significant others
(h) When preparing for discharge
(i) Prior to and following transfer
(j) Major changes in care packages.

5.0 PROCESS

5.1 Restriction of Liberty
The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patient’s dignity and privacy whilst maintaining the safety of those around them. It is recognised that clinical services will at times adopt harm minimisation and positive risk taking approaches, for example with patients who self-injure. Where these approaches are used, the clinical strategies employed should be clearly documented in the individual patient’s clinical notes and care plan, so as to communicate the appropriate information to all staff working with those individuals. All decisions about the specific level of observation should take into account:

- The patient’s current mental state;
- Any prescribed medications and their effects;
- The current assessment of risk should include the patient’s ability to perceive potential risk;
- The views of the patient.

5.2 Communication and engagement
All clinical team members who have responsibility for the delivery of this policy and procedure must have a proper awareness of its implications and an understanding of any role they have in initiating, carrying out, and reviewing supportive observations. In addition patients who may be subject to this framework need to be fully informed as to the process by which the policy and procedure is applied and reviewed and be given the opportunity to discuss any concerns or questions they may have with an appropriate member of the multi-disciplinary team.

5.3 Human Rights issues
The European Convention on Human Rights (ECHR) has been enshrined in United Kingdom law since 2000. The provisions indicate that everyone has the right to respect for his/her private life (Article 8). No patient should therefore be subject to unnecessarily intrusive observations in a way that would breach this right. In order for this policy and procedure to comply with the law observation must be justified: the ECHR permits breaches of Article 8 that are necessary for one or more of the following reasons:

- The interests of national security, public safety or the economic well-being of the country; or
- The protection of disorder or crime; or
- The protection of health or morals; or
- The protection of the rights or freedoms of others;
Proportionate: even if the use of observations is considered justified, it will only be lawful if it goes no further than is reasonably necessary in each individual case to achieve the relevant objectives. When operating this procedure clinicians will need to make sure that the use of observations remains ‘proportionate’ and that it is no more intrusive – nor continues longer – than is required by the circumstances.

5.4 Prescription of Supportive Observations
The decision to introduce or increase the frequency of observations may in the first instance be appropriately taken by a registered nursing staff or mental health practitioner, when possible in conjunction with medical staff, and in response to an assessed risk. Wherever possible, decisions about the level of supportive observation required by an individual patient should be jointly made by the multidisciplinary team. The actual practice of delivering supportive observation is largely, though not exclusively, a nursing responsibility. However the Responsible Clinician has legal and professional responsibility for the care and treatment of individual patients. This authority is exercised through appropriate delegation of responsibilities within the multidisciplinary team. Decision making in respect of the authority to change practice should be described within the care plan, so that responsibilities for managing risk are well understood. Decision making can therefore be appropriately delegated to the nurse in charge of a ward or area. The risk assessment and rationale for all changes must be clearly documented in the patient’s care plan and clinical notes.

On admission the appropriate level of observation will be introduced to reflect the degree of risk or potential risk as identified following a thorough risk assessment by the medical and nursing team. A patient on observation higher than level one/baseline observation should not be automatically excluded from off ward therapy, education or leisure. As part of an initial assessment clinical staff will need to consider the following areas:

- CPA information and contemporary risk assessment;
- Information available from care co-ordinator if known to services;
- Expressed intentions;
- Information shared by relatives and carers;
- Implied intentions;
- Past history including previous suicide attempts, self-harm or assaultive behaviour;
- Hallucinations suggesting harm to self or others;
- Paranoid ideas that pose a threat to self or others;
- Recent loss or bereavement;
- Past or current problems with drugs or alcohol;
- Poor adherence to prescribed medication;
- Marked changes in behaviour or medication;
- Risk of falls;
- Risk of physical vulnerability.
- Safeguarding issues
5.5 Managing care for patients subject to supportive observations.

Supportive observation must be used as an opportunity for supportive and therapeutic interaction to meet the holistic needs of patients. Supportive observation & engagement is an ideal opportunity for a holistic assessment to identify and plan care, taking into account the equality needs of patients including the protected characteristics which are: age, race, disability, gender reassignment, marriage and civil partnership, religion and belief, sex, sexual orientation, maternity and pregnancy. Individualised care plans are central to providing considerate care at a potentially distressing time.

The care plan should be viewed as a high intensity engagement plan, explaining what, when & why it should consider/include:-

- Where possible being written in the first person
- Signposting to any associated advanced statement or directive
- Signposting to any Personal Safety plan
- A working formulation related to the behaviour/presentation creating the requirement for increased observation/engagement
- Use of trauma informed principles
- Frequency of safety checking including at night time
- Frequency of observation/engagement recording
- Any items withheld from the patient
- What should happen during times usually associated with privacy (use of toilet, bathing etc.)
- Any delegation of responsibility to change observation levels and under what circumstances
- Any gender specific requirements
- The recording requirements
- The engagement requirements
- Activities that have been collaboratively agreed and where necessary escort requirements to accommodate same.
- Relapse signs
- Trigger factors
- Any agreed private time or unsupervised time with family/carer (s) (however please note comment above)
- Frequency of review

The care plan should be shared at each hand over. If for any reason, engaging the patient in dialogue and activities during supportive observation is not possible, then the reasons for this needs to be clearly recorded.

The clinical team should continually review risk in developing an effective care plan for a patient subject to supportive observations. If it is considered necessary to search the patient and their belongings then reference should be made to the Trust’s search policy.
Nursing staff, and in particular the nurse-in-charge/shift co-ordinator, ward manager or their deputy, must be aware of the observation/engagement levels on the ward at all times, ensuring there are adequate numbers and grades of staff available for current and future shifts. Observation status should be discussed during ward handover to ensure continuity of care.

Nurses are expected to interact with the patients whilst undertaking supportive observation/engagement. This interaction should include an evaluation of their mood and behaviours associated with identified risk. A record of these interactions should be recorded at least once a shift, and more frequently if the clinical or ward team deem this appropriate. All interactions therefore need to be documented and used in the overall assessment of the patient. Staff therefore who are tasked with providing supportive observation should be given guidance on the focus of their assessment, as well as the activities and interactions to be engaged in.

Risks associated with all patients within inpatient areas need to be considered when making decisions about supportive observation. Particular emphasis should be placed on vulnerability in terms of gender, age, sexuality, ethnicity and capacity to give informed consent. The information gathered should be used to inform the clinical decision regarding supportive observation.

If appropriate to the patient’s needs a request for support from same gender nursing staff should be facilitated where possible, unless there is a specific clinical risk or other reason why this would be inappropriate.

However, where a patient is required to be observed whilst involved in intimate personal care, the support must be provided by a practitioner of the same gender unless there is a specific clinical risk. An hourly summary of the patient's condition, risk behaviours, significant events and any therapeutic interventions must be recorded.

Supportive observations of patients do not stop at night. There is a duty of care to ensure patients are safe and not in distress either physically or emotionally. It is recognised that patients expect a greater level of privacy after retiring to bed. Observations undertaken at night need to include an assessment of an individual’s well-being with any area of concern or doubt being explored. A nominated member of the nursing team must therefore ensure that each patient is assessed through regular monitoring to ensure they remain safe and that any individual’s distress or abnormal movement should be explored further. The frequency and extent of the monitoring should be led by the level of supportive observation or based upon individual requirements. The Mental Health Act Code of Practice, (2015) states that: “Staff must balance the potentially distressing effects on the patient of increased levels of observation, particularly if these levels of observation are proposed for many hours.”

5.6 Patients supportive observation/engagement in off ward areas

Continuity of therapy, education and leisure will remain a high priority for Patients on increased levels of observation. They should not therefore be automatically excluded from off ward treatments/ activities.
Patients may wish to take part in faith/religious activities such as praying or meditation within a multi-faith area of the ward or within hospital grounds. Patients should be supported to attend to their faith needs where possible taking into account the patients’ risk assessment.

Decisions regarding attendance should be based on individual risk assessment and not the level of observation the Patient is receiving.

The individual risk assessment should:

- Consider the environmental risk in the area being proposed for the Patient to attend, e.g. observation line, glazing in windows, furniture;
- Consider the treatment/activities within the area;
- Include the member of staff from the area where it is proposed the patient will attend;
- Consider if a ward based staff needs to escort the patient in order to undertake the observation, or whether this can be safely done by a member of staff from the areas the patient is attending;
- Record the details in the patient’s health care record.

Where the responsibility for undertaking the observation is transferred to a member of staff from the area where it is proposed the patient should attend, the observation record sheet should also be transferred to that staff.

5.7 Care provision for young people aged under 18

Any person under the age of 18 years is legally classed as a child, admission of a child under the age of 18 into adult services should be rare; however, if a young person is admitted consideration should be given to the need for 1:1 support via level 3 observations.

This decision should be made on clinical need and risk management grounds, including the need to safeguard the well-being of the young person, it should not be enforced as a blanket policy. If level 3 observations are not utilised good practice would suggest identification of a member of staff to act as a ‘buddy’ and familiar point of contact for a young person on each shift.

5.8 Skills and responsibilities of staff undertaking supportive observations

The registered nurse or mental health practitioner with overall responsibility for a given environment remains accountable for the decision to delegate supportive observational roles to non-registered nurses or students in training, and for ensuring that they are knowledgeable and competent to undertake this role.

Student nurses would not normally be expected to undertake supportive observation, except where this is an agreed part of their learning objectives and all parties are satisfied with their level of competence. Trusts should liaise with their local HEI re local recommendations.
It is recognised that providing supportive observation for patients is stressful and therefore staff should rotate regularly. It is therefore recognised that generally a member of staff should not undertake a continuous period of observation above the general level for more than 2 hours, unless it is seen as appropriate following consultation with the member of staff in question.

When supportive observation is being handed from one member of staff to another, the nurse-in-charge/shift co-ordinator needs to ensure that the member of staff taking over the responsibility is aware of the focus of their assessment; the plan of care; the information documented during the previous shift and the expected activities and interactions to be engaged in. Where ever possible such handover should involve the patient, so that they are involved in key decisions about their care.

5.9 Patient and carer information and involvement

Levels of observation and the reason for their use must be explained to patients, and their carers or relatives where appropriate. Staff should assess whether the patient and or their relative have understood the rationale and implications of using supportive observation which should be clearly documented.

Where a patient, and or their relative, experience difficulty in understanding the rationale and implications of supportive observation then this should be appropriately reiterated and clearly documented.

Trusts should consider allowing carers and relatives to undertake increased observation/engagement at specified times.

5.10 Privacy, Dignity and Confidentiality of the Patient

A solicitor has a duty of confidentiality towards his/her patient and, therefore, there is a presumption that no third party will be present when the solicitor is discussing matters with a patient. However, a presumption may be overridden if there are compelling reasons in a particular case, dependent upon the level of risk.

The risks should be assessed at the time the solicitor is required to attend and it may be necessary to communicate to the solicitor the reasons why engagement of supportive observations will need to continue during the interview.

Whilst the patient’s privacy and dignity should be maintained at all times, it is recognised that there will be occasions, namely when patients are being observed on levels 3 and 4, when this could be compromised, i.e. use of the toilet, bathroom, dressing, undressing and religious observance. In this instance, staff will continue with the appropriate engagement of supportive observation, however in a sensitive manner, ensuring that the patient is aware as to the reasons for this. Appropriate staff (gender, ethnicity, faith, etc.) should be available to carry out the engagement of supportive observations in these situations or at the patient’s request. Where possible, the same gender (as the patient) clinician should undertake the engagement of supportive observation during these times.
Individual and cultural issues in relation to the engagement of supportive observation (e.g. risk in relation to religious observance, wearing clothing which obscures the face or could allow self-harm to be unobserved, sensitivity to gender issues, etc.) must be considered when prescribing observation and allocating clinicians to carry it out.

### 6.0 SECLUSION / RESTRICTED ACCESS

For seclusion and long term restricted access please refer to Trust policy and procedure.

### 7.0 PRESCRIBING, INCREASING AND DECREASING LEVELS OF ENGAGEMENT AND SUPPORTIVE OBSERVATION

#### 7.1 Prescribing

It should be noted that the assessment of engagement of supportive observation levels is a continuous process from admission through to discharge.

Levels of enhanced engagement of supportive observation must be reviewed in every 24 hour period, including weekends.

This can be done by the senior nurses. However, for good inter-professional working, this procedure recommends that discussion must take place with the nurse and doctor on duty, about the decisions on the level of engagement of supportive observations to be used.

When deciding on levels of engagement of supportive observation take into account; the patient’s current mental state, any prescribed and non-prescribed medications and their effects, the current assessment or risk and the views of the patient as far as possible. (NICE: NG10 May 2015).

Use the least intrusive level of engagement of supportive observation necessary, balancing the patient's safety, dignity and privacy with the need to maintain the safety of those around them (NICE NG10 May 2015).

Give the patient information about why they are on engagement and supportive observation, the aims of supportive observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the patient agrees, inform their carer about the aims and level of engagement of supportive observation (NICE: NG10 May 2015).

Record decisions about engagement of supportive observation levels in the patient's notes and clearly specify the reasons for the observation (NICE: NG10 May 2015).

Record clearly the names and titles of the staff responsible for carrying out a review of engagement of supportive observation levels (see recommendation 1.5 above) and when the review should take place (NICE: NG10 May 2015).
Appendix 1 the Engagement and Supportive Observation Care plan form must be used for prescribing any level of engagement of Supportive observation and recording any changes made. This must be retained within the patient’s records.

A Medical Officer and the senior nurse/nurse in charge can initiate or change any level of observation, following a documented risk assessment. The Nurse in charge may increase a patient’s observations at any time. (See 5.14 on the next page/below).

The reasons for increasing or decreasing a level of engagement of SUPPORTIVE observation and any restrictions must be explained to the patient and his/her carers, unless the patient has given specific instructions not to share any information with either carers, or, nearest relative. This must be documented in the patient’s records and the consent to share Information must be signed and dated.

The patient’s Responsible Consultant must be informed of any decision to raise the engagement of supportive observation level as soon as possible.

Unplanned leave which has not been agreed by the MDT must not be arranged at the weekend and never with a patient still under level 2, 3 or 4.

7.2 Increasing

In addition to medical team, by a senior nurse, band 6 or above who has knowledge of the patient can INCREASE a patient’s engagement of supportive observation status at any time if a patient appears to present a greater risk than originally identified. This decision by the nurse in charge must be communicated to all staff immediately and recorded in the patient’s notes. The ward doctor and the patient’s Responsible Consultant or the doctor covering, must be informed of any such decision as soon as practically possible.

7.3 Decreasing

A patient’s engagement of supportive observation status can be DECREASED by a senior nurse, band 6 or above who has knowledge of the patient in line with a previously agreed management plan, which is clearly documented and agreed by the patient’s responsible consultant, MDT or resident’s GP. A new risk assessment must be undertaken and documented with clear risk management plans in place. At the time of any decrease the medical team must be notified which would include notifying the Duty Doctor if appropriate medical team not available. In the case of the Nursing home residents the senior nurse must email the residents GP following the decrease.

For any level of engagement of supportive observation if there is significant clinical disagreement, particularly concerning a reduction of the level of observation, this must be left unchanged and reviewed by the MDT or Responsible Consultant. A consensus of agreement must be reached explaining reasons and the outcome of the discussion must be documented in all patient records.
If a risk of falls has been identified, consideration should be given to the use of falls sensor equipment in the event of a reduction in levels of observation.

### 7.4 Review of Engagement of Supportive Observation During Weekends

Ideally the multidisciplinary team (MDT) should always make decisions with regard to the prescription of observation. However, on many occasions (particularly at weekends and evenings), decisions may have to be made by a doctor and the ward nursing team. Such decisions must always be discussed at the first available opportunity with a larger number of the full MDT.

### 7.5 Discontinuation of High Level Engagement or Supportive Observation

Patients must never be removed from any of the engagement of supportive observation levels without discussion and agreement between medical and nursing staff.

Any reduction in engagement of supportive observation level must be a graduated decreasing process taking into account all aspects of risk.

The decision to discontinue engagement of supportive observation levels 2, 3, & 4 must be discussed with the patient’s Responsible Consultant or designated deputy, MDT and resident’s GP in advance and process documented in the agreed management plan.

The decision must be communicated to all members of the clinical team including the patient. Once an agreement is reached, the decision must be recorded and signed in the care records, as soon as possible by the ward doctor and the nurse in charge, and on the discontinuation of engagement of supportive observation section of the Engagement of Supportive Observation Care Plan form (Appendix 1).

### 7.6 Care Planning Supportive Observation

All levels of Observation must be care planned using Appendix 1 - The Engagement of Supportive Observation Care Plan form. The Plan must:

(a) State clearly any additional/specific instructions to be followed by the designated staff member.

(b) Must clearly show the perceived risks which led to the decision, who was involved in the decision and the patients’ opinion of the need for increased observation.

(c) Must have a summary of risk factors relating to engagement of supportive observation plan

(d) Must state the rational for engagement of supportive observation level.

(e) Must identify known risk triggers/changes in behaviour which would increase risk.

(f) Must state what would be the rationale for reducing observation levels e.g. when with visitors or sleeping.

(g) Must have a rationale for cessation of continuous engagement of supportive observation.
(h) There must also be a specific plan for each patient, which outlines the agreed changes in behaviour that would facilitate a reduction in engagement of supportive observation level and the exact procedure for this decision to be actioned.

(i) Must have details of the role of duty medical staff or senior nurses making the decision.

8.0 RECORDING

The outcome of risk assessments and the decision to place a patient on any level of engagement of supportive observation must be clearly recorded in the patient’s notes. The Engagement of Supportive Observation Care Plan form (Appendix 1) must be completed and signed.

The Engagement of Supportive Observation Care Plan form (Appendix 1) must state clearly any additional/specific instructions to be followed by the designated staff member.

Arrangements for engagement of supportive observation while the patient is using the toilet or bathroom must be recorded under “Special Instructions” on Appendix 1 of the Engagement of Supportive Observation Care Plan form. For example, the member of staff observing the patient may stand outside a closed toilet/bathroom door and may make visual checks and verbal prompts if concerned that something untoward may be happening or there may be a decision to remain with the patient at all times. Staff must always be able to access the room immediately if it is felt necessary.

Appendix 2: the competency checklist for inpatient staff.
Appendix 3: the record sheet for levels 2, 3 and 4.
Appendix 4: observation record for all patients on level1/general observation and Zoned observation.

9.0 RISK ASSESSMENT

The risk assessment must be updated whenever there are changes in the level of risk requiring changes in the level of engagement of supportive observation.

The care plan must reflect changes in the level of engagement of supportive observations.

Assessing and managing risk is the shared responsibility of all practitioners who are involved in the care of the patient, and should preferably be conducted through a collaborative process that includes the patient’s own view (Barker and Buchanan-Barker 2005).

Issues of privacy, dignity and consideration of the gender arising in allocating staff and the environmental dangers need to be discussed and incorporated into the care plan.
Staff must have awareness and show consideration of potentially intruding into a patient’s own space.

An in-date risk assessment must be used to inform decisions regarding the appropriate level of observation, and the person undertaking the observations must be familiar with the patients risk assessment and management plan.

The nurse in charge must ensure an identified member of staff is allocated to engage and supportive observe either an individual patient or a group of patients at the start of each shift.

Any searching of a person and belongings will be conducted where possible with consent as well as sensitively with due regard to legal rights as per Trust Policy Searching Patients Property and Secure Services Searching Policy and taking into account gender issues.

Searching of patient’s possessions is in direct breach of the First Protocol, Article 1 of the Human Rights Act 1998. However, in clinical risk management terms it may be deemed necessary to protect the safety of the patient and /or the safety of the general public or staff. This must be proportionate to the patient’s situation and the risk they pose to themselves and /or others.

It may be necessary to remove any tools or instruments that could be used for self-harm or harm to others. It may be necessary to search the patient and their belongings, while having due regard for the patient’s legal rights and conducting the search in a sensitive way. This may include any religious clothing.

In-patient teams caring for those who have been identified with suicidal thoughts and presenting as a significant risk, must thoroughly check AND remove all potential ligatures from the identified patient at risk. This includes belts, ties, shoelaces and bandages (DOH Safety First, 2001).

If consent is not given staff must consult the Responsible Consultant /Senior Nurse Manager/Site Officer/Unit Co-ordinator as per Trust policy MHA 28.

At all levels of observation, following each engagement of supportive observation period there must be a handover to staff, this should include, as far as is appropriate the views of the patient.

Risk Assessments must include consideration of High Risk periods including for newly detained inpatients and those within the first seven days of admission evening and at night, Safety First” (DOH, 2001).

Immediately upon admission, every patient must have a risk assessment as per CPA Policy with a management plan developed taking into account possible periods of increased risk for example:

- evenings and night
- reduced staffing
difficulties in observing patients due to environmental difficulties
- any apparent improvement in a patient’s mood
- actions to be taken in account of these increased risks

The assessment must be completed and appropriate level of observation prescribed on admission and reviewed at least within 72 hours, and as necessary.

Measures must be taken to address blind spots within environments e.g. parabolic mirrors, and any issues identified from environmental audits.

The patient who is considered to be at imminent risk of suicide, or has committed an act of self-harm, is considered at risk of harm to others or deemed vulnerable must be kept on the ward on a specific supportive observation status considered necessary by the team for the first 72 hours or longer.

If the patient is reluctant to remain on the ward, or, insists on leaving the ward, a mental health assessment for possible detention under the Mental Health Act must be made.

Risk assessment includes an interview with the patient and carers, careful study of the patient history, use of ratified risk assessment tools and must take into account the assessments of other professionals as well as the patient, e.g. Social Workers, Psychiatrists, Community Psychiatric Nurses (CPNs), G.P’s, Community Mental Health Team (CMHT) or Family.

Any thoughts, feelings and wishes with regard to suicide, self-harm and harm to others must be approached using direct and respectful questions.

The patient notes, in particular the key events chart are a vital source of information about past behaviour, as are relatives, friends and carers.

Attention to the following factors are considered important: planned intent, severity of planned intent, access to means, preparation, avoidance planning, post-death provisions, recent loss, marked changes in behaviour or medication, paranoid ideas where the patient believes that others pose a threat, withdrawal/disengagement, sudden calmness and denial of recently expressed thoughts/intent and past incidents/incident on Datix. In some instances advance directives/statement may be available.

A previous history of suicidal attempts or of attacks on others suggests that the patient must be observed until a full assessment can be carried out but this must not automatically mean someone is placed upon increased observation.

Any prescribed medications and their effects must be taken into account together with any recent changes. Please refer also to the following policy/guideline:

CPA and Non-CPA Policy
Secure Services Searching Patients Property MHA 28
Training of staff in the skill of engagement and observation is provided as part of an e-learning OLM - Online programme.

<table>
<thead>
<tr>
<th>CORE PRACTICE</th>
<th>UPDATE INTERVAL</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement of Observation</td>
<td>Annually</td>
<td>Inpatient Mental Health / Learning Disability</td>
<td>E-Learning</td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td>Nursing Staff</td>
<td></td>
</tr>
</tbody>
</table>

Senior Clinical Staff are responsible for ward based training and ensuring ongoing competency of staff in engagement and observation. Each ward must ensure staff are informed about current requirements, through ward based induction, preceptorship and supervision. Specific training for engagement of supportive observation and engagement will be provided through e learning, and competency will be checked and deficits addressed through the above processes.

The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Workforce and Business Support Service Board and Health, Safety and Security Committees.

Monthly training tracker reports will be sent to Directors and operational managers by the Information Department identifying which of their staff are up-to-date, when they are approaching update deadlines and those that are out of date. Managers are responsible for ensuring staff take action to undertake training as soon as possible. Team Managers/Ward Sisters are responsible for checking which training has been undertaken by a member of staff through:

- Training Tracker list which is on intranet.
- Reviewing monthly training report.

Staff who are booked onto mandatory / core practice training and are, for whatever reason, unable to attend, MUST inform their relevant director of their reasons.

Staff who do not attend a mandatory or core practice course will receive notification from the Systems Helpdesk informing them of their non-attendance and managers will receive a copy of this. From this information non-attendees will be automatically re-booked onto another course by the Information Department.

If an individual fails to attend on the second occasion, the Service Director will be notified and the conduct procedures will be initiated if appropriate.
11.0 MONITORING AND AUDIT

Observation is a frequent and significant event in in-patient settings. The nurse in charge will routinely monitor implementation and compliance with this clinical guideline.

It is the responsibility of each Ward Sister / Charge Nurse to monitor the implementation of this clinical guideline within each ward and to maintain competency records.

It is the responsibility of each Ward Sister / Charge Nurse to ensure that employees undertaking the engagement of supportive observations of patients complete the agreed records / documentation as set out within this procedure and its Appendices.

A component of management supervision must include the scrutiny of records / documentation relating to the engagement of supportive observation.

A Trust wide audit will be undertaken at the minimum of every three years. Service Directors/Leads will nominate clinical leads to undertake the compliance audit, with the support of the clinical audit department. The audit will include as a minimum;

- Roles and responsibilities
- Process for observations of different levels
- Record keeping

The Engagement of Supportive Observation Care Plan form (Appendix 1) can be used when auditing of the frequency, level and duration of increased levels of observation as well as the clinical reason[s] behind the choice.

The Engagement of Supportive Observation Care Plan form (Appendix 1) must state clearly any additional/specific instructions to be followed by the designated staff member.

- Must clearly show the perceived risks which led to the decision, who was involved in the decision and the patients’ opinion of the need for increased observation. This audit trail is key information both in monitoring of frequency of the usage of raised levels of observation and in Critical Incident Reviews.

- Summary of risk factors relating to engagement of supportive observation plan

- Rational for engagement of supportive observation level.

- Known risk triggers/changes in behaviour which would increase risk

- What would be the rationale for reducing observation levels e.g. when with visitors or sleeping.
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- Rationale for cessation of continuous engagement of supportive observation.

- There must also be a specific plan for each patient, which outlines the agreed changes in behaviour that would facilitate a reduction in engagement of supportive observation level and the exact procedure for this decision to be actioned.

- Details of the role of duty medical staff or senior nurses making the decision.

The following will also be audited:

- Clinicians understanding of the policy and procedure and different observation levels.

- Have staff been assessed against observation core competencies (Competency is checked with staff using Appendix 2).

- Clinicians’ awareness of their responsibilities and accountability.

- Where applicable has the relevant paperwork been completed in line with this policy and procedure.

The findings of such audits will be reported to the relevant Director and discussed at relevant local quality/governance groups and committees.

The outcome of audits will be used to inform any review and / or changes to this policy and procedure and the Trust’s programme of training.

The monitoring of training compliance will be undertaken by Workforce, Development and Training as outlined in this procedure.

12.0 A QUICK REFERENCE GUIDE TO THERAPEUTIC OBSERVATION

<table>
<thead>
<tr>
<th>Level 1 (General SUPPORTIVE Observation)</th>
<th>Level 2 (Defined SUPPORTIVE Observation)</th>
<th>Level 3 (Within Eyesight)</th>
<th>Level 4 (Within arms- length)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is it?</td>
<td>Defined random checks of the patient. at least <strong>four</strong> times during each hour at <strong>irregular</strong> intervals.</td>
<td>Continuous engagement of SUPPORTIVE observation of the patient keeping them within eyesight.</td>
<td>Continuous engagement of SUPPORTIVE observation of patients keeping them within arms-length.</td>
</tr>
<tr>
<td>Awareness of whereabouts of patients at all times. Hourly checks (minimum).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31 of 35
<table>
<thead>
<tr>
<th>When should it be used?</th>
<th>For patients assessed as being potentially at risk of absconding and/or disturbed or violent behaviour, or requiring regular monitoring due to physical condition and/or effects of medication. Can be used as step down from a level 3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all inpatients unless a higher level of engagement of SUPPORTIVE observation is indicated.</td>
<td>For patients assessed as being at a high risk of harming themselves or others or where constant monitoring of the patient’s physical condition and/or effects of medication/treatment is required. May be used for managing absconding issues when all other management strategies have proved ineffective.</td>
</tr>
<tr>
<td></td>
<td>For patients assessed as being at the highest risk of harming themselves and/or others.</td>
</tr>
<tr>
<td>Who decides?</td>
<td>Engagement of SUPPORTIVE observation level may be increased or decreased at any time by the nurse in charge, following consultation with the MDT. The Responsible Clinician’s opinion must have been previously sought and recorded indicating potential reasons for changes in observation level.</td>
</tr>
<tr>
<td>Nurse In Charge or Medical Team</td>
<td>Engagement of SUPPORTIVE observation level may be increased or decreased at any time by the nurse in charge following consultation with the MDT. The Responsible Clinician’s opinion must have been previously sought and recorded indicating potential reasons for changes in observation level.</td>
</tr>
<tr>
<td></td>
<td>SUPPORTIVE observation level may be decreased at any time by the nurse in charge following consultation with the MDT. The Responsible Clinician’s opinion must have been previously sought and recorded indicating potential reasons for changes in observation level.</td>
</tr>
<tr>
<td>Who can carry out SUPPORTIVE observation?</td>
<td>Experienced member of staff (registered/unregistered).</td>
</tr>
<tr>
<td>Experienced member of staff (registered/unregistered).</td>
<td>Experienced member of clinical staff or student nurses in final year of training under.</td>
</tr>
<tr>
<td>Experienced member of clinical staff or student nurses in final year of training.</td>
<td>Experienced member of clinical staff or student nurses in final year of training.</td>
</tr>
<tr>
<td>Experienced registered clinician.</td>
<td>When delegated to unregistered.</td>
</tr>
<tr>
<td>How often should SUPPORTIVE observation levels be reviewed and by whom?</td>
<td>MDT Mandatory review every 24 hours</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Review at regular intervals – daily.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special considerations</th>
<th>Minimum number of checks, i.e. 4 an hour (maximum of 6). The observation level/frequency of checks can be increased/decreased dependent on assessed level of risk. Careful consideration of identified and potential risks should be given prior to granting leave.</th>
<th>Leave from the unit should only be granted in exceptional circumstances whilst on this level engagement of SUPPORTIVE observations</th>
<th>Leave from the unit should only be granted in exceptional circumstances. Engagement of SUPPORTIVE Observation record sheet must be completed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>½ hour SUPPORTIVE observations when patients are physically unwell. Where a unit decides to SUPPORTIVELY record using a checklist etc. this must explicitly state the time the patient was seen/checked and their whereabouts on the unit. Also who carried out the engagement of SUPPORTIVE observation on the patient.</td>
<td>Engagement of SUPPORTIVE Observation record sheet must be completed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Seclusion and Long Term Segregation Policy and Procedure

Clinical Risk Assessment, Management and Safety Policy and Procedure

Care Programme Approach (CPA) & Non-CPA (Standard Care) Policy

Prevention and Management of Violence and Aggression at Work Policy, Procedure and Guidelines

A Joint Policy Relating to Section 136 Mental Health Act 1983 as amended by the Mental Health Act 2007

Incident Reporting Policy and Procedure

Searching Patient’s/Visitor’s Property Policy/Procedure

Unified Health and Social Care Written Record Policy

Management of Patients Who Self Harm Policy and Patient Safety Environmental Standards

In-Patient Leave Procedure and Policy

Privacy and Dignity – Safeguarding Good Practice

Guidance and Protocol on the Management of Staffing Levels

Training need analysis

Trust Auditable standards and monitoring arrangements

REFERENCES


Dennis, S. SUPPORTIVE Observation in acute in-patient setting: Mental Health Care vol.21, Sept.1998

Department of Health Safety First ‘February 2001


Seclusion & Long Term Segregation Policy - CLP41.


NICE guidelines [NG10] Published date: May 2015


Standing Nursing and Midwifery Advisory Committee (SNMAC) Practice Guidance: Safe and Supportive Observation of Patients at Risk, June 1999

The Scottish Office Home and Health Department clinical research advisory group (CRAG) CRAG/SCOTMEG. Nursing observation of acutely ill psychiatric patients in hospital. Edinburgh: HMSO, 1995

Observation and Engagement Policy: Anne Leithch, Southern Health NHS, April 2015


Metal Health Act 1983 as amended by the Mental Health Act 2007 and Revised Code of Practice

PRECEPTORSHIP CLINICAL GUIDELINE

POLICY REFERENCE NUMBER: CG9
VERSION NUMBER: 1
REPLACES SEPT DOCUMENT Preceptorship Clinical Guideline
REPLACES NEP DOCUMENT
KEY CHANGES FROM PREVIOUS VERSION Adoption of new Preceptorship pathway flowchart. Integration of NEP and SEPT Clinical Guidelines
AUTHOR: Corporate Learning Manager EPUT work stream merger group
CONSULTATION GROUPS:
IMPLEMENTATION DATE: October 2017
AMENDMENT DATE(S): N/A
LAST REVIEW DATE: N/A
NEXT REVIEW DATE: October 2020
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB COMMITTEE: 19th October 2017
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POLICY SUMMARY

This Clinical Guideline and workbooks (Appendix 1) set the standards for preceptorship within EPUT, ensuring that professionals working within EPUT deliver the very highest standards of treatment and care.

The Trust monitors the implementation of and compliance with this policy in the following ways:

<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust wide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essex MH&amp;LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Director responsible for monitoring and reviewing this Clinical Guideline is Andy Brogan - Executive Director of Mental Health and Deputy Chief Executive
1.0 INTRODUCTION

2.0 DUTIES

3.0 DEFINITIONS

4.0 PRINCIPLES

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

APPENDICES

APPENDIX 1: Workbook (Generic / Nursing)
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PRECEPTORSHIP CLINICAL GUIDELINES

This Clinical Guideline and workbooks (Appendix 1) set the standards for preceptorship within EPUT, ensuring that professionals working within EPUT deliver the very highest standards of treatment and care.

The Trust will ensure that each newly registered or re-registered practitioner, including practitioners returning to practice, complete a 6-12 month period of preceptorship with the guidance and support of a dedicated preceptor.

The anticipated benefits of a robust multi professional preceptorship policy are that it will ensure that staff feel valued and are competent and confident in their work. It will aim to ensure parity across professions within the Trust.

1.0 INTRODUCTION

1.1 The fundamental aim of preceptorship is to enable a smooth transition for newly registered practitioners and those returning to practice. The following of a structured pathway will help support practitioners to become competent and accountable in their professional practice.

1.2 The preceptorship period is viewed as the starting point for the staff development process defining the knowledge, skills and competencies required for them to become effective competent practitioners.

1.3 This Clinical Guideline includes a workbook (Appendix 1) for use by the Preceptor and Preceptee throughout the period of preceptorship. Its purpose is to provide a clear understanding of roles and supports the implementation of preceptorship.

2.0 DUTIES

2.1 The Chief Executive is responsible for:

- Ensuring that the principles of this Clinical Guideline and other associated documentation is implemented across the organisation;
- Ensuring the necessary financial resources.
2.2 The Executive Director of Clinical Governance & Quality and Executive Nurse will ensure:

- That these Clinical Guidelines are embedded within clinical practice.
- That this Clinical Guideline is reviewed and updated regularly, in accordance with recommended best practice and national guidance.
- That the implementation of this Clinical Guideline is monitored through quality assurance activities.

2.3 Directors and Associate/Deputy Directors/Senior Managers will ensure:

- That the principles contained within this Clinical Guideline are implemented.
- That all staff, including new employees, whether temporary or permanent, are made aware of the principles detailed within this guideline and that the related procedural guideline is implemented.
- That action learning sets are considered within the locality for newly qualified practitioners to aid in the preceptorship process.

2.4 Workforce Development and Training Service will ensure:

- The provision of training and education to meet identified needs.
- A central register of all newly qualified clinical staff (Preceptee’s) will be maintained by the Workforce Development and Training Service.
- A central register of Preceptors will be maintained by the Workforce Development and Training Service (WDTS).
- WDTS will ensure that staff have the opportunity to complete training around the Enhanced Practice Support Framework and other training so that they will have the knowledge to become mentors/coaches of the future workforce.
- Letters to be sent out to each new member of staff setting out the Trust’s requirements.

2.5 Human Resource Department will ensure:

- That Workforce Development & Training Service (WDTS) is notified when there are newly qualified staff recruited within the Trust so that they may be added to the central register. This will be provided on a monthly basis to the Workforce Development and Training Service.
2.6 The Unit Manager / Team Lead will ensure that:

- A suitably experienced registered practitioner is allocated as a named Preceptor for each Preceptee from day one of employment.
- Inform the new member of staff of the name of the allocated Preceptor and inform the WDTS.
- They meet with the Preceptor and Preceptee at the beginning of the preceptorship programme and again after six months to agree / review the Preceptee’s personal development plan and ensure that all the review meetings are being conducted as per pathway.
- They maintain overall responsibility for the preceptorship process.
- The Preceptee/ Preceptor have time allocated to be able to complete all the preceptorship requirements.
- They undertake a preceptorship outcome review upon the completion of the preceptorship period and audit the progression of development plans.
- The Team Lead will help facilitate the Preceptee undertaking rotations between departments during the preceptorship period in order to gain additional competencies. If the Preceptee has not been given the opportunity to rotate or spend time in other departments as required, a rationale must be given as to why in the Preceptee’s workbook.

- The Team lead must ensure that the Preceptee is not left with sole responsibility of being in charge of the environment or caseload until the manager is confident that they have the competencies to undertake this level of responsibility and they have completed the sections in the workbook covering the areas of
  1. Medication management
  2. Delivering safe care
  3. Risk assessments

- The Team lead will liaise with the Preceptor and Preceptee when the above has been achieved.

2.7 The Preceptor will ensure that:

- They will provide an overview of the preceptorship process and identify the Preceptee’s learning and development needs in the context of the individual’s professional responsibilities and the needs of the employer (Department of Health, 2010).
- They assist the Preceptee to achieve the competencies as required by their individual service, and will help the Preceptee develop their role supporting the transition from student to registered practitioner. The preceptor will monitor the Preceptee’s progress in line with this policy and the Preceptorship Pathway.
Use a variety of learning and assessment methods to enable the Preceptee to demonstrate their knowledge, skills and competencies and provide guidance as is required.

Preceptor will ensure that accurate records of the Preceptee’s progress are maintained and ensure that the service appropriate preceptorship workbook is completed with the Preceptee.

The Preceptor will help the Preceptee identify any learning objectives to use when rotating to other departments and liaise with the Team Manager regarding the additional placements required in order to enhance the Preceptee’s experience.

The Preceptor will ensure that the Team lead is informed of the Preceptee’s progress.

2.8 The Preceptee will ensure that they:

- Attend Trust induction.
- Complete relevant mandatory training programmes.
- Work collaboratively with his/her Preceptor following the Preceptorship Pathway (See Figure1) and complete the appropriate workbook for their service in order to achieve their competencies.
- Meet with their Preceptor on a minimum of a 2 weekly basis and have formal reviews as per Preceptorship Pathway.
- Take responsibility for his/her own learning to include the use of a range of learning resources and methods in meeting his/her own learning development.
- Take the opportunity to work regularly with the Preceptor.
- Undertake rotation opportunities within the Trust as identified by their Preceptor or Team Lead.
- During the period of preceptorship the Preceptee will be required to undertake learning around:
  1. The support of learners (Bands 1-4) undertaking the care certificate.
  2. The coaching model to support all pre-registration students undertaking a health care qualification.
  3. Attend the Trust run workshops on Leadership and Resilience building.
  4. Attend a suicide prevention programme
  5. Undertake training in medicines management specific to their field of work.
3.0 DEFINITIONS

3.1 **Preceptorship** is defined as: ‘a period of structured transition for the newly registered practitioner during which she/he will be supported by a preceptor to develop their confidence as an autonomous professional, refine skills, values and behaviours, and to continue on their journey of lifelong learning’ (Department of Health, 2010)(DH)

3.2 The **newly registered practitioner** is ‘a nurse, midwife or Allied Health Professional who is entering employment for the first time following professional registration with the NMC or HCPC. While engaged in preceptorship, a newly registered health professional is referred to as a preceptee’ (DH, 2010)

3.3 A **Preceptor** is ‘a registered practitioner who has been given a formal responsibility to support a newly registered practitioner (or Preceptee) through preceptorship’ (DH, 2010). The preceptor will have a minimum of twelve months post registration experience and be able to demonstrate the competencies and attributes required of the role within the clinical area (DH, 2010). The preceptor will also have undertaken the relevant training as indicated by the Trust undertake the role of preceptor.

3.4 Preceptorship is **NOT**:

- a replacement for mandatory training programmes;
- a substitute for performance management processes;
- a period during which another registered practitioner takes responsibility and accountability for the Preceptee’s responsibilities and actions, formal coaching (though coaching skills may be used),
- mentorship, statutory or clinical supervision, or a replacement to induction processes,
- a distance or e-learning package (DH, 2010)

4.0 PRINCIPLES

4.1 It is recommended that a variety of learning methods are integrated within preceptorship so that the programme can be personalised to meet the needs of the Preceptee in building their confidence as a practising professional (for example: self-directed learning, clinical practice focus days, reflective practice, shadowing, individual support, portfolio building, e-learning and role-modelling).

4.2 Upon completion of the Preceptorship period, the practitioner’s competency to practice will be reviewed by the Preceptor and Line Manager prior to the appraisal.
4.3 The Preceptee and Preceptor will follow the format as set out in the Preceptorship Pathway (Figure 1) and the additional workbooks as agreed by the professional leads for all services.

4.4 In the event of concerns regarding competence to practice the Preceptor will:

- Identify and explain where the Preceptee has not met the required level of achievement and escalate to line manager.
- Develop a further personal learning and development plan with the practitioner to ensure that she/he is given the opportunity to develop and demonstrate competency
- Provide opportunities for accessing any additional training and support that may be required
- Line manager to set review date with Preceptor and Preceptee

4.5 The implementation of Preceptorship must be based upon the Code of Professional Practice relevant to each service

4.6 The Preceptorship programme will also be linked into the probation review process

4.7 During the period of preceptorship the Preceptee will be required to undertake

- The support of learners (Bands 1-4) undertaking the care certificate or Apprenticeship programmes
- Participation in the coaching model to support all pre-registration students undertaking a health care qualification
- Attend the Trust run workshops on Leadership and Resilience building
Outline of Preceptorship Pathway

Figure 1

Newly Qualified Appointed

Preceptorship explained through induction process with future review dates agreed. Preceptor and learning outcomes identified, documented and agreed to comply with timeframe

Preceptorship sessions are to be mapped to take place a minimum of two weekly intervals, rotation opportunities to be identified and allocated

Preceptor formal review at months 1 and 3 incorporating feedback from colleagues, carers and patients and action plan (if required)

Preceptor formal review at 6 months incorporating feedback (as above). Review of agreed learning objectives in line with any action plan that is in place. Review by Team Lead if appropriate.

Preceptorship outcome review completion of workbook at 6-12 months incorporating:
  • Reviewing achievements /competencies
  • Review of learning needs
  • Review of learning contract
  • Completion of workbook and evaluation of preceptorship/CPD activities. Preceptor will have observed and assessed colleagues in their completion of the Care Certificate

Preceptor and Line Manager review all documentation and review all feedback prior to appraisal, agree future CPD activity and review learning activities undertaken such as:
  • Enhanced Practice Support Framework/Coaching Model
  • Leadership Development
  • Support of care Certificate
  • Attendance of suicide prevention programme
5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 This Clinical Guideline will be monitored by undertaking a sample audit of newly qualified nursing and AHP employees and will be coordinated by the Clinical Governance and Quality directorate. Operational monitoring will be through supervision and appraisal.

5.2 The findings of quality monitoring and any associated audit activities will be reported to the Executive Director of Clinical Governance and Quality and presented at the EPUT Clinical Governance forums.

5.3 The Executive Nurse will ensure that this clinical guideline is reviewed as appropriate.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION


7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

7.1 The following policies and procedural guidelines must be read in conjunction with this policy:

- Supervision and Appraisal Policy
- Induction / Mandatory Training Policy
- Disciplinary Procedure
- Capability Procedure

END
Preceptorship Workbook

This workbook is generic, and parts can be used for all services. Additional service specific workbooks may also be completed.

Your Name:

Your Signature:

Your Preceptor's Name:

Your Preceptor's Signature:

Team Manager Name:

Start Date of Preceptorship:

Agreed Frequency of Preceptorship Sessions:

Clinical Area:

Completion Date of Preceptorship:
Purpose and Use of Workbook

The preceptorship workbook is provided as a toolkit to support both the preceptee and preceptor throughout the period of preceptorship and should be followed alongside the Preceptorship Clinical Guidelines (CG9)

This workbook is intended to be used as a record and template for agreeing a personalised preceptorship programme in accordance with the agreed learning and development needs of the preceptee.

A Preceptorship Profile is provided as a developmental tool for use by the preceptee in recording evidence of the achievement of core competences.

The Preceptorship Profile should be adapted for use by the preceptee within their practice setting and should not be considered as an all-inclusive list of required competences.

The aim of Preceptorship is to support you through the transition from student nurse to registered practitioner, and this will be the first stage of your Continuing Professional Development Programme. It is underpinned by the Trust Values of:

- Open
- Compassionate
- Empowering

The Preceptorship Programme requires evidence of your continued development of the clinical and professional competencies deemed core to your new role. In order for you to achieve the competency statements within the Preceptorship Programme, you must demonstrate to an assessor that you possess the:-

1. Knowledge, which underpins clinical practice. This is required for all the competency statements. The emphasis is upon achieving clinical competence based upon a sound knowledge base. Practitioners must be able to accurately state rationale for their interventions and discuss reasonable alternatives. Reference to current Trust Policy, literature and validated research is to be encouraged and commended.

2. Ability, which enables you to perform clinical skills safely, and with due regard for the physical and psychological wellbeing of the service user, which includes the ongoing management of risk. Effective team working is also an essential component of a safe and effective practitioner.
3. Confidence and competence to practice as a professional with minimal or no supervision in the future, which engenders public confidence. **In addition, your preceptor must ensure that:**

4. You have the insight and experience to know the limitations of your competency and be able to recognise when a situation requires referral to a more experienced colleague.

5. The care and safety of service users, the public or colleagues are never to be compromised by any action or omission on your part.

6. Your preceptor/manager must where operationally possible ensure that you have the opportunity to rotate into other areas such as acute, community or mental health that have synergy with the team that you are within to enhance your skills and awareness of the patient pathway.

7. In order to support you through this you are expected to meet with your preceptor in a timely and structured basis throughout the preceptorship period.
Outline of Preceptorship Pathway

Newly Qualified Appointed

Preceptorship explained through induction process with future review dates agreed.
Preceptor and learning outcomes identified, documented and agreed to comply with timeframe

Preceptorship sessions are to be mapped to take place a minimum of two weekly intervals, rotation opportunities to be identified and allocated

Preceptor formal review at months 1 and 3 incorporating feedback from colleagues, carers and patients and action plan (if required)

Preceptor formal review at 6 months incorporating feedback (as above). Review of agreed learning objectives in line with any action plan that is in place. Review by Team Lead if appropriate.

Preceptorship outcome review completion of workbook at 6-12 months incorporating:
- Review of achievements /competencies
- Review of learning needs
- Review of learning contract
- Completion of workbook and evaluation of preceptorship/CPD activities Preceptee will have observed and assessed colleagues in their completion of the Care Certificate

Preceptor and Line Manager review all documentation and review all feedback prior to appraisal, agree future CPD activity and review learning activities undertaken such as:
- Enhanced Practice Support Framework/Coaching Model
- Leadership Development
- Support of care Certificate
- Attendance at suicide prevention programme
What happens if you do not progress as planned?

It is important to note that both the Preceptor and the Preceptee must aim to maintain an open and constructive dialogue at all times. If you feel unhappy with your progress or with the support you are able to access, you should discuss this initially with your Preceptor or with the Team Manager.

Action plans set out within this document are corrective to support your development and learning whilst in your Preceptorship Period.

Your Preceptor will review these with you and discuss with you and the Team Manager any additional support that is required.

Record of Signatures

Assessment of competencies may be undertaken by other qualified staff other than the Preceptor. All assessors must complete the signature record below

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Initials</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
Competencies for Preceptorship

The preceptorship competencies in this workbook are provided as a developmental tool for the use of the Preceptee in agreeing and recording evidence of the achievement of core competences.

The preceptorship workbook can be adapted for use by the Preceptee, as it is not intended as an all-inclusive listing of the required competences and you may identify more competencies relevant to your own learning needs and clinical area.

This preceptorship workbook is clearly linked to the Trust values.

As part of your induction and initial preceptorship you are required to self-assess your current level of competency using the Competency Domains below and a RAG (Red Amber, Green) rating system which the Preceptee will need to complete. These are the competencies you will be working on throughout your preceptorship.

Although the workbook is for generic use, non-nursing professionals may use service specific Preceptorship Workbooks.

### Competency Domains

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>1</td>
<td>Accountability</td>
</tr>
<tr>
<td>2</td>
<td>Career development</td>
</tr>
<tr>
<td>3</td>
<td>Communication</td>
</tr>
<tr>
<td>4</td>
<td>Dealing with conflict/managing difficult conversations</td>
</tr>
<tr>
<td>5</td>
<td>Delivering safe care</td>
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<tr>
<td>6</td>
<td>Emotional intelligence</td>
</tr>
<tr>
<td>7</td>
<td>Leadership</td>
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<tr>
<td>8</td>
<td>Quality improvement</td>
</tr>
<tr>
<td>9</td>
<td>Resilience</td>
</tr>
<tr>
<td>10</td>
<td>Reflection</td>
</tr>
<tr>
<td>11</td>
<td>Safe staffing / raising concerns</td>
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<tr>
<td>12</td>
<td>Team working</td>
</tr>
<tr>
<td>13</td>
<td>Medicines management</td>
</tr>
<tr>
<td>14</td>
<td>Inter-professional learning</td>
</tr>
</tbody>
</table>

These competencies will not relate to all professional roles so where competencies are not applicable please mark the section as N/A in the achieved section.

The aim of this learning contract is to ensure the provision of a meaningful experience of preceptorship, focusing upon meeting the preceptee’s identified learning and development needs and leading to evidence of the achievement of required practice competences. Each competency learning plan should be reviewed at each review meeting to ensure that domain has the required evidence to meet with competency and assessment standards.
## Self-Assessment

<table>
<thead>
<tr>
<th>RAG Rating</th>
<th>Theoretical understanding, but :-</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No knowledge or theory, or</td>
<td></td>
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<tr>
<td>- No practical experience, or</td>
<td></td>
</tr>
<tr>
<td>- Need supervision and direction</td>
<td></td>
</tr>
<tr>
<td>- Little/no practical application,</td>
<td></td>
</tr>
<tr>
<td>- Feels unsure and wants continued supervision / encouragement</td>
<td></td>
</tr>
<tr>
<td>- Limited theoretical understanding, with some practical application,</td>
<td></td>
</tr>
<tr>
<td>- Feels unsure/ needs continued supervision/ encouragement</td>
<td></td>
</tr>
<tr>
<td>- Theoretical understanding</td>
<td></td>
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<tr>
<td>- Demonstrating some skills in application</td>
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<tr>
<td>- Feeling more confident, although support &amp; encouragement is welcomed.</td>
<td></td>
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<tr>
<td>- Connects theory to practice.</td>
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<tr>
<td>- Has gained sufficient experience to develop necessary skills &amp;</td>
<td></td>
</tr>
<tr>
<td>- Feeling confident and competent in this area.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Detail of Competence</th>
<th>Current RAG Rating</th>
<th>Comment</th>
<th>Initials and Signature of Preceptor</th>
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<tr>
<td>01/01/16</td>
<td>Medicines Management</td>
<td>Red</td>
<td>Did not demonstrate knowledge of calculations</td>
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<td>AM</td>
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<tr>
<td>Team / Work Area</td>
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<tr>
<td>Name of Preceptee</td>
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<tr>
<td>Name of Preceptor</td>
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<td></td>
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</tr>
<tr>
<td>Planned future meeting Dates</td>
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<tr>
<td>Learning and Development Needs Identified from Initial RAG rating</td>
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<tr>
<td>Development Plan for onward achievement of competencies</td>
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<tr>
<td>Target Dates</td>
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<tr>
<td>Feedback from Preceptor to Preceptee</td>
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<tr>
<td>Feedback to Preceptor from Preceptee</td>
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</tbody>
</table>

| Signature of Preceptee |  |
| Signature of Preceptor |  |
| Date |  |
Review of Initial Induction Action Plan at End of Month one

Name of Preceptee

Name of Preceptor

Planned future meeting Dates

Review against Identified Learning and Development Needs & progress regarding competency framework

Achievements to date / Progress made

Target Dates

Feedback from Preceptor to Preceptee

Feedback to Preceptor from Preceptee

Initials and signature of Preceptee

Initials and signature of Preceptor

Date
<table>
<thead>
<tr>
<th>Name of Preceptee</th>
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</thead>
<tbody>
<tr>
<td>Name of Preceptor</td>
<td></td>
</tr>
<tr>
<td>Planned future meeting Dates</td>
<td></td>
</tr>
<tr>
<td>Review against Identified Learning and Development Needs &amp; progress regarding competency framework (including feedback from colleagues)</td>
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<tr>
<td>Target Date</td>
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<tr>
<td>Feedback from Preceptor to Preceptee</td>
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<tr>
<td>Feedback to Preceptor from Preceptee</td>
<td></td>
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<tr>
<td>Initials and signature of Preceptee</td>
<td></td>
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<tr>
<td>Initials and signature of Preceptor</td>
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<tr>
<td>Date</td>
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<tr>
<td>Name of Preceptee</td>
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<tr>
<td>Name of Preceptor</td>
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</tbody>
</table>

**Review against Identified Learning and Development**

**Goals / Objectives achieved**

<table>
<thead>
<tr>
<th>Initials and signature of Preceptee</th>
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</thead>
<tbody>
<tr>
<td>Initials and signature of Preceptor</td>
<td></td>
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<tr>
<td>Date</td>
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</tbody>
</table>
### Six Month Review

<table>
<thead>
<tr>
<th>Name of Preceptee</th>
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<tbody>
<tr>
<td>Name of Preceptor</td>
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</table>

<table>
<thead>
<tr>
<th>Planned future meeting Dates</th>
<th></th>
</tr>
</thead>
</table>

Review against Identified Learning and Development Needs & progress regarding competency framework (including feedback from colleagues)

**Target Date**

Feedback from Preceptor to Preceptee

Feedback from Preceptee to Preceptor

<table>
<thead>
<tr>
<th>Initials and signature of Preceptee</th>
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</thead>
<tbody>
<tr>
<td>Initials and signature of Preceptor</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
Six Month Action Plan

Name of Preceptee

Name of Preceptor

Review against Identified Learning and Development Needs

Goals / Objectives achieved

Initials and signature of Preceptee

Initials and signature of Preceptor

Date
Final Review of Preceptorship 6-12 months  (Linked to Appraisal)

<table>
<thead>
<tr>
<th>Name of Preceptee</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name of Preceptor</td>
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</tbody>
</table>

Evidence of Achievements / Review of all Competences (including feedback from colleagues)

Preceptorship Outcome Review

- Review of achievements /competencies
- Review of learning needs
- Review of learning contract
- Completion of workbook and evaluation of preceptorship/ CPD activities
- Preceptee will have observed and assessed colleagues in their completion of the Care Certificate

Identified continued professional learning needs post Preceptorship
Feedback from Preceptor to Preceptee

Feedback to Preceptee from Preceptor

Preceptee’s Summary of Achievement during Preceptorship

Preceptor’s Evaluation of Preceptorship
Team Manager’s Feedback (including feedback from colleagues)

<table>
<thead>
<tr>
<th>Outcomes of Preceptorship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Duration of Preceptorship in months</td>
</tr>
<tr>
<td>2. Unplanned absences</td>
</tr>
<tr>
<td>3. Number of actual or near miss incidents involving Preceptee</td>
</tr>
<tr>
<td>4. Mandatory Training completion</td>
</tr>
</tbody>
</table>

**Additional Comments**

<table>
<thead>
<tr>
<th>Signature of Preceptee</th>
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</thead>
<tbody>
<tr>
<td>Signature of Preceptor</td>
</tr>
<tr>
<td>Signature of Team Manager</td>
</tr>
<tr>
<td>Date of Completion</td>
</tr>
</tbody>
</table>

A copy of the learning contract should be placed in the preceptee’s personal file
Please complete the following competencies as are relevant to your service over the course of the preceptorship

**Competency 1: Accountability**

<table>
<thead>
<tr>
<th>Objective 1: Demonstrate knowledge of, and ability to exercise, professional accountability and responsibility</th>
<th>Evidence / Development plan</th>
<th>Achieved Yes/No</th>
<th>Initials of preceptee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of relevant professional code of conduct</td>
<td></td>
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<tr>
<td>Demonstrate respect and dignity for service users, carers and colleagues</td>
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<tr>
<td>Identifies area(s) of care which may be outside of their sphere of practice</td>
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<tr>
<td>Able to discuss limitations in knowledge and experience</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 2: Demonstrate an understanding of legal, ethical and organisational aspects of health care</th>
<th>Evidence / Development plan</th>
<th>Achieved Yes/No</th>
<th>Initials of preceptee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies organisational objectives</td>
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<tr>
<td>Examines the aims of the role, e.g. health promotion</td>
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<tr>
<td>Understands job description and role within the team</td>
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<tr>
<td>Able to identify the roles and responsibilities of other disciplines</td>
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<tr>
<td>Able to discuss complementary and conflicting roles</td>
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<tr>
<td>Able to obtain consent prior to providing treatment and care</td>
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<tr>
<td>Works to protect confidential information</td>
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<tr>
<td>Works in the best interests of the individual</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3: Maintains Competence and Professional Development</th>
<th>Evidence / Development plan</th>
<th>Achieved Yes/No</th>
<th>Initials of preceptee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies learning needs</td>
<td></td>
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<tr>
<td>Objective 4: Demonstrates an ability to effectively share information</td>
<td>Evidence / Development plan</td>
<td>Achieved Yes/No</td>
<td>Initials of preceptor</td>
<td>Date</td>
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<tr>
<td>Able to provide clear and meaningful verbal reports e.g. within team/shift handovers</td>
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<tr>
<td>Able to prepare specific and concise written reports</td>
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<tr>
<td>Able to report incidents, accidents and near misses</td>
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<tr>
<td>Recognises Information Governance</td>
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</tbody>
</table>
Evidence of Achievement of Competency 1. Understanding Accountability during Preceptorship period

(At least one piece of evidence for each review period)

Preceptor__________________________
Date______________________________

Preceptee__________________________
Date______________________________
## Competency 2: Career Development

<table>
<thead>
<tr>
<th><strong>Objective:</strong> 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To revisit professionalism, professional conduct and behaviour</strong></td>
<td>Demonstrate the importance of professional accountability to the professional body, employer, colleagues, service users and self</td>
<td></td>
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<tr>
<td></td>
<td>Discuss your awareness of your limitations and develop skills based on professional judgement and evidence for best practice</td>
<td></td>
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</tr>
<tr>
<td><strong>Objective:</strong> 2</td>
<td>Evidence / Development plan</td>
<td>Date Achieved</td>
<td>Initials of Assessor</td>
<td>Initials of preceptee</td>
</tr>
<tr>
<td><strong>To begin to think about own professional career development</strong></td>
<td>Engage fully with the Appraisal process – define goals and a Personal Development Plan</td>
<td></td>
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<tr>
<td></td>
<td>Demonstrate full understanding of the Care Certificate and the implications to other roles</td>
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<tr>
<td></td>
<td>To have assessed three colleagues in their completion of the care certificate.</td>
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</tbody>
</table>
Evidence of Achievement of Competency 2: Career Development during Preceptorship period
(at least one piece of evidence for each review period)

Preceptor____________________________
Date_________________________________
Preceptee___________________________
Date_________________________________
### Competency 3: Communication

<table>
<thead>
<tr>
<th>Objective 1: Demonstrates the ability to communicate effectively with a range of service users, carers, colleague and other professionals</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes and maintains good relationships with other</td>
<td></td>
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<tr>
<td>Articulates nursing opinion and perspectives effectively to multi-disciplinary team</td>
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<tr>
<td>Demonstrates ability to communicate effectively in challenging circumstances.</td>
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<tr>
<td>Provides accurate feedback to team from multi-disciplinary reviews/meetings</td>
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<tr>
<td>Acts as an advocate for service users</td>
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<tr>
<td>Can described and utilise strategies to manage conflict at work</td>
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<tr>
<td>Adapts communication strategies to meet cultural differences.</td>
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<tr>
<td>Identifies alternative methods of communication to meet sensory or cognitive impairment</td>
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<tr>
<td>Demonstrates good communication with carers in order to enhance the recovery process</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 2: To understand the importance of keeping concise documentation in line with Trust policy and registration body guideline</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands access to records/sharing information</td>
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<tr>
<td>Access IT network including email, intranet and electronic service user records</td>
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<tr>
<td>Task</td>
<td>Notes</td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>Records events notes, care plans, reviews and risk assessment on the appropriate electronic database as used with the unit/team</td>
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<tr>
<td>Demonstrates an understanding of the NMC standards for record-keeping</td>
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<tr>
<td>Ensure all record keeping is based on current Trust guidelines</td>
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<tr>
<td>Can describe what is meant by confidentiality and the limitations of confidentiality</td>
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<tr>
<td>Demonstrates ability to develop care plans in collaboration with service users based on risk and needs assessment</td>
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</tbody>
</table>
Evidence of Achievement of Competency 3: Communication during Preceptorship period
(at least one piece of evidence for each review period)

Preceptor____________________________________
Date________________________________________
Preceptee___________________________________
Date________________________________________
## Competency 4: Dealing With Conflict/Managing Difficult Conversations

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of Preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates a knowledge of own and others behaviour and factors that may contribute to conflict</td>
<td>Acts as a positive and effective role model</td>
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<tr>
<td></td>
<td>Identify elements of good team dynamics</td>
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<tr>
<td></td>
<td>Recognises and deal with stress in self and others</td>
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<tr>
<td></td>
<td>Maintains professional composure in emotional situations</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 2</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of Preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop an awareness of the need to have difficult conversations and be able to demonstrate these while maintain/recognising the potential effect on relationships</td>
<td>Demonstrates an ability to identify factors that may result in conflict</td>
<td></td>
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<tr>
<td></td>
<td>Able to utilise both negotiation and conflict resolution skills</td>
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<td></td>
<td>Able to take part in team discussions, expressing self and having an understanding of others points of view</td>
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<tr>
<td></td>
<td>Discuss preferred behaviour style and how it might impact on others</td>
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<td></td>
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<tr>
<td></td>
<td>Discuss awareness of own emotions and how you might manage these effectively</td>
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<tr>
<td></td>
<td>Explore a model to have a courageous conversation</td>
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<tr>
<td></td>
<td>Discuss a range of practical tips/techniques for dealing with a range of difficult behaviour</td>
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<tr>
<td></td>
<td>Demonstrate effective communication during times of conflict or in difficult conversations with peers and/or service users</td>
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</tbody>
</table>
Evidence of Achievement of Competency 4: Dealing With Conflict/Managing Difficult Conversations

(at least one piece of evidence for each review period)

Preceptor__________________________
Date______________________________

Preceptee__________________________
Date______________________________
<table>
<thead>
<tr>
<th>Objective : 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be confident and competent in your clinical skills and objectives specific to your area of work</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective : 2</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has an understanding of the Mental Health Act (1983) Revised 2015 including DoLS, MCA</td>
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</tbody>
</table>

<p>| | | | | |
| | | | | |
| Can accept Mental Health section Papers and scrutinise them for accuracy including completion of Form 14 | | | | |
| Advise service users of rights and restrictions of detention in accordance with Section 132 | | | | |
| Can describe the process for application of Section 38/39 to ensure medication is administered correctly | | | | |
| Can describe the process for the transfer for service users between hospitals (Form 24) | | | | |
| Can outline the policy for the transportation of Section papers | | | | |
| Can describe the appropriate application of Section 5(4) | | | | |
| Can identify when Section 17 leave may be cancelled (in accordance with nurses discretion) | | | | |
| Can outline a knowledge of Section 117 aftercare and what this means in practice | | | | |
| Can outline principles of consent to treatment and discuss situations where treatment may be given without consent | | | | |
| Can demonstrate an understanding of Section 136 | | | | |
| Can demonstrate an understanding of and ability to complete a Deprivation of Liberty assessment | | | | |</p>
<table>
<thead>
<tr>
<th>Objective : 3</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies the differences between a service user requiring CPA care and non-CPA care</td>
<td></td>
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<tr>
<td>Understands the role of the named nurse, lead professional and care co-ordinator</td>
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<tr>
<td>Understands the process of and is able to undertake needs assessment and risk assessment</td>
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<tr>
<td>Understans the process of and is able to undertake collaborative care planning and risk management planning</td>
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<tr>
<td>Able to actively participate within CPA care review meetings</td>
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<tr>
<td>Able to effectively chair a CPA care review meeting</td>
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<tr>
<td>Access appropriate training relating to the implementation of CPA</td>
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</table>

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<thead>
<tr>
<th>Objective : 4</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has an awareness of, and adheres to, the Trust Policy/admission process</td>
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<tr>
<td>Has an awareness of admission documentation</td>
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<tr>
<td>Can complete all necessary admission documentation to Trust standards</td>
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<tr>
<td>Has an awareness of, and adheres to, the Trust Policy/discharge process</td>
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<tr>
<td>Has an awareness of discharge documentation</td>
<td></td>
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</tr>
<tr>
<td>Can complete all necessary discharge documentation to Trust standards</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Objective : 5</td>
<td>Evidence / Development plan</td>
<td>Date Achieved</td>
<td>Initials of Assessor</td>
<td>Initials of preceptee</td>
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<tr>
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<tr>
<td>Demonstrates an ability to conduct a comprehensive assessment of service users</td>
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<tr>
<td>Identifies the need for assessment/reassessment</td>
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<tr>
<td>Assesses service users using an agreed care model/framework</td>
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<tr>
<td>Identifies the service users strengths and needs</td>
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<tr>
<td>Identifies risk issues</td>
<td></td>
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<tr>
<td>Involves the service user, carer and the multi-disciplinary team within the assessment process</td>
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<tr>
<td>Prepares a clear and meaningful written record of the assessment</td>
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<tr>
<td>Concludes an assessment with a formulation and summary of needs</td>
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</table>

<table>
<thead>
<tr>
<th>Objective : 6</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates an ability to complete a meaningful risk assessment and risk management plan</td>
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<tr>
<td>Understands the risk assessment process and can utilise risk assessment tools as required</td>
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<tr>
<td>Understands the concept of positive risk taking</td>
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<tr>
<td>Identifies the need for risk assessment</td>
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<tr>
<td>Conducts a comprehensive assessment of risk</td>
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<tr>
<td>Gathers information from different sources in conducting / undertaking risk assessments</td>
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<tr>
<td>Identifies key risk and protective factors relevant to service users presentation</td>
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<tr>
<td>Identifies warning signs/indicators of risk</td>
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<tr>
<td>Concludes risk assessments with a formulation and summary of needs</td>
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<tr>
<td>Preparae a clear and meaningful risk management plan/ care plan relating to risk issues</td>
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<tr>
<td>Forms risk management decisions based upon best available evidence</td>
<td></td>
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</tr>
<tr>
<td>Involves others in forming risk management decisions</td>
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<tr>
<td>Preparae a clear and meaningful written record of risk management plans</td>
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<tr>
<td>Effectively presents risk assessments and risk management plans to the multi-disciplinary team</td>
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</tbody>
</table>

**Objective : 7**
**Demonstrate the knowledge and an ability to effectively implement specific risk management interventions**

<table>
<thead>
<tr>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
</table>

- Able to identify indicators of potential and immediate risk
- Able to effectively implement formal observation through engagement, in accordance with Trust Policy and Procedure
- Aware and acts to maintain a safe environment

**Objective : 8**
**Demonstrate an ability to plan, implement and evaluate care in collaboration with service users, carer(s) and the multi-professional team**

<table>
<thead>
<tr>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
</table>

- Able to prioritise the needs of service users
- Able to agree SMART goals as a focus for care
- Able to formulate a plan for care that addresses the identified needs of the service user
- Able to complete a meaningful and personalised written care-plan in collaboration with the service user / carer
<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Demonstrates the knowledge and an ability to effectively implement Safeguarding procedures</td>
<td></td>
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<tr>
<td>10</td>
<td>Demonstrates an awareness of standard infection control precautions in accordance with Trust policy and procedural guidelines</td>
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<tr>
<td>11</td>
<td>Demonstrates an ability to assess and monitor physical health issues</td>
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</tbody>
</table>

- Able to provide the rationale and evidence to support planned intervention(s)
- Able to coordinate the provision of care by others, in accordance with the plan of care
- Able to report on progress or deterioration in accordance with the plan of care
- Able to present a summary of progress within the context of the shift handover and care review meetings
- Able to monitor and evaluate the progress and outcomes of care
- Able to meaningfully record the evaluation/review of care
- Understands and implements local Safeguarding procedures
- Identifies appropriate actions to protect vulnerable adults/children
- Demonstrates good practice and an ability to apply standard infection control precautions in accordance with Trust policy and procedural guidelines
- Able to recognise the deteriorating service user and use escalation process
- Able to accurately measure and record temperature, pulse, respiration, BP (automated and manual), height, weight and BMI
<table>
<thead>
<tr>
<th>Objective</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Demonstrates knowledge of the use of health promotion and preventive strategies and a willingness to discuss and educate service users on health promotion</td>
<td>Evidence / Development plan</td>
<td></td>
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<tr>
<td>13</td>
<td>Demonstrates the delivery of safe care</td>
<td>Evidence / Development plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Able to accurately measure and record blood glucose levels and administer insulin
- Able to check and accurately use emergency equipment
  - Administer oxygen
  - Suction machine
  - Defibrillator
- Understand and is able to apply basic life support and first aid
- Observes changes in the service users physical condition and appearance
- Able to assess nutritional and hydration needs of the service user
- Able to offer support and advice to service users on health promotion, whilst respecting choice;
  - Acting as a positive role model
  - Maintaining a healthy lifestyle (e.g. healthy eating, activities/exercise, non-smoking)
  - Implementing health promotion strategies
- Is aware of safe staffing and procedure to follow should staff levels be below those required
- Is aware of skill-mix and the need for a mixed level of staffing
- Is aware of benchmarking and essence of care
- Uses evidence based practice to inform interventions with service users
Evidence of Achievement of Competency 5: Delivering Safe Care

(at least one piece of evidence for each review period)

Preceptor____________________________________
Date____________________________________

Preceptee____________________________________
Date____________________________________
### Competency 6: Emotional Intelligence

<table>
<thead>
<tr>
<th>Objective: 1 To understand the concept of Emotional Intelligence</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the concept of Emotional Intelligence</td>
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<tr>
<td>Discuss personal strengths and vulnerabilities related to emotional intelligence</td>
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<tr>
<td>Discuss actions that can increase self-awareness and self-management</td>
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<tr>
<td>Emotional intelligence is observed in handling of various situations</td>
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</tbody>
</table>

**Evidence of Achievement of Competency 6: Emotional Intelligence**

(at least one piece of evidence for each review period)

Preceptor______________________
Date__________________________

Preceptee______________________
Date__________________________
## Competency 7: Leadership

### Objective: 1
To understand the importance of leadership in relation to practice settings

<table>
<thead>
<tr>
<th>Discuss leadership in relation to practice settings</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss leadership in relation to nursing and nursing activities</td>
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<tr>
<td>Discuss your own role in relationship to leadership</td>
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</tbody>
</table>

### Objective: 2
To begin to develop self as a leader

<table>
<thead>
<tr>
<th>Discuss leadership ideas and build participation rapport</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand own and others leadership behaviours</td>
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<tr>
<td>Understand the impact of yours and others leadership behaviours on difficult situations</td>
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<tr>
<td>Demonstrate strategies to deal with difficult situations</td>
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</table>

### Objective: 3
Understand the concept and importance of time management

<table>
<thead>
<tr>
<th>Discuss how time management affects clinical practice</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
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</thead>
<tbody>
<tr>
<td>Discuss effective time management strategies</td>
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<tr>
<td>Discuss the principles of prioritising work</td>
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</table>

### Objective: 4
Demonstrate good leadership, management development and team working

<table>
<thead>
<tr>
<th>Able to fulfil the role of a named nurse/lead professional/ care coordinator</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
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</thead>
<tbody>
<tr>
<td>Able to organise and coordinate a shift/ clinic</td>
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<tr>
<td>Able to delegate to other team members</td>
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<tr>
<td>Recognises and encourages the work of other team members</td>
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<tr>
<td>Ensure the continuity of care</td>
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<tr>
<td>Able to positively influence others</td>
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<tr>
<td>Responds positively to service users</td>
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<tr>
<td>Able to make referrals to other agencies/professionals</td>
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<tr>
<td>Demonstrates the appropriate use of temporary workforce</td>
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<tr>
<td>Demonstrates the appropriate use of on-call manager</td>
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<tr>
<td>Explains how to deal effectively with a complaint, promoting local resolution</td>
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</tbody>
</table>
Evidence of Achievement of Competency 7: Leadership

(at least one piece of evidence for each review period)

Preceptor ____________________________
Date ________________________________

Preceptee ____________________________
Date ________________________________

37
### Competency 8: Quality Improvement

<table>
<thead>
<tr>
<th>Objective: 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify relevant measures and tools for monitoring meaningful outcomes within the service user group</td>
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<tr>
<td>Able to effectively introduce, implement and interpret the findings of selected outcome monitoring tools/methods</td>
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<tr>
<td>Able to explain and discuss the findings of outcome measures with service users, carers and other team members</td>
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<thead>
<tr>
<th>Objective: 2</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
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</thead>
<tbody>
<tr>
<td>Awareness of agreed quality practice</td>
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<tr>
<td>Able to contribute to the development of quality practice standards</td>
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<tr>
<td>Able to contribute to the design and completion of audit activities within the work setting</td>
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<tr>
<td>Recognises and demonstrates high standards of customer care</td>
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<tr>
<td>Identifies and reports areas where quality is compromised, contributing to action plans focusing upon quality improvement</td>
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<tr>
<td>Understands the place of clinical governance within the work setting</td>
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<tr>
<td>Assist in the facilitation of student mentoring</td>
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<tr>
<td>Able to contribute to the development of the clinical learning environment</td>
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<tr>
<td>Objective : 3</td>
<td>Demonstrate a knowledge of and support the implementation of service improvement frameworks</td>
<td>Evidence / Development plan</td>
<td>Date Achieved</td>
<td>Initials of Assessor</td>
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<tr>
<td>Understands the service improvement model/framework e.g. Essence of Care</td>
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<tr>
<td>Able to contribute to the implementation of the identified service improvement programme</td>
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<tr>
<td>Able to accurately share the findings of service improvement activity and support forward actions</td>
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<tr>
<td>Able to promote practice change as a component of service improvement activity</td>
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</table>

<table>
<thead>
<tr>
<th>Objective : 4</th>
<th>Demonstrate an ability to reflect upon practice and performance through a framework of clinical and managerial supervision</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
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</thead>
<tbody>
<tr>
<td>Understands the principles of reflective practice and supervision</td>
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<tr>
<td>Engages within both managerial and clinical supervision</td>
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<tr>
<td>Contributes to the agreement of a contract for supervision</td>
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<tr>
<td>Adopts the role of supervisor with a junior team member</td>
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<tr>
<td>Able to initiate and encourage reflective thinking and discussion</td>
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</tbody>
</table>
Evidence of Achievement of Competency 8: Quality Improvement (at least one piece of evidence for each review period)

Preceptor__________________________
Date______________________________

Preceptee__________________________
Date______________________________
## Competency 9: Resilience

<table>
<thead>
<tr>
<th>Objective: 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>To build personal resilience in order to maintain high performance and positive well-being</td>
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<tr>
<td>Describe trigger factors for stress</td>
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<tr>
<td>Describe signs and symptoms of stress and how these may present physically, psychologically and emotionally</td>
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<tr>
<td>Identify triggers to your own stress levels</td>
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<tr>
<td>Describe your own symptoms that may present when you are feeling stressed</td>
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<tr>
<td>Be aware of stress management techniques</td>
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<tr>
<td>Describe services that may be able to support you during periods of high stress</td>
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<tr>
<td>Be able to recognise and commit to own role in improving well-being, leadership style and working environment</td>
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<tr>
<td>Display resilience and encourage staff motivation</td>
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</table>
Evidence of Achievement of Competency 9: Resilience

(at least one piece of evidence for each review period)
### Competency 10: Reflection

<table>
<thead>
<tr>
<th>Objective: 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>To examine the importance of the concept of reflection</td>
<td>Describe specific reflective models – identifying strengths and weaknesses of the most commonly used reflective models</td>
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<tr>
<td></td>
<td>Understand the concept of ‘reflection on practice’ and ‘reflection in practice’</td>
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<td></td>
<td>Described how using reflection can improve knowledge</td>
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</table>

<table>
<thead>
<tr>
<th>Objective: 2</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the impact of feelings on the learning process</td>
<td>Describe how reflection can help to create a greater sense of self awareness</td>
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</tbody>
</table>

### Evidence of Achievement of Competency 10: Reflection

(at least one piece of evidence for each review period)

Preceptor 
Date

Preceptee 
Date
### Competency 11: Safe Staffing / Raising Concerns

<table>
<thead>
<tr>
<th>Objective: 1</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have an awareness of the importance of safe staffing</td>
<td>Describe the meaning of ‘safe staffing’</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Why are we required to record staffing levels</td>
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<tr>
<td></td>
<td>What is the process for recording safe staffing</td>
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<td></td>
<td>Who sees the Safe Staffing information</td>
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<tr>
<td></td>
<td>What is the process when staffing levels do not meet the requirement of safe staffing</td>
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<td></td>
</tr>
<tr>
<td>Objective: 2</td>
<td>Evidence / Development plan</td>
<td>Date Achieved</td>
<td>Initials of Assessor</td>
<td>Initials of preceptee</td>
</tr>
<tr>
<td>Demonstrate an awareness of Health, Safety and Security</td>
<td>Can demonstrate an understanding of the process and considerations, including risks, of manual handling for a service user when aids are required</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Can demonstrate four actions, as listed in the needle stick injury policy, which must be followed in the event of a needle stick injury</td>
<td></td>
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<tr>
<td></td>
<td>Performs a health and safety inspection of the environment/unit, understanding the importance of the inspection</td>
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<tr>
<td></td>
<td>Can describe personal responsibilities under the Health and Safety at Work Act 1974</td>
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<tr>
<td></td>
<td>Has read and demonstrates an understanding of Section 7 of Health and Safety Manual</td>
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<tr>
<td></td>
<td>Can describe key elements of policy for Display Screen Equipment</td>
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<tr>
<td></td>
<td>Has completed the relevant Health and Safety mandatory training</td>
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</tbody>
</table>
Describes procedures for fault reporting (including out of hours) i.e. Estates and departmental procedure

<table>
<thead>
<tr>
<th>Objective 2: Is fully aware of how to raise concerns and the obligations around raising concerns</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is fully aware of how to raise concerns within the team</td>
<td></td>
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<tr>
<td>Is fully aware of the Trusts Raising Concerns policy</td>
<td></td>
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<tr>
<td>Has access to Datix, is fully aware of how to complete Datix and the role that Datix plays in information sharing</td>
<td></td>
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<tr>
<td>Is fully aware of the Trust safeguarding service and their function</td>
<td></td>
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<tr>
<td>Is aware of Trust guardian service and how to access same</td>
<td></td>
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</tr>
</tbody>
</table>
## Competency 12: Team Working

<table>
<thead>
<tr>
<th>Objective: 1</th>
<th>Understand team dynamics</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the strengths of team working</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Identify factors that can contribute to poor team cohesion</td>
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<tr>
<td>Identify opportunities for team decision making</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective: 2</th>
<th>Multi-professional team working</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate professional understanding and attitude towards other professionals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Discuss how inter-professional working can improve the patient journey</td>
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</tbody>
</table>

### Evidence of Achievement of Competency 12: Team Working

(At least one piece of evidence for each review period)

Preceptor__________________________

Date______________________________

Preceptee__________________________

Date______________________________
### Competency 13: Medicines Management

<table>
<thead>
<tr>
<th>Objective: 1 Demonstrate in practice knowledge of NMC standards for medicines management and EPUT policies and procedures for medicines management.</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of the procedure for ordering stock, non-stock and leave medication.</td>
<td></td>
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<tr>
<td>Aware of the procedure for secure and appropriate storage of all medications.</td>
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<tr>
<td>Aware of the requirements for written prescriptions that meet NMC Guidelines</td>
<td></td>
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</tr>
<tr>
<td>Aware of guidelines for the prescription and ordering of drugs in the community setting</td>
<td></td>
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</tr>
<tr>
<td>Aware of Trust Policy on the Administration of Medication</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Aware of the Trust policy on the Administration of Injections</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Aware of the specific procedure for administering injections? To follow instructions for licenced administration of specific injectable vaccines Removed i.e. Pabrinex, Risperdal Consta</td>
<td></td>
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</tr>
<tr>
<td>Aware of the legal requirements and EPUT policy for ordering, storage, recording, administration and disposal of controlled medications</td>
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</tr>
</tbody>
</table>

### Objective: 2 Demonstrates safe administration of medication: part 1 – oral medication

<table>
<thead>
<tr>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepares required equipment and medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be certain of the patient’s identity.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
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<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Administer or withhold in the context of the patient's condition observing physical and mental state</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks the prescription is clearly written and unambiguous, signed and dated by the prescriber. Check the medication, strength, form, route and timing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctly identifies the medication and checks the label on the medication (as clear and unambiguous)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks the expiry date of the medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks that the service user is not allergic to the medication</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Correctly measures the medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers the medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks that the service user has taken the medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediately records that the medication has been given/refused or withheld</td>
<td></td>
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</tbody>
</table>

| Objective: 3
Demonstrates safe administration of medication: part 2 – injectable medications | Evidence / Development plan | Date Achieved | Initials of Assessor | Initials of preceptor |
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Correctly identifies the service user</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observes the service user's physical and mental state</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks that the service user is not allergic to the medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares equipment for preparing and administering an injectable medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks the prescription for medication, form, route and timing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctly identifies the medication and checks the label on the medication (as clear and unambiguous)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks the expiry date of the medication</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prepares the service user for administration of the injection (with attention to privacy, dignity and hygiene)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Safely administers the injection</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Immediately records that the injection has been given</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safely clears away equipment</td>
<td></td>
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</tr>
</tbody>
</table>

**Objective: 4**
Demonstrates a knowledge of medications – **Assessor should select 5 medications and ask the following questions for each medication**

<table>
<thead>
<tr>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the therapeutic uses of the medication? How does it fit with the plan of care/care pathway?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the normal does range and frequency for this medication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the common side-effects for this medication? How do you detect and manage them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the precautions and contra indications for the medication?</td>
<td></td>
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</tr>
<tr>
<td>Demonstrate a knowledge of, and use in practice of a range of side effect monitoring tools which may be service specific</td>
<td></td>
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<tr>
<td>Able to recognise when to and actions contacting prescriber</td>
<td></td>
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</tr>
<tr>
<td>Demonstrate an awareness of responsibility for correct storage of medicines in clinical rooms, medicine fridges, trolleys and cupboards.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Objective: 5</td>
<td>Evidence / Development plan</td>
<td>Date Achieved</td>
<td>Initials of Assessor</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------</td>
<td>---------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Can demonstrate appropriate response in special situations</td>
<td><strong>Verbalise what you would do if a service user was in bed at the time when prescribed medications were due to be administered</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Verbalise what you would do if you discovered that a service user is allergic to the medication or he/she develops a reaction to the medication / injection?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Verbalise what you would do if a prescribing doctor asks you to administer a medication that has not yet been prescribed on the medication chart?</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Verbalise what you would do if a newly admitted service user brings their own supply of medications for physical health conditions, for which there is no stock medication?</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Verbalise what you would do for the service user who is commencing leave shortly, but for whom leave medication has either not been ordered or supplied? (Mental Health / Learning disability staff only)</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Verbalise what you would do if you made a drug error or had a near miss with medication</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Describes the physical monitoring and recording necessary when administering medication in an emergency, in accordance with Rapid Tranquilisation Policy</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Obtain medication out of hours</strong></td>
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<tr>
<td></td>
<td><strong>Demonstrates an awareness of responsibility for holding the medicines cupboard and controlled drug cupboard keys</strong></td>
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<tr>
<td>------------------------------------------------------------</td>
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</tr>
<tr>
<td>Demonstrates an understanding of the requirements and Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy in relation to controlled drugs</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Demonstrates an awareness of the requirements of Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy for covert administration of medicines</td>
<td></td>
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</tr>
</tbody>
</table>
Evidence of Achievement of Competency 13: Medicines Management

(at least one piece of evidence for each review period)

Preceptor________________________________
Date____________________________________

Preceptee________________________________
Date____________________________________
### Competency 14: Inter-professional Learning

<table>
<thead>
<tr>
<th>Objective: 1</th>
<th>To understand the role of allied health professionals</th>
<th>Evidence / Development plan</th>
<th>Date Achieved</th>
<th>Initials of Assessor</th>
<th>Initials of preceptee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Describe the difference in the roles of those professionals who make up the MDT</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Describe the relationship between the different professional groups and collaboration</td>
<td></td>
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<tr>
<td></td>
<td>Describe how different professional groups contribute to a service users care / care planning</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Objective: 2</td>
<td>To identified opportunities for multi-professional learning</td>
<td>Evidence / Development plan</td>
<td>Date Achieved</td>
<td>Initials of Assessor</td>
<td>Initials of preceptee</td>
</tr>
<tr>
<td></td>
<td>Identify the benefits and importance of multi-professional learning</td>
<td></td>
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<tr>
<td></td>
<td>Encourages and facilitates inter-professional learning within the practice area</td>
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<tr>
<td></td>
<td>Discuss the rationale for professionals meeting</td>
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<tr>
<td></td>
<td>Describe the main differences between professionals meeting and a CPA meeting</td>
<td></td>
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</tbody>
</table>
Evidence of Achievement of Competency 14: Inter-professional Learning

(at least one piece of evidence for each review period)

Preceptor _________________________
Date ____________________________

Preceptee _________________________
Date ____________________________
OT Preceptorship
and
CPD Handbook

IN PARTNERSHIP WITH
SOUTHEND HOSPITAL NHS FOUNDATION TRUST
BASILDON AND THURROCK UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
NORTH EAST LONDON NHS FOUNDATION TRUST

<table>
<thead>
<tr>
<th>Name</th>
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</table>

<table>
<thead>
<tr>
<th>Team/s</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Supervisor/s</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Start Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Draft NEP version 1</th>
<th>Agreed in NEP Consultant OT Meeting 13/11/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEPT version 1</td>
<td>Agreed 2009 at Heads Task and Finish</td>
</tr>
<tr>
<td>SEPT version 2</td>
<td>Agreed 2016 at Heads Meeting</td>
</tr>
<tr>
<td>Revision post-merger Version 3</td>
<td>Agreed in OT Heads/Leaders Meeting 22/5/18</td>
</tr>
</tbody>
</table>
Introduction

In 2010, the Department of Health launched a Preceptorship Framework for newly registered nurses, midwives and allied health professionals. The Framework, which is based on evidence from national and international sources, establishes clear principles of good preceptorship. It indicates what needs to be undertaken to ensure that local systems succeed and enable a smooth transition for newly registered practitioners as they progress their professional careers and continue their journey of lifelong learning.

The Framework defines **Preceptorship** as:

‘A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.’

**Preceptor** refers to a registered practitioner who has been given a formal responsibility to support a newly registered practitioner through preceptorship.

From the moment they are registered, practitioners are autonomous and accountable but have ongoing learning needs. Preceptorship is ‘a foundation period at the start of their careers which will help them begin the journey from novice to expert’.

Preceptorship provides a structured process for the induction and development of staff taking up roles that require a significant level of knowledge and skills with some degree of autonomy. At the end of the preceptorship period, it is anticipated that the practitioner will have become an effective, confident and fully autonomous individual able to deliver high-quality care.

The newly registered practitioner and the employer should have a clear understanding of where the boundaries of preceptorship lie. In addition, they should be aware of other processes and systems in place to manage ability and performance in relation to the competency of the newly registered practitioner.

Preceptorship is **not** therefore:

- intended to replace mandatory training programmes
- intended to be a substitute for performance management processes
- intended to replace regulatory body processes to deal with performance
- an additional period in which another registrant takes responsibility and accountability for the newly registered practitioner’s responsibilities and actions (i.e. it is not a further training period)
- formal coaching (although coaching skills may be used by the preceptor to facilitate the learning of the newly registered practitioner)
• mentorship
• statutory or clinical supervision
• intended to replace induction to employment
• a distance or elearning package for a newly registered practitioner to complete in isolation.

The overall aims of the preceptorship programme are to:

• Provide support to newly qualified Occupational Therapists during the transition from the role of student to the role of qualified practitioner.
• Facilitate the development of clinical skills and professional behaviour
• Promote reflective practice.
• Enable newly qualified Occupational Therapists to meet the competency standards after 6 months and 12 months in post and ensure that preceptees are prepared adequately for this role.
• Assist newly qualified Occupational Therapists to identify an appropriate personal development plan with their supervisor

This Handbook needs to be read in conjunction with the following documents:
• Trust Appraisal/Development Review Policy and Procedure
• Trust Guidelines for Clinical Supervision
• RCOT Preceptorship Handbook for Occupational Therapists 3rd edition (2013) by Dr Mary Morley
• RCOT Professional standards for occupational therapy practice (2017) and the HCPC standards of proficiency (2013).

**Preceptorship national standards of practice**

The preceptorship process includes a review of progress against relevant professional standards. This programme sets out a common set of standards that have been adopted from the RCOT Professional Standards of Occupational Therapy practice (RCOT 2017). The RCOT Standards are universally used in the UK and are compatible with the experience and expectations of practitioners.

The preceptorship standards should be used as benchmarks in the preceptorship process and to facilitate self-evaluation and shared feedback in the first year of practice. In addition, all practitioners need to be aware of the full set of RCOT Professional Standards for Occupational Therapy Practice (RCOT 2017) and the HCPC Standards of Proficiency (HCPC 2013) against which all OTs, including preceptees, will be held responsible.
From Health Education England
National Standards

- the organisation facilitates protected time for preceptorship activities
- there is a clearly defined purpose of preceptorship that is mutually understood by preceptors and preceptees
- preceptors have undertaken training and education that is distinctive from mentorship preparation
- a named preceptor allocated from day one of employment
- preceptorship is tailored to meet the need of the individual preceptee
- preceptorship is monitored and evaluated on a scheduled basis
- preceptees contribute to the development of the preceptorship programme
- the preceptorship programme is clearly linked to the NHS Constitution and the 6Cs. It includes the following elements:
  - accountability
  - career development
  - communication
  - dealing with conflict/managing difficult conversations
  - delivering safe care
  - emotional intelligence
  - leadership
  - quality improvement
  - resilience
  - reflection
  - safe staffing/raising concerns
  - team working
  - medicines management
  - inter-professional learning.

Preceptorship procedure

The preceptorship standards relate to key task areas that are found in the job role of all newly qualified practitioners and specify the required level of practice:
• when working with clients and groups
• when working with colleagues
• in written communications
• when using local clinical policies relating to health and safety in practice.

The preceptee will be required to identify objectives which will include one task from each of the four domains.
<table>
<thead>
<tr>
<th>Key task area</th>
<th>Examples of activity</th>
<th>Standard of practice</th>
</tr>
</thead>
</table>
| 1 Working with clients and groups                 | Carrying out an occupational therapy assessment, planning and facilitating a clinical session | 1a Assessment and goal setting  
The occupational therapist (OT) must identify and assess client’s occupational needs  
OR  
1b Intervention and evaluation  
The OT will enable the service user to move towards their stated goal by carrying out occupational-focused activities |
| 2 Working with colleagues and other agencies      | Feeding back at a clinical meeting, making a referral to another service              | 2 Team working  
The OT must work in collaboration with other professionals and agencies and ensure effective communication |
| 3 Written communication                           | Clinical notes, a report, an assessment                                              | 3 Record keeping  
Occupational therapy records should be well organised, well managed and clear to ensure they are accessible to those who may need to refer to them |
| 4 Using local clinical policies relating to working practice | Lone-working, risk assessment and management                                         | 4 Safe working practice  
The OT must take responsibility for assessing and managing risk to ensure safe working practice |

**The preceptorship review process**

- The period of preceptorship will be integrated within the clinical supervision framework.
- The preceptee’s clinical supervisor will be a qualified Occupational Therapist with a minimum two years post-graduate experience and sufficient knowledge of the preceptee’s area of work.
- Wherever possible the supervisor/preceptor will work alongside the preceptee.
- During the twelve months of preceptorship the preceptee will be given four half days in each six month rotation CPD time to complete the required pieces of work.
- Any additional CPD time given is at the discretion of the Head of Department/Consultant OT for each area.
• The supervisor/preceptor will be responsible for the six and twelve month review process with the support of the Head of Department/ Consultant OT.

• The Head of Department/ Consultant OT in liaison with the line manager will identify the appropriate person to act as preceptor. This will be their professional supervisor.

• The preceptor will be identified from day one.

• In the first month, the preceptee will meet with their preceptor and learning objectives for the first six months. These will be entered in the new agree starter’s Personal Development Plan (PDP) (Appendix 1).

• During the first 12 months of employment in a Band 5 post, preceptees will have two development reviews. The first review after six months will seek to establish whether the preceptee is on track in development towards their PDP. They will also be expected to produce written evidence of learning for their portfolio.

• In keeping with the spirit of a development review, there should be ‘no surprises’ as the preceptee should have received regular feedback on their performance.

• The preceptee and their reviewer should include a review on the Review Form recording that the four preceptorship tasks have been completed (Appendix 3).

• When reflecting on performance, the preceptee must consider their professional behaviours (Appendix 4)

• At the six month tracking review the preceptor and preceptee agree an updated PDP (Appendix 1). For rotational posts this will be passed to the new preceptor.

• For the second six month period the PDP will include development of a detailed case study evidencing that the preceptee has applied the required knowledge and skills of their post. (Appendix 10)

• After 12 months, the second development review will form part of the annual appraisal focussing on progress towards the PDP and the extent to which the preceptee has demonstrated the expected knowledge and skills (Appendix 10)

• During the preceptorship year there is an expectation that the preceptee OT will attend the monthly/ bimonthly Band 5 peer support groups. A minimum of 3 groups attended will be expected in order to sign off preceptorship.

• They will need to be up to date on mandatory training.

• Participation in the support of students on Fieldwork practice is expected.
For rotational posts there is an expectation that preceptorship is completed after 12 months or by the end of the second rotation.

**Lifelong learning**

Preceptorship is part of a professional’s lifelong learning. The process described is closely aligned with the appraisal and development review process and therefore can be used throughout the preceptee’s career to build their portfolio.

**Flowchart of OT preceptorship process**

1. **Induction**
   - Agree initial personal development plan (PDP) *(Appendix 1) (optional SWOT Appendix 5)*
   - Plan for preceptorship tasks in the four identified key areas with preceptor
   - Undertake reflective written tasks and observed practice in each key area
   - Discuss at each stage with preceptor and identify evidence
   - Six month tracking review to review personal development objectives *(Appendix 1 and 3)*
   - Involve Consultant OT/Head OT at this stage

2. **Agree objectives for 6-12 months (Appendix 1) (if on rotation these need to be reviewed and updated with the next preceptor)**
   - Undertake planned learning activities including detailed case study
   - Regularly discuss with preceptor and identify clinical reasoning
   - Record evidence of learning in portfolio *(include Appendix 6 where possible)*

3. **12 month development review meeting involve Consultant OT/Head OT at this stage for sign off (Appendix 10)**
   - Review contributes to first annual appraisal
   - Preceptorship period completed
   - Continue to engage in lifelong learning

**REGULAR SUPERVISION THROUGHOUT WHOLE PROCESS**
What if progress isn’t as planned?

The preceptor and the preceptee should maintain an open and constructive dialogue at all times. If the preceptee is unhappy with progress or support, this should be discussed initially with the preceptor or line manager.

Where an improvement to a satisfactory level has not been made and the level of performance is still below the standard required, or where preceptorship has not been satisfactorily completed, the line manager may extend the review period.

The probation policy and procedure accompanies the first 6 months of preceptorship and will assess and support capability.

A preceptee should discuss with the line manager if they wish to change their preceptor.

On completion of the pack

- the original document is to be kept in the preceptee’s own portfolio
- a copy to be kept by in preceptee’s personnel file.
- a copy to be sent to Associate Director for Allied Health Professions and you may be asked if anonymised examples may be used for the purpose of teaching.
Examples of preceptorship activities

Use the evidence sheets and reflective model to describe any learning or experiences whilst doing preceptorship activities such as:

- Critical review of a group programme or group activity. Analysis of your impact. What will you do to continue to develop your practice?
- Reflecting on preceptee’s own role in the team to include professional aspects and generic components. Does this differ from other members of the team, should it? Or if not, how can the preceptee make changes?
- Presenting a case study at a local forum
- Shadowing other staff: from senior OTs to Associate Director of AHPs. Other professions? Does the preceptee know their specific skills/what they offer to the care pathway?
- Reflecting on incidents observed or participated in. What Trust policy applies? How should these be reported? Has the team learnt or should learn from this incident? Has it changed the preceptee’s practice, should it change OT practice?
- Exploring other areas of the Trust. How does the OT role work there? How does it fit in with the MDT work? If services have no OT, is there a need? If so, what?
- Reflecting on an OT assessment, ADL assessment. What went well? How did the service user benefit? How were the findings shared? How did the preceptee ensure others note their professional expertise and recommendations?
- A reflection on how your report writing has developed over a period of time to include style, contents, prioritisation, objectives and recommendations, sharing

Note

This list is not exhaustive or a firm guide to preceptorship activities

Please speak to other Band 5 staff and share ideas

Signature Record

All assessors must complete the Signature Record

Record of signatures for .................................................................

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<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Initials</th>
<th>Designation</th>
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Appendix 1

OT Preceptorship Personal Development Plan (PDP)

<table>
<thead>
<tr>
<th>Identified development need (include mandatory training not covered at Trust induction)</th>
<th>SMART objectives</th>
<th>How do you plan to address this need (e.g. shadowing/ one-to-one/ training course)?</th>
<th>By when?</th>
<th>Comments/ actions at end of review period (objective fully achieved or not and reasons)</th>
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Preceptor name and signature: …………………………………………………………………………………………… Date: …………..

Precepee name and signature: ………………………………………………………………………………………………… Date: …………..
Appendix 2

Observed Practice Planning Form

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Date/time of observed practice</td>
<td></td>
</tr>
<tr>
<td>Venue for observed practice</td>
<td></td>
</tr>
<tr>
<td>Brief description of session, e.g. 1:1 / assessment session / lifestyles group</td>
<td></td>
</tr>
<tr>
<td>Specific clinical aims for session, e.g. carry out initial assessment</td>
<td></td>
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<tr>
<td>Please identify at least one goal/outcome for the observation using list below as a guide:</td>
<td></td>
</tr>
<tr>
<td><strong>Development of working practice</strong></td>
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<tr>
<td>E.g. overcome difficulties in clinical practice, gain a greater awareness in clinical reasoning, meet clinical standards</td>
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<tr>
<td><strong>Professional development</strong></td>
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</tr>
<tr>
<td>E.g. gain greater clinical knowledge, develop risk assessment skills, develop team-building skills, share ideas and experience, be able to make better decisions, be more assertive, improve problem-solving skills, get feedback on professional behaviours</td>
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<tr>
<td><strong>Personal development</strong></td>
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<tr>
<td>E.g. Manage stress, gain self-confidence, develop interpersonal skills, learn to receive constructive criticism, be honest about own limitations, increase sense of autonomy</td>
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<tr>
<td><strong>Other</strong></td>
<td></td>
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<tr>
<td>Which key task area could this provide evidence for?</td>
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<tr>
<td>How do you anticipate that this observed practice will contribute to the quality of your practice and service delivery?</td>
<td></td>
</tr>
<tr>
<td>How do you anticipate that this observed practice will be of benefit to your service user?</td>
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</table>

Adapted from Morley M et al (2010)
Observed practice feedback session template (optional)

Talk me through the session. *Do observers and observed person’s accounts agree?*

What went well/according to plan?

In what ways was the session challenging? *Refer to critical events*

How did you feel about the organisation of the session? Preparation, timing

How did you seek to engage the service user(s) in the session? *Introduction, adapting your approach, encouragement etc*

How do you think the service user(s) experienced the session?

Can you describe your overall approach? *What else have you tried?*

Can you explain why you chose to do what you did? *How/why did you adapt your approach during the session?*

How effective do you think it was/you were? *Is there anything you would have done differently?*

Did you learn anything new about the service user/group? *What factors related to either the service user or their environment may influence the ongoing effectiveness of your intervention?*

To what extent were the learning objectives for the observed session met?

To what extent were the preceptorship standards of practice met?

How did the observed view their professional behaviour during the session?

How will this session influence your future practice?

How has this process been for you? *Most helpful/least helpful aspects?*

HCPC Standard 3 – *How have you benefited from this CPD activity?*

HCPC Standard 4 – *How has your learning benefited your service users?*

What is your action plan?
# Appendix 3

## OCCUPATIONAL THERAPY PRECEPTORSHIP PROGRAMME

### Six Month Review Form

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<thead>
<tr>
<th>Preceptee:</th>
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<tr>
<td>Preceptor:</td>
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<tr>
<td>Post/ Rotation:</td>
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<tr>
<td>Date started in Band 5 post:</td>
</tr>
<tr>
<td>Date of Review:</td>
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<table>
<thead>
<tr>
<th>Task one: Working with clients and groups</th>
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<td>Comments:</td>
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<td>Achieved Y/N</td>
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<td>Comments:</td>
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<tr>
<td>Achieved Y/N</td>
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<tr>
<th>Task Three: Written communication</th>
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<td>Comments:</td>
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<td>Achieved Y/N</td>
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<table>
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<tr>
<th>Task Four: Using local clinical policies relating to working practice</th>
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<td>Comments:</td>
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<td>Achieved Y/N</td>
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<th>Professional Behaviours:</th>
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<td>Comments:</td>
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<tr>
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<th>Demonstrate compliance with CQC Fundamental Standards of Care:</th>
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<td>Comments:</td>
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<td>Achieved Y/N</td>
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<th>CPD Portfolio:</th>
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<tr>
<td>Achieved Y/N</td>
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<td>Signature</td>
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</table>

I confirm that the tracking review standards for occupational therapy practice have been met.

Signed (Preceptor)       date:  
Signed (Preceptee)       date:  
Signed (Head of Department) date:
Appendix 4

Occupational Therapists’ Professional Behaviours

DEPENDABILITY
- Following through agreed action plans
- Completing tasks on schedule
- Being consistent

PROFESSIONAL PRESENTATION
- Presenting oneself in a manner acceptable to clients, peers and colleagues
- Using body posture and affect that communicates interest or engaged attention
- Conveying positive attitude towards the OT role

INITIATIVE
- Demonstrating energetic, positive, motivated manner
- Self-starting projects, tasks and programmes
- Taking initiative to direct own continuous learning

EMPATHY
- Being sensitive and responding to the feelings and behaviours of others
- Listening to and considering the ideas and opinions of others
- Responding with sensitivity to the needs of other professionals
- Rendering assistance to all individuals without bias

COOPERATION
- Involving clients and carers in the decision-making process
- Working effectively with others
- Contributing ideas to the task at hand

ORGANISATION
- Prioritising self and tasks
- Managing time to balance clinical and non-clinical requirements

CLINICAL REASONING
- Analysing, synthesising and interpreting information
- Giving alternative solutions to issues and situations
- Demonstrating ethical decision-making skills

SUPERVISORY PROCESS
- Seeking feedback on personal reflection of own performance
- Modifying performance in response to meaningful feedback
- Operating within the scope of one’s own skills and seeking assistance when needed

COMMUNICATION
- Utilising teaching skills for clients, students and peers
- Sharing perceptions and opinions with clarity and quality of content
- Communicating ideas and opinions clearly and concisely in written reports and records

Adapted from Kasar and Muscari (2000)
Appendix 5

SWOT analysis (optional)

The SWOT (strengths, weaknesses, opportunities and threats) analysis is widely used within healthcare and business settings in assisting change. In your case it could be used to answer the following question:

‘What do I do next in order to move towards my longer-term goal of developing as a newly qualified professional?’

This enables you to undertake a situational analysis in order to answer the question:

‘Where do I stand in relation to a given set of circumstances?’

Sub-questions:
- What are my current strengths in relation to my development as a newly qualified professional?
- What are my relative weaknesses in relation to my development as a newly qualified professional?
- What opportunities does my situation present for me to build on my strengths to address my relative weaknesses?
- What threats or obstacles do I need to overcome in order to take advantage of the opportunities and to move forward?

It is important to remember that these four categories are not fixed. They shift and they interact with each other. Nevertheless, this is a useful way of breaking down complex situations into key components in order to clarify your thinking and support your planning.

SWOT helps you look at the balance between your strengths and your weaknesses in a given situation and therefore helps you recognise your developmental needs. What you need to do next is express your plan of action to meet those developmental needs.
Below is a template to complete this activity. It is important to remember as you progress through your preceptorship that your analysis will change and so this template should be completed again. These can be used within your portfolio.

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
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</thead>
<tbody>
<tr>
<td>What are my current <strong>strengths</strong> in relation to my development as a newly qualified professional?</td>
<td>What are my relative <strong>weaknesses</strong> in relation to my development as a newly qualified professional?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What <strong>opportunities</strong> does my situation present for me to build on my strengths to address my relative weaknesses?</td>
<td>What <strong>threats</strong> or obstacles do I need to overcome in order to take advantage of the opportunities and to move forward?</td>
</tr>
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Appendix 6

Logsheet for CPD activity
(Attach evidence behind sheet)

Preceptorship task and/or objective:

<table>
<thead>
<tr>
<th>Date</th>
<th>Details of CPD activity and any supporting evidence</th>
<th>HCPC category of learning</th>
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<tbody>
<tr>
<td></td>
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<td>Work-based (WB)</td>
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<td>Professional (P)</td>
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<td>Self-Directed (SD)</td>
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<td>Formal (F)</td>
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</table>

Name:

**HCPC Standard 3**
How have you benefitted from this CPD activity? (e.g. aspects of work changed, updated knowledge)

**HCPC Standard 4**
How has your learning benefited your service users? (e.g. clients, carers, colleagues, students, staff)
## Appendix 7 (optional)

Template for preceptorship reflective account (using Johns’ reflective model)

<table>
<thead>
<tr>
<th>Date</th>
<th>Evidence number</th>
<th>Key task area</th>
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</table>

### Aesthetics

### Personal feelings

### Ethics

### Empirics

### Reflexivity

### HCPC CPD Standard 3
How have you benefited from this CPD activity (e.g. aspects of work changed, updated knowledge)?

### HCPC CPD Standard 4
How has your learning benefited your service users (e.g. clients, carers, colleagues, students, staff)?

### Signed (Preceptee)
Appendix 8 (optional)

Template for preceptorship reflective account (using Gibb' reflective cycle)

<table>
<thead>
<tr>
<th>Date</th>
<th>Evidence number</th>
<th>Key task area</th>
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</table>

Description

Personal feelings

Evaluation

Analysis

Conclusion

Action plan

HCPC CPD Standard 3
How have you benefited from this CPD activity (e.g. aspects of work changed, updated knowledge)?

HCPC CPD Standard 4
How has your learning benefited your service users (e.g. clients, carers, colleagues, students, staff)?

Signed (Preceptee)
Appendix 9

Occupational Therapy Preceptorship Programme
Standards of Practice

These Standards have been adapted from the COT Professional Standards of Occupational Therapy Practice (COT 2011)

1 Working with clients and groups

Assessment
The OT must identify and assess the client’s occupational needs.
In order to do this the OT must:
1a Actively involve the service user and/or carers, explaining the nature and purpose of the assessment to facilitate their involvement.
1b Use standardised and non-standardised assessment tools that are appropriate to the OT’s service users and their circumstances.
1c Fully document the details of the assessment, including the date, time, location, those present and the outcomes.
1d Ensure the assessment accepts and values the background, lifestyle and culture of the service user.
1e Agree realistic and achievable goals for intervention in discussion with the service user and/or their carer, based on their priorities and needs as indicated by the assessment.

Intervention and evaluation
The OT will enable the service user to move towards their stated goal by carrying out occupational-focused activities.
In order to do this the OT must:
1f Select the media or activities on the basis of which offer the best options for achieving the agreed therapeutic goals and have most meaning for the service user.
1g Ensure that the intervention is in accordance with national guidelines, best or evidence-based practice.
1h Work in collaboration with other professionals to fit in with the overall programme of intervention the service user is receiving.
1i Engage the service user in activities which have been selected, adapted, graded and sequenced according to their needs.
1j Evaluate the effectiveness of the OT’s intervention using recognised outcome measures where possible.

2 Working with colleagues and other agencies
OTs must work in collaboration with other professionals and agencies and ensure effective communication.
In order to do this the OT must:
2a Build positive relationships with other members of the team.
2b Communicate their professional role, skills and opinion to other team members.
2c Use communication skills and a common language that promotes collaborative working.
2d Inform the team about the intervention they are planning and/or providing to their service users and its outcome(s).
2e Take account of the perspectives of various stakeholders.

3 Written communication
The OT records should be well organised, well managed and clear to ensure they are accessible to those who may need to refer to them.
In order to do this the OT must:
3a Maintain legible records.
3b Keep records securely and in an organised, systematic way.
3c Sign, date and time records. Print name and designation.
3d Write in plain English avoiding jargon and abbreviations.
3e Ensure the records are complete, factual, objective and concise.
3f Record entries as soon after the event as possible in chronological order.

4 Using local clinical policies relating to working practice
The OT must take responsibility for assessing and managing risk to ensure safe working practice.
In order to do this the OT must:
4a Identify positive risks to be taken safely by service users and/or staff, in cases where such risks are a necessary part of intervention and strategies to deal with such risk.
4b Assess the likelihood of risk to the health and safety of anyone affected by their activities.
4c Clearly document the outcome of any risk assessment.
4d Ensure contingency plans are in place for risks that cannot be eliminated.
4e Adhere to local risk management policies and incident-reporting procedures, including and in relation to infectious diseases.
4f Identify and be aware of procedures to be carried out should an incident occur.

Reference: College of Occupational Therapists
## OCCUPATIONAL THERAPY PRECEPTORSHIP PROGRAMME

### 12 Month Review Form

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<th>Precepee:</th>
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<tr>
<td>Preceptor:</td>
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### CASE HISTORY (approx. 2000 words) Comments:

- Brief history of patient/client relevant to O.T:

- Review of medical condition, investigations, treatments, and prognosis:

- Relevant legislation:

- Liaison/involvement with others:

- Approaches and models used:

- Description and clinical reasoning of treatment media including treatment plan:
<table>
<thead>
<tr>
<th>Description and clinical reasoning of treatment media including treatment plan:</th>
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<tbody>
<tr>
<td>Sequence of measures taken to effect change and your role in the treatment process:</td>
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<tr>
<td>Evaluation of treatment:</td>
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<tr>
<td>Summary of findings on case study</td>
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<td>Achieved Y/N</td>
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</table>

**Professional Behaviours**

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**Demonstrate compliance with CQC Fundamental Standards of Care**

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**CPD Portfolio**

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<td>Achieved Y/N</td>
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</table>
I confirm that the 12 month review standards for Occupational Therapy practice (band 5 sub-set outlines) have been met.

Signed (Preceptor) date:

Signed (Preceptee) date:

Signed (Head of Department) date:
## Appointment Log

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Appendix 12

The first year of practice: challenges and opportunities

*Summarised from Tryssenaar and Perkins (1999)*

Many final year OT students often feel that life will be easier after graduation. They have reached saturation point with student life – essay writing, exam preparation and a lack of independence that has lasted into their adult lives.

They contrast this with life after graduation, with its perceived freedom from the many years of stressors that they find so burdensome. At the same time, they may have unrealistic expectations for OT practice. Others have unspoken feelings of not knowing enough or not understanding enough to be good therapists. The combination of high expectations and low self-confidence can result in a painful and stressful first year of practice. New graduates and final year students can prepare themselves to minimise the difficulties of the first year of practice and enhance their professional growth.

**First year challenges**

Most newly qualified staff identify many of the same problems and stresses during that critical first year. They are expected to change from students to independent professionals. They begin their first position and discover that they were somewhat sheltered during student fieldwork and placements shielded them from the world of real practice with its professional strains, demands and imperfect solutions. New graduates discover that they must now deal with time pressures, work politics and less than perfect patient or client care. Often, they discover that there is less flexibility in their schedule than there was in university. They cannot help but compare themselves to those therapists who are more competent and more experienced and who seem to juggie a heavy caseload effortlessly. Fears of inadequate preparation clash with their pride in knowing cutting-edge theory, making for an uneasy combination.

New graduates may also not recognise the clinical reasoning skills that an expert therapist uses to focus and streamline treatment without compromising quality of care, viewing this streamlining as substandard practice, which can cause disillusionment.

In our work with new graduates, the following ‘how to’s’ have emerged that may help alleviate some of the stresses of therapists’ first year of practice.

**Strategies**

As a new therapist you should, if possible, choose a job where there is allowance for your learning curve and where there is an experienced therapist. They can explain the rationale for particular treatments and assessments (and why others were not selected) and their clinical reasoning.
Reflect regularly on your day-to-day practice and look at early entries to affirm your growing skills and competence. We often learn far more from our mistakes and challenges than from our successes.

Pay attention to your balance of work, rest and play. Gather resources to help you understand and deal with stresses of work and to learn the skills that will make work less stressful.

Many of the materials on clinical reasoning and the reflective aspect of professional practice may not have seemed important during student life. These become more valuable once you are in practice. Build time for discussions and readings on professional practice into your schedule, even if only for a few minutes a week.

Recognise that the first year is tough and that you adapt to your first job in stages. Needing time to get up to speed is an essential part of development that cannot be skipped, and this natural process should not be mistaken for incompetence.

Make an effort to enjoy the challenges and pressures of new learning on a client-by-client basis – you are gathering material that you will use in years to come. Some of these memories will always remain fresh as reminders of valuable learning situations.

Engage in regular supervision. Pay attention to the persons with whom you work who can support you, confront you and teach you.

Use the strengths of other disciplines to enhance your own practice. This interaction and co-operation within a team can lead to more effective teamwork and an improved work atmosphere.

Bite the bullet. You will need to do additional daily and weekly preparation on your own time. All professionals who practise effectively do this.

Take your holidays and call in sick if you do not feel well. If you are sick, you need to recover, not push yourself harder.

Pay attention to how much you and others complain about your work life and get out of that group if it is too much. Change the things you can and recognise when it may be to limit contacts and move on.

Learn what you can, even in a job that is not quite right for you. You may need to work in a number of different settings before you find your niche as an OT.

Recognise the value of the skills you do have. You are up to date on theory, enthusiastic, open to new ideas, committed to lifelong learning, and prepared as an
evidence-based practitioner. You will learn from your job, but you also have much to contribute.

Identify continuing education activities in your deficit areas or on topics specifically related to your new position. Do this even if it is not an area of great interest for you.

Learning new skills from enthusiastic practitioners is one way to increase interest in an area and to lower your anxiety over job demands.

Conclusion
We close our discussion with a summary of advice from other therapists at the end of their first year of practice. These are the things they wished they had known at the start:

• realise that you are better prepared than you think. You have the skills to find the necessary resources and to problem solve.
• understand that your first job will be challenging because of all the adjustments (new job, full caseload, changes to the health care system, synthesising basic skills and knowledge in daily practice)
• try to limit the work you take home with you, and make sure you leave work on time at least one or two nights a week. Otherwise, you will burn out and start to resent your job.
• be prepared for the difficulty of separating from your clients when you leave a job.

Everything is difficult before it becomes easy - including clinical practice – this process is a normal stage of professional development. Developing coping strategies in areas within your control may lower your stress levels and ease your adaptation to the exciting world of professional practice.

References
Successful completion of
The Preceptorship Programme
Statement

I confirm that the Preceptee________________________________
has successfully completed their period of Preceptorship and has
achieved their Preceptorship Learning Outcomes

Preceptee sign _________________________________________

Preceptor sign __________________________________________

Clinical Manager sign _____________________________________

Date of successful completion ______________________________

On completion of this form the appropriate OT lead to be contacted to
review portfolio of evidence and confirm completion of Preceptorship
Programme

Head/ Consultant OT or Associate Director/ Lead AHP Sign

___________________________________

This form to be retained on the preceptee’s personnel file with copy to
Associate Director for Allied Health Professions
# CLINICAL GUIDELINE - NAMED NURSE

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## SCOPE

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The Director responsible for monitoring and reviewing this Clinical Guideline is Executive Nurse
1.0 INTRODUCTION

2.0 SCOPE

3.0 DEFINITIONS

4.0 RESPONSIBILITIES

5.0 ALLOCATION OF THE NAMED NURSE

6.0 ROLES & RESPONSIBILITIES OF THE NAMED NURSE

7.0 ASSOCIATE NURSING

8.0 MONITORING

9.0 ASSOCIATED POLICIES & PROCEDURAL GUIDELINES

10.0 REFERENCES
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

NAMED NURSE CLINICAL GUIDELINE

Assurance Statement

This purpose of this guideline is to provide a framework for the implementation of Named Nursing across EPUT mental health & learning disability in-patient/Nursing Home areas and to ensure that there is clarity on the role and responsibilities of the named nurse.

1.0 INTRODUCTION

1.1 The Trust’s commitment to high quality care and safety is paramount and as such the purpose of these clinical guidelines is to provide clear guidance to staff in relation to the role of the named and associate nurse when a patient is admitted to EPUT in-patient services.

‘Patient’ will be the terminology used throughout this document and refers to patients, residents and individuals.

1.2 Originally launched within the UK in 1991, all patients have the right to receive the care of a named nurse (DH, 1991). Named nursing is best considered a development of primary nursing, which involves four essential elements: patient allocation and the acceptance of responsibility for decision-making; individual assignment of daily care to a single nurse; direct communication; responsibility for the quality of care delivered to an individual patient (Shebini & Agarwal, 2008). Francis (2013) recommends the practice of identifying “nurse who is in charge of each patient’s care, so that patients and families are clear who is in overall charge of that care.”

1.3 The primary role of the named nurse is to co-ordinate the delivery of individualised comprehensive nursing care from the point of admission to the point of transfer/discharge in collaboration with the multi-disciplinary team

1.4 To ensure continuity of care; an associate nurse, who will fulfil the duties of the named nurse during his/her absence, will be allocated to the patient. It is the responsibility of the ward/unit Senior Sister / Nursing Home Manager/Charge Nurse to ensure that the leave periods of the named nurse and associate nurse do not overlap. Where this is not possible, for example where either of the individuals has unplanned absence and the other is on leave, a further associate nurse must be allocated.

1.5 People who use services should have their individual needs established through assessment when they are referred or begin to use the service.

1.6 The key objective of named nursing is to provide and coordinate the best possible quality of care, by recognising and utilising the skills of all team members, led by the named nurse.
1.7 The benefits of this model of care are as follows:
- patients are able to identify one nurse who is specifically and consistently responsible for their overall care;
- there is the opportunity for the nurse to maximise the therapeutic value of the practitioner-patient relationship and thereby enhance trust and collaborative working;
- there are opportunities to develop consistent and extensive knowledge across episodes of care;
- those involved in the care of the individual can easily identify the nominated nurse who coordinates the patient Nursing Home and in-patient care;
- Named nursing increases the equitability and consistency of workload distribution among team members.

1.8 Within in-patient services the care of the patient should be managed within the framework set out in the Care Programme Approach (CPA). The role of the named nurse, therefore, is to work with the care co-ordinator, who will plan and provide care in accordance with the CPA framework.

1.9 For Nursing Homes the framework for care of the patient will be set out within the Nursing Home Manual and Model of Care.

2.0 SCOPE

2.1 This clinical guideline sets out the standards for the allocation and responsibilities of a named and associate nurse and applies to all nurses working within EPUT Mental Health and Learning Disability in-patient units/wards and Nursing Homes.

2.2 This clinical guideline applies to adults (people of working age and older people), children and adolescents and adults with a learning disability in a Nursing Home and on in-patient units across EPUT.

3.0 DEFINITIONS

3.1 The named nurse is a registered nurse who is responsible for assessing, planning, implementing, evaluating and coordinating patient care on an individual basis with a patient or a caseload of patients from admission / transfer to transfer / discharge.

3.2 An associate nurse is a registered or enrolled nurse, or an experienced and skilled support worker (who has been assessed by the Senior Sister / Charge Nurse/Nursing Home Manager as possessing the appropriate competencies) who provides nursing care in the named nurse’s absence.

4.0 RESPONSIBILITIES

4.1 The Trust Board is responsible for:
- Ensuring that the principles of this clinical guideline and other associated policies are implemented across the organisation;
- Ensuring the necessary financial resources.
4.2 **The Executive Director of Mental Health / Executive Nurse** will ensure:
- That this clinical guideline is embedded within clinical practice;
- That this clinical guideline is reviewed and updated regularly in line with recommended best practice and national guidance;
- That the learning derived from quality monitoring and from the review of published local and national enquiries is incorporated into clinical practice.

4.3 **Unit/Ward Senior Sisters / Charge Nurses/Nursing Home Managers** will ensure:
- The appointment of a named nurse and associate nurse for each patient on admission;
- That all staff, including new employees, whether temporary or permanent, are made aware of the principles detailed within this policy and that the related procedural guidelines are implemented in order to ensure adherence with all relevant guidance;
- That the implementation of this clinical guideline is monitored with support from the risk management and clinical audit teams (via clinical audit), and through supervision.

4.4 **The Workforce, Development and Training Department** will ensure the provision of training and education to meet identified needs.

4.5 **Individual Staff** will ensure:
- That the principles contained within this clinical guideline are implemented;
- Attendance at appropriate training.

### 5.0 ALLOCATION OF THE NAMED NURSE

5.1 The Nursing Home Manager/ward / unit Senior Sister / Charge Nurse (or their deputy) is responsible for the allocation of a named and associate nurse to the individual within the first 24 hours of admission to an in-patient or Nursing Home facility.

5.2 The process of allocation must give due consideration to issues relating to the patient’s expressed preferences, age, gender, religion, diversity and specific needs. The patient’s preferences should be honoured where possible and appropriate.

5.3 In ideal circumstances, the admitting nurse should be allocated as either the named or associate nurse, as this will allow for the nurse to be fully engaged in establishing a therapeutic relationship and become familiar with the individual and his/her needs from the point of admission.

5.4 Where there is evidence of prior named nursing of a person, particularly where a sound therapeutic relationship has been developed, and where all are in agreement, the named nurse can be re-allocated (*dependent on workload*).
5.5 The Nursing Home / ward / unit Senior Sister / Charge Nurse (or their deputy) must consider the availability of the named and associate nurse when making decisions about allocation, and ensure that leave / study periods of the named nurse and associate nurse do not overlap. Where this is not possible, for example where either of the individuals has unplanned absence and the other is on leave, then a further associate nurse must be allocated.

5.6 It is recommended that the named / associate nurse will not be allocated more than 5 patients at any one time.

5.7 A named nurse or associate nurse must not undertake the role of named nurse for a patient who is a friend or relative.

6.0 ROLES AND RESPONSIBILITIES OF THE NAMED NURSE

6.1 The named nurses’ overall responsibility is to be accountable and provide continuity for the coordination of inpatient care, which will involve regular liaison with the patient's community care coordinator (where one has been allocated).

6.2 The named nurse will introduce themselves and explain their role as the named nurse to the patient and his/her main carer(s). This should be clearly identified within the clinical records and care planning documents of the individual.

6.3 The named nurse and the associate nurse are responsible for establishing a therapeutic relationship with the patient in order to further assess his/her condition and risk status, agree goals for care, plan care in accordance with individual needs and risk issues, and provide the patient with time for receiving individual care intervention on the ward/nursing home when they are on shift.

6.4 A flexible approach will be needed to foster and maintain purposeful and effective engagement with the individual. Engagement must be based on assessment and identification of need and the individual must be made aware of the frequency and duration of individual sessions.

6.5 For in-patient services where the patient is not previously known to EPUT services the named nurse will act as the care coordinator until one is appointed from within a community team (referral for a care coordinator should be made within 3 days of admission).

6.6 The named nurse will maintain a high level of communication and cooperation between all those involved in the care and treatment of the patient. Where the patient has an allocated community care coordinator, the named nurse will maintain open communication with the care coordinator about the individuals' progress and recovery. The community care coordinator will retain his/her responsibilities for actively over-seeing the patient’s CPA care plan, in close liaison with the named nurse throughout the period of in-patient/nursing home care.
6.7 The named nurse will coordinate the development, implementation and evaluation of the agreed collaborative care plan, appropriate to the patient’s needs. Every effort should be made to involve the individual and his/her carers where appropriate, evidencing their involvement within the care record.

6.8 The named nurse will consider the individual's likely needs upon discharge, from the point of admission, thereby facilitating effective and timely discharge planning.

6.9 The named nurse will ensure that all those involved in the patients care are informed of significant changes in their circumstances.

6.10 With the consent of the patient, the named nurse will make regular contact with the patient’s family carer(s) in promoting their engagement, providing information and offering support as appropriate.

6.11 The named nurse will address issues raised by the patient and make these known to those involved in his/her care, and particularly if the patient feels unable to do this.

6.12 The named nurse will attend multi-disciplinary care review / CPA meetings as appropriate.

6.13 The named nurse will fulfil the requirements of the Mental Health Act (MHA), Code of Practice and Mental Capacity Act where appropriate, which will include: explaining legal rights to the patient; ensuring the assessment of capacity; preparing reports for and attending MHA Review Tribunals.

6.14 The named nurse will be responsible for all care documentation relating to comprehensive clinical assessment, care planning and its implementation. This will include ensuring that there is a written and personalised care plan, of contacts with the patient and the carers’ views on the content of the care plan, and ensuring that the documentation is completed as required by Trust policy.

6.15 The named nurse is responsible for taking reasonable steps to ensure the continuity of planned care in their absence (see next section).

7.0 ASSOCIATE NURSING

7.1 The associate nurse will fulfil the duties of the named nurse during his/her absence to ensure continuity of planned care.

7.2 The associate nurse will introduce themselves and explain their role to the patient and his/her main carer(s). This should be clearly identified within the clinical records and care planning documents of the individual.
8.0 MONITORING

8.1 The team leader/manager will routinely monitor implementation and compliance with this guideline.

8.2 A component of management supervision must include the scrutiny of records/documentation relating the responsibilities of the Named and Associate Nurse.

9.0 ASSOCIATED POLICIES AND PROCEDURAL GUIDELINES

This clinical guideline should be read in conjunction with the following:

CG20 - Clinical Handover Clinical Guideline
CG24 - Admission, Discharge and Transfer Clinical Guideline
CLP30 - CPA Policy and Handbook
CP9 - Records management policy

10.0 REFERENCES


END
# CLINICAL GUIDELINE FOR CLINICAL HANOVER

| CLINICAL GUIDELINE REFERENCE NUMBER: | CG20 |
| VERSION NUMBER: | Clinical Guideline for Clinical Handover |
| REPLACES SEPT DOCUMENT | No previous guidance |
| REPLACES NEP DOCUMENT | |
| KEY CHANGES FROM PREVIOUS VERSION | Associate Director Older Peoples Inpatient Services, Associate Director, Practice Development |
| AUTHOR: | |
| CONSULTATION GROUPS: | Team Leads Trustwide (MH/LD) Operational Service Leads/Managers Compliance Team Risk Team Mobius Team Workforce Development and Training Clinical Governance & Quality Sub-committee |
| IMPLEMENTATION DATE: | May 2018 |
| AMENDMENT DATE(S): | |
| LAST REVIEW DATE: | February 2018 |
| NEXT REVIEW DATE: | February 2021 |
| APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB COMMITTEE: | 16th March 2018 |

## CLINICAL GUIDELINE SUMMARY

These Clinical Guidelines provide concise guidance to ensure that there is a system of effective communication between shift changes, which is intended to transfer essential information and highlight any associated risks necessary for the delivery of safe, holistic care of patients.

‘Patient’ will be the terminology used throughout this document and refers to patients, residents and service users.

The Trust monitors the implementation of and compliance with this clinical guideline in the following ways:

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The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Director, Mental Health
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2.0 SCOPE

3.0 STANDARDS

4.0 RESPONSIBILITIES

5.0 MONITORING & REVIEW

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7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

APPENDICES

APPENDIX 1 – CLINICAL HANDBOOK STANDARD MONITORING TOOL

APPENDIX 2 – CLINICAL HANDBOOK RECORD

APPENDIX 3 – SHIFT CHECKLIST
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1.0 INTRODUCTION

1.1 Clinical handovers focus upon the transfer of information and the establishing of a shared plan of care for the oncoming shift. It involves the accurate and reliable sharing of information that relates to the planning of patient care, the identification of safety concerns and the continuity of safe and effective care (based upon: Alvarado et al 2006).

1.2 The handover of information will predominately relate to the patient’s / resident’s health and will always include the following:
- Discussion on the current presenting risk,
- physical health observations and physical health care issues,
- level of engagement and prescribed observation levels,
- Mental Health Act (MHA) status,
- leave status,
- updating staff on current plans made in Multi-Disciplinary Teams (MDT) or care reviews,
- any untoward incidents or occurrences,
- allocation of tasks for the oncoming shift;

1.3 The clinical handover process will be undertaken at the commencement of each shift and is of particular importance to members of staff who have returned to work following days off from duty. Staff-members must ensure that they have given a comprehensive hand over as required to maintain safe practice.

1.4 The features of an effective clinical handover are recognised as: ensuring good communication; no / minimal interruptions; focusing upon relevant information; and prioritising the transfer of important information.

1.5 Clinical handovers will be undertaken in a clear, succinct manner, following a standardised system, allowing for effective, safe, risk focused communication between staff.

1.6 All contributions from staff attending the clinical handover should be heard with an expectation of challenge between members in an effort to achieve consensus.

2.0 SCOPE

2.1 This Clinical Guideline sets out the standards for Clinical Handovers within EPUT mental health inpatients.

2.2 This includes Mental Health wards, nursing homes and other teams within EPUT mental health inpatients where clinical handovers take place.
3.0 STANDARDS

3.1 Location

All clinical handovers will be undertaken in an area free from disruption, and the time dedicated will be protected from any non-emergency interruptions (NHS Institute 2008).

This will ensure that:
- All patient issues will be discussed free from the distraction of telephones, other healthcare professionals, relatives and patients;
- Discussions will remain private and not overheard.

3.2 Key Information to be included

At commencement of shift the oncoming nurse in charge walks the ward with outgoing nurse in charge to visibly confirm patients / residents. As a minimum clinical handover documentation should include an updated copy of the following for each patient / resident:

- patient’s / resident’s name;
- date of admission;
- current reason for admission;
- physical health issues;
- diagnosis including physical illnesses;
- named nurse / Care Co-ordinator;
- MHA (legal) status;
- level of engagement, therapeutic observation and leave status;
- summary of identified risks and risk status (where the zoning clinical risk management method is implemented, the patient’s / resident’s RAG status will be identified);
- presentation and any incidents in the previous 24 hours;
- summary of the plan of care and required interventions;
- current medication and any changes;
- any interventions that will impact on the staffing requirements (i.e. escorts)

The nurse leading the clinical handover should directly and verbally refer to:

- the patient / resident current physical and mental health presentations for the shift and identified health problems and required interventions, using the SBAR (Situation, Background, Assessment & Recommendation) model of escalation, and the outcome provided / offered interventions;
3.3 Staff Attendance

The clinical handover will be attended by:

- At least one qualified nurse from the outgoing shift or a person judged to be competent for areas that have been designated as not requiring a qualified nurse on duty
- The support worker who has been allocated to each patient / resident should handover those who have been in their care;
- All staff from the oncoming shift and, when possible, staff who are working long days;
- The team doctors (when available);
- Allied Health Professionals (when available)

Students and new staff to the area will attend clinical handovers as frequently as possible in addition to their start of shift handover. Senior students will be expected to be supervised by qualified staff to practice leading clinical handovers.

Other health and social care professionals who have input to the care of patients / residents can be asked to attend when appropriate.

3.4 Conducting the clinical handover

The clinical handover will commence on time, at the beginning of each shift, and all verbal exchange to be succinct, to the point and relevant to patient’s current presentation. It is the individual responsibility of each member of the oncoming team to ensure they attend on time to receive the information regarding the care of the patients / residents.

The nurse(s) who will be responsible for conducting the handover of information to the oncoming shift must be allocated at the beginning of the shift, allowing adequate time to prepare. To ensure the accuracy and enhance the quality of information that will be handed over the verbal exchange of information must be complemented through the use of written information such as the care records and the use of a written shift handover sheet (Appendix 2) or electronic screen where available.

The shift handover sheet (Appendix 2) must be used to hand over to the oncoming night staff and can be used again for the following morning shift hand over. The completed tool must then be signed by both the outgoing and oncoming nurse in charge to ensure all documentation is
up to date, be appropriately stored as per record keeping policy requirements (CP9 Records Management Policy) either through electronic file management or within a suitable folder and secured at the team base.

All new admissions / transfers must be handed over with direct reference to the care record.

Mental Health Nurses in an in-patient or nursing home setting have 24 hour responsibility, therefore after each clinical handover the outgoing and oncoming nurses must account for the wellbeing and whereabouts of each patient including reflection upon mental state and condition. The Nurse in Charge has ultimate responsibility for ensuring this is undertaken as per Trust Engagement and Observation Clinical Guideline CG 8.

3.5 Supervision of Patients

The nurse in charge of the outgoing shift will allocate sufficient staff to be available in patient areas to maintain prescribed levels of observation / engagement.

Staff from the outgoing shift will not leave the ward / home until the handover ends, unless advised otherwise by the nurse in charge.

Allied health professionals attending the ward / unit outside of the handover times should have access to the handover sheets. They should be given the opportunity to ask questions and advised of any risks or details of the patient / resident they will be working with.

3.6 Time Management

All clinical handovers must commence promptly at the agreed scheduled shift start times.

All staff will ensure their timely attendance for the clinical handover. Staff not present at the formal handover will ensure that they receive a handover from the nurse in charge.

The duration of the clinical handover should be set by issues to be discussed on the day.

4.0 RESPONSIBILITIES

4.1 Ward Sisters / Charge Nurses / Home Managers or Team Leaders are accountable for ensuring all staff on their wards / teams / home are aware of the clinical guidelines and that they are competent to carry it out. The individual shift leader is responsible for implementing the clinical guidelines.

4.2 Clinical Leads and Clinical Managers are accountable for ensuring that their service areas are upholding the clinical guidelines at all times.
4.3 Qualified staff are expected to be competent to handover. In areas where a non-qualified person is required to handover, the qualified staff will ensure that the delegated person is competent to lead a handover.

5.0 MONITORING AND REVIEW

5.1 In order to achieve and ensure a high quality of practice a series of quality standards for clinical handovers have been established in the form of a monitoring tool, Appendix 1. This tool can be completed by any member of the team to audit and monitor the Implementation of the clinical handover practice standards bi-monthly and/or at the discretion of the Ward Sister/Charge Nurse/Home Manager/Team Leader whose responsibility it is to ensure that regular audits of the clinical handover are undertaken.

5.2 Matrons/Ward Managers will monitor the completion of Appendix 1 through the Ward Sister/Charge Nurse/Home Manager/Team Leader’s appraisal and supervision. The monitoring tool can be used to report areas of concern, and to identify and implement changes to practice, along with providing advice on the review and appropriate changes to this guideline.

6.0 REFERENCE TO OTHER TRUST POLICIES / PROCEDURES

- Records Management Policy and Procedure CP9 and CPG9
- Engagement and Observation Clinical Guideline CG8
- Time off in Lieu Agenda for Change NHS Handbook 2014

END
# CLINICAL HANDOVER STANDARD MONITORING TOOL

**Ward/Team:**

**Date:**

**Name of person completing this form:**

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| 4 Non-emergency situations / all potential interruptions to the clinical handover should be minimised (exceptions: emergency situations):
  - telephones are re-directed (where applicable)
  - a sign is placed on the door to avoid external interruptions | | | |
| 5 The handover is led by a qualified nurse or where required is delegated to a competent permanent member of the ward team | | | |
| 6 The handover is attended by all staff for the oncoming shift | | | |
| 7 The clinical handover record appendix B is used by the person leading the meeting | | | |
| 8 At commencement of shift the oncoming nurse in charge has completed walk of the ward with outgoing nurse in charge to visibly confirm patients / residents. | | | |
| 9 For each patient the key information listed below is included:
  - patient’s / resident’s name;
  - date of admission;
  - current reason for admission
  - physical health issues;
  - diagnosis including physical illnesses
  - named nurse / Care Co-ordinator;
  - MHA (legal) status;
  - level of engagement, therapeutic observation and leave status;
  - summary of identified risks and risk status (where the zoning clinical risk management method is implemented, the patient’s | | | |

**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

**CLINICAL HANDOVER CLINICAL GUIDELINE - CG20**

**APPENDIX 1**
<p>| | |</p>
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<tbody>
<tr>
<td>resident’s RAG status will be identified); presentation and any incidents in the previous 24 hours; summary of the plan of care and required interventions; current medication and any changes; any interventions that will impact on the staffing requirements (i.e. escorts)</td>
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<tr>
<td>10</td>
<td>SBAR has been used</td>
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<tr>
<td>11</td>
<td>Medication chart has been checked</td>
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<tr>
<td>12</td>
<td>Newly admitted patients and those presenting priority risk / healthcare issues are prioritised within the handover with use of their care records</td>
</tr>
<tr>
<td>13</td>
<td>The team diary and/or communication book is reviewed for any required actions that need to be carried out and tasks are allocated</td>
</tr>
<tr>
<td>14</td>
<td>The oncoming Shift Lead coordinates work for the oncoming shift, ensuring the allocation of responsibilities for: o therapeutic observation o physical observations o individual intervention o health &amp; safety (inc. fire warden, first aid, rapid response)</td>
</tr>
<tr>
<td>15</td>
<td>The clinical handover is completed within the agreed timescale</td>
</tr>
<tr>
<td>16</td>
<td>The clinical handover record is signed by the relevant staff-members</td>
</tr>
</tbody>
</table>

**Date monitored by Clinical/Lead/Consultant Practitioners:**

**Signature of Clinical/Lead/Consultant Practitioners:**
<table>
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## Shift Handover Sheet (to be completed for each patient/resident)

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**Vital Signs**

**Physical Health:**

**Mental Health:**

**Information from night staff**

**Long Day**

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**DNAR Date:**

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**NAME:**

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**DNAR Date:**

**DOLS Date:**
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CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT POLICY

CLINICAL GUIDELINE REFERENCE NUMBER: CG28

VERSION NUMBER: 2

REPLACES SEPT DOCUMENT: CG28 Clinical Risk Assessment and Management Clinical Guideline

REPLACES NEP DOCUMENT: Not applicable

KEY CHANGES FROM PREVIOUS VERSION: Information on patient transfer has been added to the procedure on page 8 (6.4)

AUTHOR: Practice Development Lead Nurse and Service Manager

CONSULTATION GROUPS: MH & LD Managers/Team Leads Clinical Governance & Quality Committee Mental Health SMT

IMPLEMENTATION DATE: 1st July 2017

AMENDMENT DATE(S): March 2017; November 2017

LAST REVIEW DATE: 17 March 2017

NEXT REVIEW DATE: May 2020

APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB COMMITTEE: 25 May 2017

RATIFICATION BY QUALITY COMMITTEE: 15 June 2017

CLINICAL GUIDELINE SUMMARY

The principles contained within this policy and the associated documents will ensure that all clinical staff, who work within Essex Partnership University NHS Trust (EPUT) Mental Health and Learning Disability Services or Nursing Homes and are involved in assessing and managing clinical risk, have current information available to them to systematically assess patients, with patient safety in mind.

The therapeutic relationship between the patient and/or relative / carer, and the professional is considered a fundamental element to effectively assessing and managing clinical risk. It is considered that staff, patients, relatives and/or carers will work in collaboration to ensure a thorough assessment of the person, which will include a consideration of risk factors.

To ensure recognised national terminology is used throughout this document the “patient” is used to refer a patient, resident, client or service user.

The Trust monitors the implementation of and compliance with this clinical guideline in the following ways:

<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
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<tbody>
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<td>Trustwide</td>
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<td>CHS</td>
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The Director responsible for monitoring and reviewing this Policy is the Executive Director of Nursing
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Clinical Risk Assessment, Management and Safety Policy

CONTENTS

1.0 INTRODUCTION
2.0 SCOPE
3.0 RESPONSIBILITIES
4.0 LEGAL CONSIDERATIONS
5.0 MONITORING AND REVIEW
6.0 ASSOCIATED DOCUMENTS
7.0 REFERENCES
1.0 INTRODUCTION

1.1 Risk is viewed by the Trust as being dynamic and multi-dimensional, where the process of managing risk is not just focused on eliminating risk, but on realising potential benefits while reducing the likelihood of harms occurring as a result of taking risks, which fits well with a recovery approach to mental health.

1.2 This clinical policy promotes the safety of patients, carers and the public in relation to a range of clinical risks to self and others (including, self-harm, suicide, neglect, vulnerability and violence) whilst maximising the patients independence, social inclusion, and recovery.

1.3 The policy and associated guidelines identifies key principles for assessing and managing clinical risk with patients: promoting open and honest communication between all patients and staff; treating each patient as an individual, promoting choice, collaborative risk assessment and safety management and positive risk taking.

1.4 For patients subject to CPA the Trust’s Care Programme Approach (CPA) and Non CPA Policy and Handbook provides documentation and further information on the principles to be followed by staff with regard to the CPA process, which includes risk assessment and risk management.

1.5 Specific objectives are to:
- ensure that clinical risk is robustly managed and, in the event of an incident, investigated, which will include understanding the root causes and identifying learning;
- improve practice and/or systems and policies;
- minimise the risk of incidents and accidents occurring;
- comply with practice and governance requirements.

1.6 A person’s care must be based upon an individual assessment of needs and risks that is developed in a collaborative and therapeutic manner, in accordance with the Trust’s CPA and Non CPA Policy (CLP30). The development of the therapeutic relationship is considered the most valuable tool in reaching decisions regarding care and treatment.

1.7 This clinical policy considers recommendations made following The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCIS) Making Mental Health Care Safer (Annual Report and 20-year Review, October 2016) and lessons learned from various independent inquiries and various organisational and national reports from the National Patient Safety Agency (NPSA).
1.8 Forming an open and transparent therapeutic relationship with the patient and carer is critical to the process of developing a meaningful, collaborative risk assessment and risk safety plan. Professional skills and clinical judgement are key to the success of this collaboration and require professionals to critically consider each patients individual circumstances and to develop interventions that are directly tailored to the individual.

1.9 Provides consistency with the government Department of Health (March 09) guidance for assessing and managing risk in mental health services which provides a benchmark for daily practice. The guidance balances care needs against risk needs and emphasises:

- positive risk management
- collaboration with the patient and others involved in care
- the importance of recognising and building on the patients strengths
- the organisation’s role in risk management alongside the individual practitioner’s (Dept. of Health March 2009).

2.0 SCOPE

2.1 Is for all Trust and social care seconded staff, whether permanent or temporary, who are working with patients in EPUT Mental Health and Learning Disability Services, including Nursing Homes.

2.2. This policy should be used in conjunction with the associated Trust policies, procedures and protocols, covering aspects of care pathways and risk/safety management including CPA and non CPA care.

2.3 This policy and associated procedure endorses that working in partnership with patients, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3.0 RESPONSIBILITIES – DUTIES

3.1 Accountability for managing risk: Responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, patients and carers

3.2 The Trust Board is responsible for:

- Ensuring that the principles of this policy and procedure and other associated policies are implemented across the organisation;
- Ensuring necessary financial resources.
3.3 **The Executive Director of Nursing** will ensure:
- That this policy and procedure is embedded into clinical practice;
- The regular review and updating of this policy and procedure and in accordance with national guidance;
- The identification and implementation of training to meet educational needs arising from any relevant audits, reviews, reports and lessons learnt.

3.4 **Directors and Senior Management** will:
- Monitor the implementation of this policy and procedure via regular clinical audit and supervision, in accordance with the Trust’s Policy on the Supervision of Staff.
- Co-ordinate the management of clinical risk within the Trust and identify risks in a clinical context. This includes designing and implementing steps to investigate those risks.
- Reports to the appropriate Committee/Quality group for decision making.
- Have a structured, robust approach to incident investigation which looks beyond immediate actions and assumed causes and identifies the contributory factors, latent conditions and root causes which lead to an incident occurring.
- Monitor risk issues such as ligature risks including clinical risk issues
- Address clinical risk issues with relevant line managers
- Ensure the implementation of national guidance
- Assist in the setting of standards and create mechanisms for monitoring and audit.

3.5 **Managers /Team Leaders/ Matrons/ Sisters and other Persons in Charge** will:
- Ensure the procedures and principles detailed within this policy are followed, to meet with all relevant guidance.

3.6 **Individual:**
- Must ensure that the principles contained within this policy and associated procedures are followed.
- Must adhere to Trust policy and procedures.

3.7 In order to achieve the aim of minimising and managing risk, the following mental health practice standards will be implemented. These include standards set by the Royal College of Psychiatrists, the Nursing and Midwifery Council and the Health Professional Council for Allied staff.
Practice Standards – all staff will:

a) Receive a local induction and be briefed on appropriate procedures. Individuals will be required to sign to confirm that the following areas have been covered within their induction: clinical policies; record keeping policies; agreed clinical protocol for ECT; security training for secure services.

b) Have clear lines of responsibility for the administrative maintenance of clinical records, including the filing of reports and records of treatment CP9 Record Management Policy.

c) Have access to Trust’s electronic systems. That will be fully documented: within Essex, systems will be in place to ensure ease of access and 24-hour availability of information for all clinical staff (CPA and Non CPA Policy); within Bedfordshire, systems will be in place to ensure that out of hours contact is documented as soon as is practicable.

d) Have a clear understanding of the interface between health and social care. It is essential that care plans, support plans and risk management safety plans record the responsible agency and individual.

4.0 Key Legal and Governance Frameworks Underpinning Approaches to Risk:

4.1 Duty of care
Organisations must maintain an appropriate standard of care in their work and not be negligent. Individuals who have mental capacity to make a decision, and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.

4.2 Human rights
All public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights, especially when the person has capacity.

4.3 Health and safety
There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.

4.4 Mental capacity
This is concerned with a person’s ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.
4.5 **Fluctuating mental states and dementia**

The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.

4.6 **Safeguarding**

For people who are considered to be vulnerable there is a need to consider the factors of empowerment and safety, choice and risk. Practitioners need to consider when the need for protection overrides decisions to promote choice and empowerment (DH 2007b).

### 5.0 MONITORING

5.1 Ward sisters/managers/team leads will review their team care plans monthly with staff in supervision.

5.2 Yearly audits are done once a year by peer to peer (ward sisters/managers/team leads auditing each other’s) which is co-ordinated by the audit team.

5.3 In addition an annual audit will be undertaken of a random sample of clinical records from each service. The number of records for each service is agreed based on reported incidents and Serious Incidents Requiring Investigation.

5.4 This clinical policy will be reviewed at least once every three years.

5.5 Any amendments to this clinical policy will be submitted to the Clinical Governance & Quality Committee for approval.

5.6 It is the responsibility of each ward sister/nursing home manager/team leader to monitor and to maintain competency of records. Through supervision, ward sisters/nursing home managers/team leaders must review staff in relation to their clinical practice in relation to clinical risk.

5.7 Monitoring of compliance with training will be undertaken by Workforce Development department.

### 6.0 ASSOCIATED DOCUMENTS

6.1 This policy and associated procedure is consistent with the following professional and government bodies’ guidance:
- Nursing and Midwifery Council.
- Royal College of Psychiatrists
- The Health Professional Council
- NPSA/2005/010- Safer Practice Notice
6.2 Associated Trust Documents

- Adverse Incident Policy
- Being Open Policy
- Freedom of Information Act 2000
- Care Programme Approach CLP 30

7.0 REFERENCES

Department of Health: Guidance for Assessing and Managing Risk in Mental Health Services, 31 March 2009.

Department of Health: Best Practice in Managing Risk, June 2007.

NICE Evidence Search | mental health risk management


NICE guidance CG01, Schizophrenia, 2002


The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Making Mental Health Care Safer (Annual Report and 20-year Review, October 2016)
**APPENDIX 1**

Aide Memoire for Assessing Risk and Compiling a Safety Management Plan

<table>
<thead>
<tr>
<th>A Structured Approach to Risk Decision Making</th>
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- Is the required decision *reactive* (to what the person is doing or plans to do) or *proactive* (to be initiated more by the service providers)?
- Is the Patient’s understanding and experiences of risk clearly understood (it may be very different from the professional’s assessment of the risks)?
- Is the carer’s (as appropriate) understanding and experiences of risk clearly understood (it may at times contradict that of the Patient)?
- What behaviours are identified as being risky in relation to the specific circumstances of the decision (i.e. what is your risk assessment)?
- What is the clear definition of the risk that is being taken (the emphasis is on the detail)? Have you considered the other options that are available?
- What are the positive desired *outcomes* to be achieved through taking the specific risk (short &/or long-term)?
- What *strengths* can be identified and used in pursuit of a positive risk-taking plan (including personal qualities, abilities, achievements, resources, motivations and wishes)?
- Are there any clearly defined stages to be accounted for in a risk-taking plan?
- What are the potential pitfalls, and estimated likelihood of them occurring? Have you thought of these in relation to the other appropriate options? [Important for demonstrating that alternatives have been evaluated in the risk decision-making process]
- What are the potential safety nets (inc. early warning signs, crisis and contingency plans)?
- Has this course of action been tried before, and if so what were the outcomes?
- If tried before, how was the plan managed and what can now be done differently (what needs to, and can change)?
- What is your *formulation* from all the above information (clearly weighing up the different alternatives considered and presenting the reasoned decision that has been taken, with appropriate reasons why you have not taken the alternative decision)?
- Who agrees (and importantly disagrees) with the plan?
- How will progress of the plan be monitored?
- When will the plan be reviewed?
APPENDIX 2

Guidelines for Good Documentation

The first question is who are you recording information for (the Trust, you & colleagues, the Patients)?

- Write in language everyone can understand… jargon only serves to exclude people, so if it has to be used add an explanation
- Less use of abbreviations, or clearly reference what they mean
- History is a collaborative process… avoiding making assumptions based on history that are not substantiated in the present… be clear about the relative weight being given to historical information as it links to the present
- Quality chronology of events (an event diary) is about the accuracy of dates and the detail of information (inc. creating a timeline electronically)
- Recency and frequency of events could reflect urgency
- Include a specific focus on individual’s strengths and protective factors
- Reference decisions against something!
- Focus on safety rather than risk (i.e. we assess the risks in order to increase a person’s safety)

Remember

Risk/safety management works best when a Patient’s strengths are recognised alongside the possible problems they might encounter and with which they might present. Every time a problem is identified, a strategy should be suggested and explored, building on the strengths of the Patient.

The emphasis should always be on a recovery approach and on the next stage in developing the Patient’s ability to cope when they are feeling vulnerable or as if difficult demands are being placed on them.
CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT PROCEDURE

PROCEDURE REFERENCE NUMBER: CGPG28
VERSION NUMBER: 2
REPLACES SEPT DOCUMENT CG28 Clinical Risk Assessment and Management Clinical Guideline
REPLACES NEP DOCUMENT Not Applicable
AUTHOR: [Redacted] Practice Development Lead Nurse and [Redacted] Service Manager.

CONSULTATION GROUPS:
- Mental Health and Learning Disability service leads in all areas.
- Frontline clinical staff in MH & LD.
- Risk Department
- Compliance Team
- Mobius Team
- Clinical Governance Subcommittee

IMPLEMENTATION DATE: 1st July 2017
AMENDMENT DATE(S): March 2017; November 2017; June 2018
LAST REVIEW DATE: 17 March 2017
NEXT REVIEW DATE: May 2020
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE: 25 May 2017
RATIFICATION BY QUALITY COMMITTEE: 15 June 2017
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PROCEDURE SUMMARY
This document is intended to guide mental health practitioners who work with patients to manage the risk of harm. It provides a list of tools that can be used to structure the often complex risk management process. The philosophy is one that balances care needs against risk needs, and that emphasises:

- positive risk management;
- collaboration with the Patient and others involved in care;
- the importance of recognising and building on the Patient’s strengths; and
- the organisation’s role in risk management alongside the individual practitioner’s.
To ensure recognised national terminology is used throughout this document the “patient” is used to refer a patient, resident, client or service user.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
SEE CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT POLICY

<table>
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<th>Services</th>
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The Director responsible for monitoring and reviewing this procedure is Executive Director of Nursing
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3.0 DEFINITIONS

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5.0 ACCOUNTABILITY FOR CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT

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15.0 THIS PROCEDURE SHOULD BE READ IN CONJUNCTION WITH THE FOLLOWING TRUST DOCUMENTS

16.0 REFERENCES

17.0 BIBLIOGRAPHY

APPENDICES

APPENDIX 1 - Aide Memoire for Assessing Risk and Compiling a Safety Management Plan

APPENDIX 2 - Guidelines for good documentation
Assurance Statement

Clinical Risk Assessment and Safety Management is part of the Trust's overall risk management strategy and is fundamental to maintaining safety. This policy defines the overarching standards to be employed within all local services relating to the risk assessment and safety management of individual Patients.

It should be used by all staff involved in the assessment and management of clinical risk.

Risk and risk taking are intrinsic to practice in Mental Health/Learning Disability Trusts. Properly managed they are a means of encouraging autonomy, choice and participation for users of mental health services and combating their stigmatisation and social exclusion.

This document is intended to guide mental health practitioners who work with Patients to manage the risk of harm. It provides a list of tools that can be used to structure the often complex risk management process. The philosophy is one that balances care needs against risk needs, and that emphasises:

- positive risk management;
- collaboration with the patient and others involved in care;
- the importance of recognising and building on the Patient’s strengths; and
- the organisation’s role in risk management alongside the individual practitioner’s (Dept. of Health March 2009).

“The most effective organisations are those with good systems in place to support positive approaches rather than defensive ones. The corporate approach to risk that an organisation takes overwhelmingly influences the practice of its workforce (DH 2007).”

1.0 INTRODUCTION

1.1 In Essex Partnership University Trust (EPUT) we are concerned with delivering the best possible mental health service for patients, their family and carers. This means providing a service that is effective, involves patients, their family and carers in decision making so that it is as safe as possible for all involved.

1.2 Risk is viewed by the Trust as being dynamic and multi-dimensional, where the process of managing risk is not just focused on eliminating risk, but on realising potential benefits while reducing the likelihood of harms occurring as a result of taking risks, which fits well with a recovery approach to mental health.

1.3 Managing risk should not just focus on eliminating risk, it is about providing a process for ensuring the potential benefits identified are increased and the likelihood of harms occurring as a result of taking risks are reduced (Titterton, 2005).
1.4 Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted'. (DH, 2007)

1.5 The Trust aims to support patients to recover and safety is integral to this process. Safety can be promoted by treating each patient as an individual, promoting choice, collaborative risk assessment and safety management and positive risk taking.

2.0 PURPOSE

2.1 To provide an agreed Trust-wide structure for assessing clinical risks presented by mental health primary and secondary care patients.

2.2 To utilise agreed tools to assist in clinical risk assessment in conjunction with professional judgment.

2.3 To embed Clinical Risk/Safety Management principles in day-to-day practice, in particular as part of the Care Programme Approach (CPA).

2.4 To enable staff to feel that risks can be identified and reduced by intervention and that tragedies are not always inevitable.

2.5 To enable staff to feel that the clinical management of risk can be strengthened.

3.0 DEFINITIONS

3.1 Risk
Is defined as the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. The risk has to be assessed in respect of the combination of the likelihood of something happening, and the impact which arises if it does actually happen (HMSO 2004).

3.2 Clinical Risk
Is the likelihood or probability of an adverse and / or harmful outcome to an episode of mental illness or distress, or to a particular behaviour associated with that illness or distress.

3.3 Risk Assessment
Is the process of gathering information about a patient's mental state, behaviour, intentions, personal psychiatric history, including any history of physical, sexual or emotional abuse, and social situation, and forming a judgement about the likelihood or probability of an adverse and / or harmful outcome based upon that information.
3.4 Key legal and governance frameworks underpinning approaches to risk:

a) **Duty of care** – organisations must maintain an appropriate standard of care in their work and not be negligent. Individuals who have mental capacity to make a decision, and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.

b) **Human rights** – all public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights, especially when the person has capacity.

c) **Health and safety** – There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.

d) **Mental capacity** – this is concerned with a person’s ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.

e) **Fluctuating mental states and dementia** – The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.

f) **Safeguarding** – For people who are considered to be vulnerable there is a need to consider the factors of empowerment and safety, choice and risk. Practitioners need to consider when the need for protection overrides decisions to promote choice and empowerment (DH 2007b).

3.5 **Formulation**
The application of clinical knowledge in predicting risks, identifying cues and interviewing, to bring together a formulation of risk.

3.6 **Measurement**
The use of an appropriate tool that helps predict the likelihood of a risk occurring.

3.7 **Risk Management**
Is the process of weighing the risk of an adverse and/or harmful outcome to any given situation or course of action against the possible therapeutic and social benefits that may accrue from it, and consequently planning and sanctioning activity or providing safeguards with the aim of minimising the risk and maximising the benefits.

3.8 **Safety Plan**
A safety plan is a prioritised written list of coping strategies and sources of support that patients can use during or preceding crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as
well as a list of individuals or agencies that patients can contact in order to help them lower their imminent risk.

Key risk/safety management/safety planning activities are treatment (e.g. psychological care, medication), supervision (e.g. help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others, and so on), monitoring (i.e. identifying and looking out for early warning signs of an increase in risk, which would trigger treatment or supervision actions), and, if relevant, victim safety planning (e.g. helping a victim of domestic violence to make herself safe in the future and know better what to do in the event of perceived threat).

This approach is consistent with the Recovery Model, which views patients as collaborators in their treatment and fosters empowerment, hope, and individual potential.

3.9 Contingency Planning
Is the process of considering what might go wrong and pre-planning strategies to minimise adverse and/or harmful outcomes.

3.10 Crisis Management
A crisis plan setting out the action to be taken if the patient becomes ill, or their mental health is deteriorating rapidly.

Any early warning signs, relapse indicators, triggers, key events, other risk indicators are to be taken into account in a crisis and the nature of response to a crisis.

3.11 Protective Factor
Any circumstance, event, factor with the capacity to prevent or reduce the severity or likelihood of harm to self, or others.

4.0 CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT PHILOSOPHY: POSITIVE RISK/SAFETY MANAGEMENT AS PART OF BEST PRACTICE

4.1 The Trust is committed to a philosophy of care that values each individual patient and seeks to maximise their well-being and potential for self-fulfilment. This can only be realised if patients are enabled and encouraged to take an active role in the ordering of their own lives.

4.2 Trust practitioners must encourage independence, self-reliance and competence in all patients whilst avoiding a punitive approach. Risks should be balanced against potential benefits using professional judgement and experience within the framework for practice set by the Trust and by their professional bodies.

4.3 Applies to all patients and their relatives and carers.

4.4 Caring for and treating someone living with mental health problems effectively and safely is not an exact science. Consequently, there is likely to remain some risk.
This means that some therapeutic risk-taking may be necessary and unavoidable if individual patients are to progress. Methodical assessment and active management of risks are key steps towards minimising harm and maximising benefit.

4.5 Properly-managed risk-taking based on sound risk assessment can enhance autonomy, empowerment, choice, participation and social inclusion for patients and their relatives and carers, whilst combating stigma. Thus, it is vital that all those caring for and treating people living with mental health problems:

- Identify and understand the risks for and from each individual;
- Evaluate and manage those risks within an agreed framework to the highest professional standards;
- Plan for contingencies and share that plan with patient, carers and all relevant colleagues;
- Clear and concise documentation relating to risks and share appropriately.

<table>
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<tr>
<th><strong>5.0 ACCOUNTABILITY FOR CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT.</strong></th>
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<tr>
<td><strong>5.1</strong> Responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, patients and carers.</td>
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<td><strong>5.2</strong> The Board will ensure that the following is provided:</td>
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<tr>
<td>a) There is an agreed procedural framework for risk/safety management that staff can work to;</td>
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<tr>
<td>b) Training in the assessment and management of risk;</td>
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<tr>
<td>c) Training in the use of systems and techniques that support risk assessment and management;</td>
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<td>d) Safe environments from which services will be delivered;</td>
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<td>e) Necessary agreed flexible strategies and protocols to govern practice;</td>
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<tr>
<td>f) Support staff in the assessment, management and minimisation of risk through supervision and support mechanisms;</td>
</tr>
<tr>
<td>g) Ensure that adherence to relevant legislation and national guidance is audited and procedures are updated appropriately.</td>
</tr>
<tr>
<td><strong>5.3 PROFESSIONALLY REGISTERED PRACTITIONERS</strong></td>
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<tr>
<td>Are responsible for ensuring that they are adequately trained and skilled to carry out patient risk assessments and safety management plans and that they have fulfilled their training requirements.</td>
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Practitioners also have a duty to ensure they carry out patient risk assessments and management/safety planning as part of their professional practice, in line with the principles contained within this policy and the best available evidence.
5.4 **NON-REGISTERED PRACTITIONERS**

Are responsible for supporting the implementation of the risk assessment and management/safety process, under the supervision of a registered practitioner.

5.5 **ALL PRACTITIONERS**

The Trust expects its practitioners in undertaking their duties with patients, relatives, carers and with the public to:

Extend their vision of risk to include:
- The patient
- The patient’s family, friends and carers
- The public
- Children
- Trust staff colleagues
- Workers in other agencies

To also:

a) Understand the concepts of risk and risk/safety management in clinical practice, and the Trust’s philosophy of care;

b) Have a methodical and evidence-based approach to the assessment and management of risk, using agreed tools and methodologies only, following a structured clinical judgement approach;

c) Understand risk as including environmental, psychological and physical aspects;

d) Identify, assess, positively manage and, where possible, minimise risk and increase safety for all, whilst undertaking assessment.

e) Formulate an initial risk assessment within 24 hours and review a risk assessment at least every 6 months and more frequently where risks are fluctuating. Inpatient risk assessment should be at least weekly.

f) For Mental Health / Learning Disability in-patient services and nursing homes, the risk assessment must be reviewed as considered necessary by the clinical team, which may be as frequent as daily, with a formal evaluation of care being undertaken at least once each week, at the patients care review meeting / ward round. This will be coordinated by the named nurse.

g) For community Mental Health / Learning Disability (MH/LD) services, risk assessment must be reviewed as considered necessary by the clinical team however the care coordinator is responsible for ensuring reviews are undertaken, as set out within the Care Programme Approach (CPA) and Non CPA Policy and associated guidelines at a minimum of 6 monthly CPA reviews. For non-CPA patients the allocated caseworker is responsible for facilitating reviews as considered necessary by the clinical team but at least once a year.
h) Risk assessment is a dynamic process and should be under continuous review.

i) Risk/safety management must always be based on awareness of the capacity for the patient’s risk level to change over time and recognition that each patient requires a consistent and individualised approach.

j) Be aware of Trust’s guidance on capacity and consent for all patients, irrespective of age. If the person’s capacity is in question, then undertake an assessment in line with Assessment of Mental Capacity Policy.

k) Weigh the risk of harm to the patient or to others against the potential benefits in relation to patient empowerment and act accordingly.

l) Take no action that contributes to or increases risk;

m) Plan for contingencies dependent upon the risk assessment.

n) Record information about risk and share that information with all who may need it. A risk/safety management plan is only as good as the time and effort put in to communicating its findings to others;

o) Adhere strictly to the guidance and direction given in this document.

6.0 CLINICAL RISK / SAFETY MANAGEMENT AND THE CARE PROGRAMME APPROACH (CPA)

6.1 Clinical risk assessment and safety management is part of the CPA process; however the principles apply to those under ‘non CPA’. All patients’ risks should be assessed.

6.2 This involves identifying specific interventions based on an individual’s support needs, taking into account safety and risk issues.

6.3 A CPA care plan is drawn up, preferably with the patient/carer to meet the patient’s needs. This forms the recorded safety management plan and should include the following:
   ➢ A summary of all risks identified;
   ➢ Identify and document any unmet needs;
   ➢ Actions to be taken to manage risk in a safety plan by practitioners, patients and/or carers.

6.4 A risk assessment must be completed prior to every patient transfer to determine the appropriate mode of transport required for example, secure vehicle, ambulance, taxi and private cars. The risk assessment must include number of staff required for escort and band to effectively and safely carry out the role of escort. Detailed information on this can be found in the Trust Clinical Guide for Discharge and Transfer (CG24).
7.0 TRUST STANDARDS FOR CLINICAL RISK ASSESSMENT & SAFETY MANAGEMENT / CARE PLANS

7.1 Individual practitioners must always use their professional judgement about individual patients’ needs to decide finally whether, when and how clinical risk should be assessed. However, as general guidance, the Trust’s view is that clinical risk must be assessed in situations where:

a) A patient comes into the service for the first time in any treatment episode;

b) A patient’s mental or physical state changes significantly;

c) A patient’s social situation changes significantly including homelessness or change of accommodation, unemployment, change of support network, divorce or breakdown of established relationships and periods of significant contact with other agencies such as police, courts and housing agencies;

d) Pre-determined indicators of relapse or risk (identified in previous risk assessments) are apparent;

e) A patient loses contact with the service in an unplanned way;

f) The care and or treatment offered to a patient changes significantly, including transfer between services /Trusts particularly heightens risks moving from inpatient to community care setting.

7.2 Risk assessment must also be reviewed when the practitioner delivering the majority of the care changes.

7.3 In addition to assessment of risk in response to the events detailed above clinical risk must be reassessed / reviewed routinely (but at intervals not greater than 6 months for community MH/LD services, two weekly for secure services patients and weekly ward-round for inpatients).

7.4 If a patient is admitted or transferred to an in-patient facility for assessment/treatment, the frequency of review should increase proportionately with the risks presented with that treatment episode. This review should involve the Multi-Disciplinary Team (MDT) and any other specialist or professional input as appropriate.

7.5 It is also important that risk assessments acknowledge the reduction of risk when this occurs and the factors which have helped the patient in reducing their risk. This will serve as useful information in the formulation of future risk/safety management plans.

7.6 The Trust’s minimum requirement for risk assessment is the completion of the screening tool and recording of patients’ electronic records or (for services in north Essex) Risk Assessment Module on Paris (with the exception of substance misuse services, who use the Theseus database and Integrated Drug Treatment System (IDTS) Her Majesty Prison (HMP) / Young Offender Institution (YOI) Chelmsford and the Marginalised and Vulnerable Adult Service (MVA) who use System One).
7.7. The Trust’s minimum requirement for a CPA review is the completion of all CPA tools including the care plan and recording in the patient’s records that a CPA review has been done.

8.0 ASSESSING RISK AND COMPILING A SAFETY MANAGEMENT PLAN / CARE PLAN

8.1 Guidelines for good documentation and structured approach to decision making are in Appendix 1 and 2 of this procedure.

9. MANAGING CHALLENGING / ENDURING RISK

9.1 It is inevitable that assessment of clinical risk in people with mental illness or distress will sometimes uncover a level of risk that may be outside the capacity of the assessing practitioner and/or their colleagues to manage, e.g. an identified unmet need or gap in service provision.

9.2 In managing difficult risk, it is the assessing practitioner’s responsibility to:
   a) Inform his/her line manager as soon as possible;
   b) Take reasonable steps to minimise any risk to him/herself, or members of the public where this may be the case;
   c) Seek assistance and/or guidance from practitioner colleagues and the multi-disciplinary team;
   d) Identify other agencies and individuals that may be able to manage and minimise the risk posed and inform them of the risk as a matter of urgency;
   e) Identify other agencies and individuals that may themselves be at risk from the patient in question and inform them as a matter of urgency;
   f) Ensure that the action taken is documented electronically and appropriately, shared with individuals and relevant agencies, in accordance with local agreements and practice guidance.
   g) Discuss caseload management in relation to risk/safety regularly in mandatory supervision.

9.3 It is imperative when a difficult-to-manage risk is identified that consideration be given to holding a professionals meeting.

9.4 The practitioner’s line manager must:
   a) Inform the Director for the area or service concerned about the risk identified and the action taken;
   b) Identify and attempt to resolve any equipment, skills, or staffing deficits that exacerbate the risk;
   c) Mobilise the resources of the Trust and other agencies and individuals to manage and minimise the risk if possible. This may include authorising emergency treatment outside the Trust, authorising the temporary employment of extra staff and or involving the police or other emergency services.
10.0 RISK ASSESSMENT TOOLS

10.1 A clinical risk assessment tool is a contribution to an overall view of the risks presented by a particular patient at a particular time. Completing a risk assessment tool in the company of the patient is not all that is required. The results of a tool-based assessment must always be combined with information on relevant aspects of the patient’s life and current situation, including his or her sources of strength – or protective factors. The assessment is complete only when the practitioner develops a formulation based on the assessment findings and then develops a risk/safety management plan covering treatment, supervision and monitoring options. Most risk assessment tools don’t help evaluate the role of protective factors or to derive formulations or risk/safety management plans.

a) Clinical judgement is integral to interpreting scores attained in any tool due to the range of influential variables (i.e. cultural considerations, understanding, and stigma).

b) Risk assessment tools are not diagnostic and their utility remains founded on excellent clinical practice.

10.2 Practitioners with responsibility for risk assessment may also use one of the recognised and agreed, validated risk assessment tools.

10.3 This should be clearly documented in patients’ electronic CPA records or Paris / Mobius / Theseus / System1 and the completed tool scanned into the patient’s record as well as a copy given to the patient and family/carer.

10.4 The following tools are recognised for use in the Trust. Some tools require specialist knowledge/training to implement/interpret correctly. It is the responsibility of the practitioner to ensure that only validated tools are used and their training in the use of specific tools is up to date:

For services in North Essex:
- Sainsbury Centre for Mental Health Tool for Clinical Risk Assessment
- Beck Scales/Inventories – Hopelessness Scale, Depression Inventory - require specialist training and competency prior to use. (copyright laws – ensure tools are purchased by the service)
- Suicide Ideation Scale, Suicide Intent Scale
- Edinburgh Post Natal Depression Scale
- Worthing Weighted Risk Indicator
- Assessment Tools for Risk of Violence – HCR20 and Hare’s Psychopathy Checklists - require specialist training and competency prior to use. (copyright laws – ensure tools are purchased by the service)
- Short CANE (Camberwell Assessment of Need for the Elderly)
- Pressure Ulcers/Sores – Waterlow Pressure Sore Risk Assessment,
- Assessment of Manual Handling Needs
- Driving
- Risk of Sexual Violence (RSV) (copyright laws – ensure tools are purchased by the service)
Transport Risk Assessment Checklist for Staff Using Private Cars to Transport Clients
- Structured Assessment of Violence Risk in Youth (SAVRY)
- Drug Use Screening Tool (DUST)
- Mother and Baby Assessment (from Mother and Baby Facilities Operational Policy)
- Falls Risk Assessment Screening Tool (from Prevention and Management of Falls Policy)
- Domestic Abuse, stalking, harassment and honour based violence (DASH) 2009 Risk Model for (MARAC – multi agency risk assessment committee)
- AUDIT
- AUDIT C

For services in Bedfordshire and South Essex
Inpatient services/Nursing Homes
- Assessment forms on Mobius, Electronic Records. *(On Mobius - Form 2.1)*
- Trust Needs and Risk Assessment Tools Form 2.1, 2.2 and risk section in Form 16.10. *(On Mobius and on Insite)*
- Malnutrition Universal Scoring Tool (MUST). *(Form 3.5 on Mobius and on Insite)*
- Waterlow Tool. *(On Mobius and Insite (3.33-06))*
- Falls Risk Assessment Tool. *(On Mobius under 2.25-06 and on Insite under Policy/Guideline CG58 Appendix2)*
- Manual Handling Risk Assessment and Care Plan. *(On Mobius, 10.16-02 on Insite under RMPG 03)*
- Infection risk on admission / transfer. *(On Mobius 1.6-00)*
- VTE risk assessment. *(On Mobius 3.16-00 / Insite Form 3.12)*
- The Trust Handover tool. *(On Insite Policy/Guideline CG20 Appendix 1)*

Secure Services:
- Secure Services risk assessment. *(on Mobius 2.31-00 Risk profile)*
- Risk of Sexual Violence Protocol (RSVP) – require specialist training and competency prior to use. *(copyright laws – ensure tools are purchased by the service)*
- Stalking Assessment Manual (SAM) - require specialist training and competency prior to use. *(copyright laws - ensure tools are purchased by the service)*
- Historical & Clinical Risk – 20, 3rd edition (HCR-20) - require specialist training and competency prior to use. *(copyright laws – ensure tools are purchased by the service) [on Mobius under 2.28]*
Learning Disability Services:

- Specific Task Risk Assessment Tool. (*Service specific - kept in team system drive*)
- Initial Risk Assessment Checklist. (*Service specific - kept in team system drive*)
- Learning Disability Therapists Referring Screening Tool. (*2.8-04 on Mobius*)
- CPA documents.

Community Mental Health Teams and Crisis Resolution & Home Treatment

- ECPA Assessment forms including risk component on the care plan. (*on Mobius 10.7-01*)
- Trust Needs and Risk Assessment Tools Form 1.2, 2.1, 2.2 and risk section in Form 16.10. (*on Mobius 10.7-01*)
- Health of the Nation Outcome Scales Payment by Result (HoNOS. PbR.). (*On Live cycle only*)
- Cardio Metabolic Proforma 3-2:01CP which is on Trust intranet. (*on Mobius*)
- Geriatric Depression Scale - commonly used in older people’s services. (*on Mobius*)
- Montreal Cognitive Assessment - commonly used in older people’s services. (*on Mobius*)
- The Domestic Abuse Stalking, Harassment & Honour Based Violence Risk Assessment (DASH). (*on Insite – with Safeguarding tools*)
- Display Screen Equipment Assessment (DSE). (*on Insite*)

Early Intervention services

- EI suicide risk assessment tool which is used occasionally. (*Service specific - not kept on the system*)
- Sad Personas (Sex, Age, Depression, Previous Attempt, Excess Alcohol or Substance Use, Rational thinking, Social support, Organised plan, No Spouse, Sickness). (*Service specific – not kept on the system*)
- Positive and Negative Syndrome Scale (PANSS). (*Service specific - not kept on the system*)
- Comprehensive Assessment of at risk mental state (CAARMS) – requires specialist training to use it. (*Service specific - not on the system*)
- Process of Recovery Questionnaire (QPR) required by Access and Waiting Time (AWT) standards. (*Service specific - kept in team system drive*)
- Dialogue – required by AWT standards. (*Service specific - kept in team system drive*)
- Safety plans used where there is concern. (*Service specific - kept in team system drive*)
Psychology Department:

- Risk Assessment and Management Psychology Services (RAMPS) – used in CMHTs. [On Mobius (2.25-03) and Insite]

Improving Access to Psychological Therapies (IAPT)

- IAPT Risk Assessment form. (*Service specific - kept in team system drive*)
- IAPT Risk Management form. (*Service specific - kept in team system drive*)

10.5 Use of other specialist tools not included in the Handbook is prohibited, unless the tool has been approved by the Trust's Quality and Risk Committee in the north / Clinical Governance Sub-group in the south.

10.6 Any new tools should be submitted for recognition and inclusion by emailing the Director of Quality and Risk in the north / approved by the Clinical Governance Sub-group in the south including the rationale for changing or adding to the above list of validated tools in use in the Trust.

11.0 SAFEGUARDING

11.1 All practitioners should be aware of their responsibilities for Safeguarding and be able to fulfil their obligations required as detailed in the Trust's Safeguarding Policies which are located on the Trust intranet.

12.0 CONFIDENTIALITY AND SHARING PROTOCOLS

12.1 Trust staff have a responsibility to make themselves familiar with the Trust policies and procedures which are on the Trust intranet and these will support staff in making the right decision when to disclose and when not to disclose patient information.

12.2 The following documents can be useful to staff when assessing and managing clinical risk:

- Information Sharing & Consent Policy and Procedure
- Access to Health and Social Care Records Policy and Procedures
- The Unified Written Health and Social Care Record Policy
- Confidentiality and Information Sharing Protocol
- Information Sharing Protocol/Memorandum of Understanding agreed between Police, Probation Service, Social Services and Mental Health Trusts in Essex (MAPPA)
- Whole Essex Information Sharing (WEIS) (internet only)
13.0 QUALITY AUDIT

13.1 All inpatients wards are required to undertake a monthly care plan and risk assessment audit of their entire caseload. This is a brief audit covering basic essential information:

   a) Care plan present in notes
   b) Evidence of carer involvement
   c) Information in patient’s care plan is linked to identified risk
   d) Care plan signed by staff
   e) Care plan signed by patient
   f) Care plan recorded in patient’s records on Paris/Mobius as shared
   g) Care plan review date
   h) Risk assessment completed and dated
   i) Risk management plan in place

13.2 The Quality Care Plan and Risk Assessment Audit consisting of set of standards (covering care planning, risk assessments, physical health, crisis plans, consent & capacity, carers and service user involvement in care planning) against which the inpatient units and community teams are to audit monthly. The audits are completed by ward managers in the team with generally a sample of five records audited per month (less than where agreed).

13.3 As the care plan and risk assessment audit is self-reported, a spot check process to be implemented whereby a few team’s results from different services are spot checked monthly by the quality team. This is to ensure that team reported results are accurate and independently verified so that additional support can be provided to teams requiring it.

13.4 Community mental health teams are required to undertake audits of care plan and risk assessment during monthly supervision with staff.

14.0 MANDATORY RECORD-KEEPING AND TRAINING

14.1 The Trust’s primary recording instrument is the electronic health record which is accessible at all Trust sites via the Trust’s network to those authorised professional staff, that must access and use the system to record patient details and all clinical activity.

14.2 For substance misuse/HMP/YOI Chelmsford (IDTS)/MVA, the electronic recording systems are Theseus and Systm1 respectively. To ensure we minimise risk to patients, Trust staff and the public, all clinical risk assessments and risk/safety management plans for a patient must be recorded in full detail on the electronic systems, providing 24 hour electronic access to the information for other Trust professional staff who may need access to the patient’s risk assessment/safety plan; this is particularly
pertinent to out of regular working hours, weekends and Access and Assessment teams.

- For any substance misuse/IDTS/MVA information on patients this can be obtained during office hours by calling the services directly.

- All substance misuse admin staff has access to ‘read only’ Paris in order to obtain details of patient risk assessments/safety plans.

- Outside of regular hours, all Access and Assessment Teams have ‘read only’ access to Theseus in order to obtain patient risk/safety plan information.

- IDTS Chelmsford offers 24 hour access via telephone for any patient risk/safety plan information.

14.3 All staff will receive training in line with the Trust Induction and Mandatory Policy. Team managers who feel they need specific training in relation to clinical risk should contact the Workforce Development Education and Training department.

14.4 Staff who work in Secure Services will receive yearly mandatory security training as face to face and online training (OLM) in line with their work area protocols.

14.5 Clinical staff providing clinical care should have a basic understanding of personalised care planning and the importance of involving patients in their process. Detailed training will be provided as required for clinicians delivering care i.e. registered nurses, therapists, doctors and any other clinicians who develop care plans. Ward Managers/Sisters / Team Leaders will provide coaching and support to new team members to ensure effective, high quality personalised care plans.

14.6 The Assessment and Management of Clinical Risk training programme will include the following:

- Principle types of risks
- Indicators of risk
- The process of assessing and managing risk
- Conducting risk assessment through a collaborative approach, involving different sources of information
- Communication between professionals, patients, agencies, and with the carer(s)
- The use of approved risk assessment tools and documentation
- Positive risk taking
- Reference to a series of associated trust clinical policies and procedures.

14.7 In addition, the Trust will provide educational programmes on the following:

- Mental Health Act
- Restricted practices.
- Staff training needs have been identified as part of a Trust-wide training needs analysis, as summarised below:
The Workforce Development and Training Department will report monthly on compliance levels for mandatory training.

The Workforce Development and Training Department will report monthly on compliance levels for mandatory training.

Managers are responsible for ensuring staff who are approaching update deadlines and those that are out of date take action to undertake training as soon as possible.

A service manager will be able to check which training has been undertaken by a member of staff through:
Trust online Training Tracking List, which will be validated to confirm training has taken place.

**15.0 THIS PROCEDURE SHOULD BE READ IN CONJUNCTION WITH THE FOLLOWING TRUST DOCUMENTS**

- Access to Health and Social Care Records Policy and Procedures
- Appointments Policy Incorporating the Non-Attendance Procedure
- Mental Capacity Act Deprivation of Liberty Safeguards Policy
- Mental Capacity Act Deprivation of Liberty Safeguards Procedure
- Care Programme Approach (CPA) & Non CPA (Standard Care) Policy and procedure
- Confidentiality and Information Sharing Protocol
- Policy for Consent to Examination or Treatment
- Discharge Policy
- Getting it Write guidance
- Guidelines for the Use of an Integrated Mental Health Information System (Paris)
- Incident Reporting Policy and Procedure
- In-Patient Leave Procedure and Policy
- In-Patient Observation and Engagement Policy
- Mandatory Training Matrix
- Manual Handling Policy and Procedure
- MAPPA Agreement
CGPG28 - CLINICAL RISK ASSESSMENT AND SAFETY MANAGEMENT PROCEDURE

- Operational Policy for the Mental Health Care Record and Information System (Paris)
- Patient Safety Environmental Standards
- Physical Health Care Policy
- Prevention and Management of Violence and Aggression at Work, Policy, Procedure and Guidelines
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Searching of Patients and their Property Policy
- Therapeutic and Safe Interventions (TASI) in the Management of Aggression and Violence (Including de-escalation and ‘time out’ and post incident reviews and debriefing) Policy
- The Unified Written Health and Social Care Record Policy
- The Use of Medicines Policy and Procedures Handbook
- Transfer of Care Policy

16.0 REFERENCES


17.0 BIBLIOGRAPHY

Centre for Mental Health and Mental Health Network, NHS Confederation. Risk, Safety and Recovery (Boardman, J. and Roberts, G. 2014)

Centre for Mental Health and Mental Health Network, NHS Confederation. Supporting recovery in mental health services: Quality and Outcomes (Shepherd et al, 2014)


NHS Code of Practice – Confidentiality, 2003


END
Policy for Cardiopulmonary Resuscitation (CPR)

POLICY REFERENCE NUMBER: CLP14
VERSION NUMBER: 1
REPLACES SEPT DOCUMENT CLP14
REPLACES NEP DOCUMENT CP8/Resuscitation/02/16
KEY CHANGES FROM PREVIOUS VERSION Merged policies; updated appendices; additional procedure Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

AUTHOR: [Redacted]
CONSULTATION GROUPS: Trust wide, Resuscitation and Deteriorating Patient Group
IMPLEMENTATION DATE: 1 July 2017
AMENDMENT DATE(S): Not applicable
LAST REVIEW DATE: May 2017
NEXT REVIEW DATE: May 2020
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE: 25 May 2017
RATIFICATION BY QUALITY COMMITTEE: 15 June 2017

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POLICY SUMMARY

The purpose of this policy is to ensure prompt, safe, early and appropriate cardiopulmonary resuscitation (CPR) within Essex Partnership University NHS Foundation Trust (EPUT). The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK) 2015).

For detailed guidance on practice and standards relating to management of the Deteriorating Patient and CPR, refer to the EPUT Clinical Procedure for Cardiopulmonary Resuscitation and Clinical Procedure: Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

All inpatient service users are monitored for signs of physical deterioration using track and trigger or an early warning scoring system.

This policy makes direct reference to Decisions Relating To Cardiopulmonary Resuscitation, Guidance from the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing, previously known as the “Joint Statement”, 3rd Edition (1st revision) 2016.

https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/
The Trust monitors the implementation of and compliance with this policy in the following ways:

The resuscitation and deteriorating patient group will be responsible for monitoring implementation and compliance with this policy as outlined in section 5 below.

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<thead>
<tr>
<th>Services</th>
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The Director responsible for monitoring and reviewing this policy is the Executive Nurse.
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR CARDIOPULMONARY RESUSCITATION (CPR) CONTENTS

1.0 INTRODUCTION
2.0 EXPLANATION
3.0 DUTIES
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5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE
6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION
7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES
1. INTRODUCTION

1.1 Essex Partnership University NHS Foundation Trust (EPUT) provides community health, mental health and learning disability services for a population of approximately 2.5 million people in a variety of settings ranging from in-patient wards to the patient’s own home. In the event of a cardiac or respiratory arrest in any setting, all EPUT staff should be able to recognise and respond appropriately to maximise the chances of survival.

1.2 Patients in mental health (MH) and learning disability (LD) inpatient settings can be vulnerable to cardiac or respiratory arrest through coexisting physical illness, through self-harm, and through the effects of medication, including rapid tranquillisation, physical intervention, or seclusion in the short term management of disturbed or violent behaviour. Patients in MH & LD inpatient settings are also vulnerable to choking, through dysphagia associated with illnesses like dementia, behaviour such as food bolting, pica (attempts to eat non-food items) or intentional self-harm. (NPSA, 2008)

1.3 The Resuscitation Council (UK) requires all healthcare staff to have ongoing training in basic life support, and additionally suggests that Automated External Defibrillators (AEDs) should be provided in any healthcare setting that might reasonably expect to use them at least once every five years.

1.4 NICE Guideline NG10 (2015) requires that any setting where restrictive interventions may be used can access staff trained to immediate life support (ILS) standards, and access appropriate equipment for ILS (including AEDs).

2. DEFINITIONS

- The term cardiopulmonary resuscitation (CPR) embraces all the procedures, from basic first aid to the most advanced medical interventions that can be used to restore the breathing and circulation in someone whose heart and breathing have stopped (referred to as a cardiac or respiratory arrest).

- Do not attempt cardiopulmonary resuscitation (DNACPR) is a decision not to attempt CPR, made and recorded in advance, to guide those present if a person subsequently suffers sudden cardiac arrest or dies.
3.0 DUTIES

3.1 The Trust Board is responsible for ensuring:
- That the principles of this Policy, the related EPUT CPR Procedure and other associated policies are implemented across the organisation;
- The necessary financial resources.

3.2 The Executive Director Mental Health, Executive Nurse will ensure that:
- This policy and the related EPUT CPR Procedure are embedded within clinical practice;
- This policy and the related EPUT CPR Procedure are reviewed and updated regularly, in accordance with recommended best practice and national guidance.

3.3 The Assistant Director, Quality and Practice will ensure that: all cardiopulmonary arrests are audited and reported on a regular basis to the Resuscitation and Deteriorating Patient Group.

3.4 The Trust’s Resuscitation and Deteriorating Patient Group reports to the Clinical Governance Sub Committee and is responsible for all resuscitation issues in the trust as follows:
- Examining and addressing issues around current and best practice, seeking expert advice when appropriate;
- Planning and the practice and monitoring of resuscitation activity;
- Approval of resuscitation equipment utilised across all services;
- Ensuring that any updated information or guidance, in accordance with the Resuscitation Council or other patient safety authority, is disseminated throughout the Trust.

3.5 The Trust’s Workforce Development Team will ensure the provision of training and education to meet identified needs/

3.6 The Consultant/GP in Charge of the individual patient’s care is responsible for individual patient treatment and clinical management, including decisions on resuscitation and DNACPR, further information is available in section 4 -7 of The EPUT CPR Procedural Guidelines.

3.7 All Consultants are responsible for ensuring that all medical staff, including temporary and locum staff, are aware of and understand this policy and the related clinical guidance.
3.8 **Service / Unit Managers** are responsible for ensuring that:

- All staff, including new employees, whether temporary or permanent, are made aware of this policy and the related EPUT CPR Clinical Guidance;
- All in-patient nursing staff have had appropriate training, including use of track and trigger or an Early Warning Scoring System in accordance with identified needs;
- Resuscitation equipment is checked in accordance with the CPR procedural guideline, and ensuring that all equipment is maintained in good working order and is continually available;
- That a debriefing session is held with staff in the event of a CPR incident.

3.9 **Individual Staff-members:** Will ensure that this policy and the related guidelines are implemented and:

- Must be aware of the location of all emergency equipment within their service area and on induction should familiarise themselves with the emergency equipment held.
- Clinical staff must ensure that resuscitation equipment is checked in accordance with the clinical guideline, to ensure the availability of all required equipment and that it is in working order, recording all checks on an equipment checklist and monitoring form (for further guidance, refer to clinical guideline Section 6)
- The clinician in charge or senior member of staff must ensure that all emergency equipment is cleaned, checked and, if necessary, replaced following a CPR event (for further guidance, refer to clinical guideline Section 6)
- Must maintain an awareness of the resuscitation status of all patients within their care, which will include those for whom a valid DNACPR order / Advance Decision to Refuse Treatment is in place;
- Must promptly commence CPR in the event of a cardio-respiratory arrest;
- Must ensure that all cardiopulmonary arrests are documented through the completion of incident reporting forms and, within in-patient settings, the Cardiac Arrest Report and Review Forms (CPR Procedure Appendix 7);
- Will ensure their attendance at CPR training sessions / Enhanced Emergency Skills courses, in accordance with identified learning needs;
- Are accountable for the equipment that they carry.
- Additional requirements for in-patient staff:
  
  a. Clinical staff will be responsible for undertaking physical observations and identifying those who are critically ill, supporting decision-making and ensuring care escalation (for further guidance, refer to the CPR Procedure Section 3);
  b. Clinical staff working within the in-patient setting must ensure the use of a patient-at-risk scoring tool (such as the Modified Early Warning Signs observation tool) for those patients for whom there are concerns / signs of deteriorating physical health;
  c. Where the task of recording vital signs is delegated to a support worker or student the registered nurse must ensure that they are supervised
4.0 PRINCIPLES

In the event of an unexpected cardiac arrest, every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council (UK), unless a valid DNACPR decision or an Advance Decision to Refuse Treatment (ADRT) is in place and made known.

This policy provides a systematic approach to management of The Deteriorating Patient and CPR, with the aims of ensuring that:

- All patients in EPUT in-patient areas have vital signs monitoring using track and trigger or an early warning scoring system;
- All patients receive effective and appropriate treatment in the event of sudden or unexpected collapse;
- All identified staff receive training appropriate to their role;
- In-patient areas undertake the simulation of CPR, ensuring that skills are practiced and responses are effective;
- Processes are in place to aid decision-making by senior clinicians on ‘do-not-attempt cardiopulmonary resuscitation’ (DNACPR) refer to:

  a. Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the ‘Joint Statement’) 3rd edition (1st revision) 2016.  
    https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

  b. Clinical Guideline DNACPR

- Equipment is provided, which is assessed as appropriate within each clinical area, and monitoring and maintenance by staff working within the practice environment in accordance with the CPR Procedure

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 The Executive Director Mental Health, Executive Nurse is responsible for the regular monitoring and review of this policy and the related procedural guideline.

5.2 The Resuscitation and Deteriorating Patient Group will lead on the monitoring of all the minimum requirements, which must include:

- a description processes/procedures in place;
- Early warning systems / track and trigger being in place for the recognition of in-patients at risk of cardio-respiratory arrest;
- Post-resuscitation care;
- DNACPR Orders;
- A process for ensuring the continual availability of resuscitation equipment;
• The Trust’s expectations in relation to staff training, as identified through the training needs analysis, which will be monitored as outlined in CPR Procedure Section 9.0, Training

• Assessment of compliance with this policy and the associated procedural guideline, using information from several indicators, including:
  a. The timely completion of an incident report form following CPR;
  b. Use of early warning scoring systems preceding the cardiac arrest;
  c. The proper documentation and frequent review of DNACPR orders;
  d. The continual availability and maintenance of emergency equipment, as assured through the completion of weekly checks;
  e. The uptake of training.

• Auditing of the process outlined in this policy and the related procedural guideline will be undertaken at a minimum of every 3 years to ensure compliance. Reports will be submitted to resuscitation Committee for consideration and action.

• A simulation programme of mock incidents will be conducted within units where resuscitation equipment is available, in accordance with guidelines issued by the National Patient Safety Agency, allowing for the review of practice and for any learning needs to be identified and addressed.

• An annual report of resuscitation practice and outcome.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

1. British Medical Association, Resuscitation Council (UK), Royal College of Nursing, 2016. Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the ‘Joint Statement’) 3rd edition (1st revision) 2016.
   https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/


7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- CLPG14A - Cardiopulmonary Resuscitation Procedure
- CLPG14B - Do Not Attempt Cardiopulmonary Resuscitation
- Clinical Procedure
- RM05 - Restrictive Practice Policy
- CG6 - Clinical Guidelines For Advance Decisions and Statements (Mental Health and Learning Disability)

END
When receiving someone into your care you are responsible for checking their resuscitation status. If there is a DNACPR form it must be checked for completeness and accuracy to ensure it is valid.

Unresponsive and not breathing normally

Call 999 and ask for an ambulance

30 Chest compressions

2 Rescue breaths

Continue CPR 30:2

As soon as AED arrives switch it on and follow instructions
When receiving someone into your care you are responsible for checking their resuscitation status. If there is a DNACPR form it must be checked for completeness and accuracy to ensure it is valid.

For use in hospital sites that have access to an emergency resuscitation team
NB. If staff are not specifically trained in paediatric BLS techniques, CPR should be started with the Compression:Ventilation ratio that is familiar and for most, this will be 30:2 (Resuscitation Council UK, 2015)
Assess severity

Severe
Airway obstruction (ineffective cough)

- Unconscious
  - Start CPR

- Conscious
  - 5 back blows
  - 5 abdominal thrusts

Mild
Airway obstruction (effective cough)

- Encourage cough
  - Continue to check for deterioration to ineffective cough or until obstruction relieved
Paediatric Choking

Assess severity

Ineffective cough

Unconscious
Open airway
5 breaths
Start CPR

Conscious
5 back blows
5 thrusts
(chest for infant)
(abdominal for child > 1 year)

Effective cough

Encourage cough
Continue to check for deterioration to ineffective cough or until obstruction relieved
Anaphylactic reaction?

Airway, Breathing, Circulation, Disability, Exposure

Diagnosis - look for:
- Acute onset of illness
- Life-threatening Airway and/or Breathing and/or Circulation problems
- And usually skin changes

- Call for help
- Lie patient flat
- Raise patient's legs

Adrenaline

When skills and equipment available:
- Establish airway
- High flow oxygen
- IV fluid challenge
- Chlorphenamine
- Hydrocortisone
- Monitor:
  - Pulse oximetry
  - ECG
  - Blood pressure

1 Life-threatening problems:
- Airway: swelling, hoarseness, stridor
- Breathing: rapid breathing, wheeze, fatigue, cyanosis, $SpO_2 < 92\%$, confusion
- Circulation: pale, clammy, low blood pressure, faintness, drowsy/coma

2 Adrenaline (give IM unless experienced with IV adrenaline)
- IM doses of 1:1000 adrenaline (repeat after 5 min if no better)
  - Adult: 500 micrograms IM (0.5 mL)
  - Child more than 12 years: 500 micrograms IM (0.5 mL)
  - Child 6-12 years: 300 micrograms IM (0.3 mL)
  - Child less than 6 years: 150 micrograms IM (0.15 mL)

Adrenaline IV to be given only by experienced specialists
- Titrate: Adults 50 micrograms; Children 1 microgram/kg

3 IV fluid challenge:
- Adult: 500 – 1000 mL
- Child: crystalloid 20 mL/kg
- Stop IV colloid if this might be the cause of anaphylaxis

4 Chlorphenamine
- IM or slow IV
- Adult or child more than 12 years: 10 mg
- Child 6-12 years: 5 mg
- Child 6 months to 6 years: 2.5 mg
- Child less than 6 months: 250 micrograms/kg

5 Hydrocortisone
- IM or slow IV
- Adult: 200 mg
- Child: 100 mg
- Child: 50 mg
- Child: 25 mg
### Patient Details

1. Name .................................................

   Date of Birth…………….  Male □  Female □

   Age ………………  Ward ………………………………..

   Location of Arrest …………………

### Event Variables

2. Initial condition

   Conscious?  Yes □  No □

   Breathing?  Yes □  No □

3. Resuscitation attempted

   3.1 □ Yes (tick all used):  □ Airway  □ Defibrillation □ Chest compressions

   3.2 □ No (tick one):  □ DNACPR □ Other

4. Event Times  (enter times)

   Collapse/Onset………….  Arrest confirmed………..

   CPR team called………….  CPR started………….

   Ambulance called.........  Airway achieved………..

   CPR team arrived………..  Ambulance arrived………..

   1st defib. Shock………….  CPR stopped…………..

5. Provider of CPR:

   Nurse □  Doctor □  Other □

**How was privacy and dignity maintained?**

   …………………………………………………………………………………………………………………..
Outcome:

Survived □    Deceased □    Transferred □

Details:

..............................................................................................................................................................
..............................................................................................................................................................
..............................................................................................................................................................
APPENDIX 7b: Post Cardiac Arrest Review Form (In-patients)

1. Was there a clearly documented physiological monitoring plan stating type and frequency of observations in the 24 hours preceding the arrest (as per NICE, RCP and NCEPOD Guidance) and were these undertaken as per request?
   Yes □  No □

2. What were the patient’s Early Warning Scores in the 12 hours preceding the arrest?
   ....................

3. If the patient’s scores at any time in that 12 hour period were elevated to ‘trigger level’, as per the local escalation policy, was the correct escalation undertaken?
   Yes □  No □

4. Were there other reasons for escalating care (e.g. symptoms [chest pain], signs [clammy], laboratory results, or staff or patient/relative concern)?
   Yes □  No □

5. If there were other reasons for escalating care was the correct escalation undertaken?
   Yes □  No □

6. Did the patient receive appropriate assessment and/or treatment in response to a clearly identified reason for escalation?
   Yes □  No □

7. If the patient received treatment, did his condition improve in response to that treatment?
   Yes □  No □

8. If the patient did not improve, was the patient escalated to a more senior level in a timely manner?
   Yes □  No □

9. Did the patient have documented and discussed ceilings of care/DNACPR status?
   Yes □  No □

10. Has the review identified any other issues e.g. missing equipment or drugs, equipment failures, problems with team performance or communication?
    Yes □  No □

If the answer Q1, 3, 5, 6, 8, 10 is No, proceed to RCA.

To be completed and sent to Ann Nugent, Assistant Director, Quality & Practice on ann.nugent1@nhs.net or by post to The Lodge, Runwell, SS11 7XX
## SBAR Tool

### Communicating Concerns and Documenting Discussions

**THIS MUST BE DOCUMENTED IN THE NURSING RECORD**

<table>
<thead>
<tr>
<th>INFORMATION TO COLLECT AND HANOVER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S</strong> Situation</td>
</tr>
<tr>
<td>1. Identify yourself and the ward you are calling from</td>
</tr>
<tr>
<td>2. Identify your patient by name and the reason for your call (e.g. vomiting, feels unwell, breathlessness, pain, dizziness, fall)</td>
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<tr>
<td>3. Onset of symptoms (30 minutes, 1 day)</td>
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<tr>
<td><strong>B</strong> Background</td>
</tr>
<tr>
<td>4. Give the reason for admission</td>
</tr>
<tr>
<td>5. Explain significant past medical history</td>
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<tr>
<td>6. Give an overview of the patients’ current admission, including: admitting diagnosis, date of admission, prior procedures, current medication, allergies, pertinent laboratory results and other relevant diagnostic results.</td>
</tr>
<tr>
<td><strong>A</strong> Assessment</td>
</tr>
<tr>
<td>7. Objective observations <em>(be specific, do not use terms high or low)</em>  e.g. Temperature - 38.5, Pulse - 110, BP – 160/95, Respirations -24, O2 sats - 98%, Alert, Urinalysis positive to ketones</td>
</tr>
<tr>
<td>8. Report any evidence of bleeding and location (skull, arm)</td>
</tr>
<tr>
<td>9. Advise whether the patient is in pain and colour of skin (flushed, pale, blue?), colour of sputum (white and frothy, green?)</td>
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<tr>
<td>10. Any abnormal sounds e.g. wheezing, coughing?</td>
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<tr>
<td>11. Any abnormal smells e.g. ketones, alcohol?</td>
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<tr>
<td>12. Is the patient taking in fluids?</td>
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<tr>
<td>13. What is the patient's urine output</td>
</tr>
<tr>
<td><strong>R</strong> Recommendation</td>
</tr>
<tr>
<td>14. Recommended action from doctor/specialist contacted:  e.g. Increase observations/ commence on medication/ call ambulance</td>
</tr>
<tr>
<td>15. What are the actions of the nursing team and actions of the medical team?</td>
</tr>
<tr>
<td>16. When should this be reviewed?</td>
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</tbody>
</table>
EPUT Emergency Resuscitation Equipment Standard Check List For Mental Health and Learning Disability Services

Checking equipment is a requirement that should be undertaken to ensure that resuscitation equipment is maintained in a ready-to-use condition, expiry dates have not lapsed and checks are undertaken and recorded.

Daily checks
The defibrillator must be checked daily to ensure that the machine is rescue-ready, i.e. that the battery is charged and pads are attached, where appropriate. The oxygen cylinder gauge is visible through the resuscitation bag clear panel and should be inspected daily to ensure an adequate supply, i.e. ¾ full. The numbered tag must also be inspected on a daily basis to ensure that it is the correct serial number and that it has not been broken. Equipment should be replaced one month in advance of its expiry date, (recorded on the checklist – items that have).

Weekly check
In order to ensure that resuscitation equipment is always ready for use, the contents of the resuscitation bag must be checked weekly and the checklist completed to assure that all equipment is present and ready to use. The resuscitation bag must be sealed using a numbered tag, to indicate that it has not been tampered with between these checks. The numbered tag must be replaced weekly.

The Lifeline bag is from BOC and is ordered via E-proc. Defibrillators are ordered via E-proc. Items in grab bag are ordered via Eproc or NHS Supply chain: To access codes for ordering grab bag items from Trust Input home page type the title of this list in search box then scroll down to resuscitation lists. If not sure contact: Purchasing Department on 01375 364470 or via 0300123 0808 and ask to speak to staff in Purchasing department.

If a medical equipment item develops a fault, call Althea (prev known as TBSGB) on 0844 809 4778 if in South Essex and Bedfordshire; for services in North East and Mid call EBME Colchester (based at Colchester Hospital) – telephone 01206 742492 (direct line to EBME office); For services in West Essex area call EBME Harlow (based at Princess Alexandra Hospital) – telephone 01279 444455 (PAH switchboard – ask to be put through to EBME) More details are available on Trust Input - type Medical Device and Equipment in search page.

Use of all equipment is covered in Enhanced Emergency Skills training and is identified in students training manuals.

<table>
<thead>
<tr>
<th>Record the date of 1st expiring item (3 months before it's expiry date)</th>
<th>Signature</th>
<th>Date</th>
<th>Expired item replaced (a month before it's expiry date) (signature)</th>
<th>Date item replaced</th>
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<tr>
<td>ITEM</td>
<td>PICTURE</td>
<td>WHERE KEPT</td>
<td>Seal intact</td>
<td>EXPIRY</td>
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<td>------</td>
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</tr>
<tr>
<td>BOC Lifeline Emergency Resuscitation Kit/Bag <em>Eproc Code: D7363</em></td>
<td>Tagged</td>
<td></td>
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</tr>
<tr>
<td>Lifeline Emergency Oxygen Cylinder with exemption of locations in the Community</td>
<td>Must be in the grab bag</td>
<td>Check level – ensure replacement immediately available if less than ¾ full</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defibrillator Device and a spare battery</td>
<td>Must be in the grab bag</td>
<td>(Spare battery can be kept outside the resus bag but should be by the bag or where it is easily located)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 x AED pads to match machine (One attached to defibrillator and a spare kept in side pocket) (<em>order through NHS supply chain</em>)</td>
<td>Must be in the grab bag</td>
<td>Expiry</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Tag No</th>
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</table>

<table>
<thead>
<tr>
<th>Date Service Due</th>
</tr>
</thead>
</table>

Expiry
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Chain Code</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 X</td>
<td>Clothing Scissors</td>
<td><strong>EAZ1338</strong></td>
<td>Must be in the grab bag</td>
</tr>
<tr>
<td>1 X</td>
<td>Pocket mask with Oxygen Nipple inlet &amp; one-way valve supplied in carry case</td>
<td><strong>FDD1672</strong></td>
<td>Must be in the grab bag</td>
</tr>
<tr>
<td>2 x</td>
<td>Disposable Razors</td>
<td><strong>FSF040</strong></td>
<td>Must be in the grab bag</td>
</tr>
<tr>
<td>1 X</td>
<td>Ligature cutter For use in Mental Health locations only</td>
<td></td>
<td>Must be in the grab bag (Mental health units must also have one in the office where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>1 X</td>
<td>Magill Forceps</td>
<td><strong>FCC450</strong></td>
<td>Must be in the grab bag</td>
</tr>
<tr>
<td></td>
<td>A hand held manual suction device : Canister unit with 2 x suction tubes/ Yankuer suckers.</td>
<td></td>
<td>Must be in the grab bag</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>7639 or NHS Chain supply code: FPA635</strong></td>
<td></td>
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<tr>
<td>Guedel disposable Airways –</td>
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<tr>
<td>2 X</td>
<td>Size 1</td>
<td><strong>FDB571</strong></td>
<td>Must be in the grab bag</td>
</tr>
<tr>
<td>2 X</td>
<td>Size 2</td>
<td><strong>FDB316</strong></td>
<td>Expiry Date:</td>
</tr>
<tr>
<td>2 X</td>
<td>Size 3</td>
<td><strong>FDB317</strong></td>
<td>Expiry Date:</td>
</tr>
<tr>
<td>2 X</td>
<td>Size 4</td>
<td><strong>FDB318</strong></td>
<td>Expiry Date:</td>
</tr>
</tbody>
</table>

Order from NHS

Expiry Date:
<table>
<thead>
<tr>
<th>Supply Chain</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Supraglottic Airway (I-gels)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1 X Size 3</strong> (Yellow) NHS Supply Chain Code : FDD2840</td>
<td><strong>Size 3, 4 and 5 must be in the grab bag.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 X Size 4 (Green)</strong> NHS Supply Chain Code : FDD2841</td>
<td><strong>Expiry SIZE 3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 X Size 5</strong> (Orange) NHS Supply Chain Code : FDD2842</td>
<td><strong>Expiry SIZE 4</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 X Lubricant</strong></td>
<td><strong>Usually comes with I-gels or use normal KY jelly</strong></td>
<td><strong>Must be in the grab bag</strong></td>
</tr>
<tr>
<td><strong>1 X High Concentration Oxygen mask non rebreathing</strong> NHS Supply Chain Code : FDD138</td>
<td><strong>Must be in the grab bag</strong></td>
<td><strong>Expiry</strong></td>
</tr>
<tr>
<td><strong>1 X Oxygen Tubing 2.1m crush resistant tubing with connectors</strong> NHS Supply Chain Code : FDD1307</td>
<td><strong>Must be in the grab bag</strong></td>
<td><strong>Expiry</strong></td>
</tr>
<tr>
<td><strong>1 X bag-valve-mask</strong> (disposable) Adult with size 5 mask concertinaed space saving version NHS Supply Chain Code : FDE392</td>
<td><strong>Must be in the grab bag</strong></td>
<td><strong>Expiry</strong></td>
</tr>
<tr>
<td>Nitrile Gloves Sizes:</td>
<td>Must be in the grab bag</td>
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<tr>
<td>Small X 2 pairs FTG572</td>
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</tr>
<tr>
<td>Medium X 2 pairs FTG571</td>
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<td></td>
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<tr>
<td>Large X 2 pairs FTG570</td>
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<tr>
<td>Order from NHS Supply Chain</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium dressing pack NHS Supply Chain Code: EJA046 X 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be in the grab bag</td>
</tr>
</tbody>
</table>

The following items are kept outside the resus bag but must be available / accessible immediately in emergency situation and must be checked in the same way as items in the grab bag.

**NOTE:** In HMP Chelmsford all equipment is kept in the bags including items for immediate access.

<table>
<thead>
<tr>
<th>Date</th>
<th>Immediate Access</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(Must be where it's easily accessible by all staff)</td>
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<table>
<thead>
<tr>
<th>Disinfectant wipes NHS Supply Chain code: VJT521</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Access (Must be where it's easily accessible by all staff)</td>
</tr>
</tbody>
</table>

Penlight Torch Order on eproc system [https://www.amazon.co.uk/Liroyal-Penlight-Flashlight-Emergency-Medical/dp/B01MRDY2TA/ref=sr_1_9?ie=UTF8&qid=1505894348&sr=8-9&keywords=pen+torch](https://www.amazon.co.uk/Liroyal-Penlight-Flashlight-Emergency-Medical/dp/B01MRDY2TA/ref=sr_1_9?ie=UTF8&qid=1505894348&sr=8-9&keywords=pen+torch) or NHS Supply code FFE066

<table>
<thead>
<tr>
<th>Stethoscope NHS Supply Chain code: FFE518</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Access (Must be where it's easily accessible by all staff)</td>
</tr>
</tbody>
</table>

Dinamap Order via eproc (check latest)
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standardised lists OR</strong> Sphygmomanometer (Manual) Order via eproc (check latest standardised lists)</td>
<td></td>
<td>by all staff)</td>
</tr>
<tr>
<td><strong>Pulse oximeter</strong> Order via eproc (check latest standardised lists)</td>
<td>Immediate Access</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Hypo Box (eproc 5747) Gluco Gel &amp; Glucagon (order from Pharmacy) Gluco Tabs (AZB170) &amp; GlucoJuice (AZB178) (NHS Supply Chain)</td>
<td>Immediate Access</td>
<td>All items are present and are in date. (Glucagon in fridge) 1st Expiry Date</td>
</tr>
<tr>
<td><strong>Additional Oxygen Cylinders</strong> (where kept)</td>
<td>Immediate Access</td>
<td>Check level of oxygen and cylinders are in date (Local agreement for number of cylinders and levels before re-ordering)</td>
</tr>
<tr>
<td>Mouth-shields NHS Supply Chain Code: FDG872</td>
<td>Immediate Access</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Tags</td>
<td>Must be available</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
</tbody>
</table>
RESUSCITATION BAG / TROLLEY DAILY CHECKLIST FOR MENTAL HEALTH & LEARNING DISABILITY SERVICES

Based at

Trolley/Bag number | Month/Year

* Signature is required to show that all equipment is present AND IN FULL WORKING ORDER.

<table>
<thead>
<tr>
<th>Date Checked</th>
<th>Time</th>
<th>Security Tag in tact</th>
<th>Defibrillator Correctly assembled and functioning</th>
<th>Oxygen Cylinder ¾ full</th>
<th>Electric Suction Machine Correctly assembled and functioning</th>
<th>Action taken if all equipment NOT present – if incident form completed please state</th>
<th>Tag number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
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<tr>
<td>Date Checked</td>
<td>Date</td>
<td>Time</td>
<td>Security Tag in tact</td>
<td>Defibrillator Correctly assembled and functioning</td>
<td>Oxygen Cylinder ¾ full</td>
<td>Electric Suction Machine Correctly assembled and functioning</td>
<td>Action taken if all equipment NOT present – if incident form completed please state</td>
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</tbody>
</table>
In HMP Chelmsford all resuscitation equipment including items on this list are kept in bags.

This check list is to be completed Weekly.

<table>
<thead>
<tr>
<th>Item</th>
<th>Immediate Access</th>
<th>Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size 3 LMA</td>
<td>(Must be where it’s easily accessible by all staff)</td>
<td></td>
</tr>
<tr>
<td>Burns shield face</td>
<td>(Must be where it’s easily accessible by all staff)</td>
<td></td>
</tr>
<tr>
<td>Medium burns dressing</td>
<td>(Must be where it’s easily accessible by all staff)</td>
<td></td>
</tr>
<tr>
<td>Small burns dressing</td>
<td>(Must be where it’s easily accessible by all staff)</td>
<td></td>
</tr>
<tr>
<td>Cederroth large</td>
<td>(Must be where it’s easily accessible by all staff)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Expiry Date</th>
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<tbody>
<tr>
<td>Burns shield face</td>
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<tr>
<td>Medium burns dressing</td>
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</tr>
<tr>
<td>Cederroth large</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Immediate Access</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cederroth small</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Gauze</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Mepore dressing large</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Mepore dressing small</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Tape</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Bandage</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Nasal airway size 6, 7 and 8</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Item</td>
<td>Immediate Access</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aquagel</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Asherman chest seal</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Anaphaltix shock pack</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Naloxone</td>
<td>(Must be where it’s easily accessible by all staff)</td>
</tr>
<tr>
<td>Space blanket</td>
<td></td>
</tr>
<tr>
<td>Sharps box</td>
<td></td>
</tr>
<tr>
<td>Neck collar</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Immediate Access</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>BM Kit and equipment</td>
<td>(Must be where it’s easily accessible by all staff) Expiry Date</td>
</tr>
<tr>
<td>GTN Spray</td>
<td>Immediate Access (Must be where it’s easily accessible by all staff) Expiry Date</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Immediate Access (Must be where it’s easily accessible by all staff) Expiry Date</td>
</tr>
<tr>
<td>IV Cannula size 14, 16, 18, 20G</td>
<td>Immediate Access (Must be where it’s easily accessible by all staff) Expiry Date</td>
</tr>
<tr>
<td>Butterfly cannula</td>
<td>Immediate Access (Must be where it’s easily accessible by all staff) Expiry Date</td>
</tr>
<tr>
<td>Cannula equipment</td>
<td>Immediate Access (Must be where it’s easily accessible by all staff) Expiry Date</td>
</tr>
<tr>
<td>500ml Normal saline</td>
<td>Immediate Access (Must be where it’s easily accessible by all staff) Expiry Date</td>
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</table>
## Community Health Services (CHS)

### INPATIENT WARD DAILY RESUSCITATION EQUIPMENT CHECKLIST

 воплощаем минимальные требования для EPUT Community Health Services In-Hospital Adult Resuscitation

To be completed daily and post cardiac arrest

<table>
<thead>
<tr>
<th>quipment</th>
<th>Present/in date</th>
<th>RGN SIGNATURE &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTOMATED DEFIBRILLATOR Spare Pads (In date), Scissors, Disposable razor (Yes/No) Battery Indicating fit for use (Yes/no)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMERGENCY DRUG BOX (expiry date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANAPHYLAXIS KIT (expiry date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambu bag</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portable suction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharps box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen Cylinder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypobox (To be kept in Drug room)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drawer one</th>
<th>Present/in date</th>
<th>RGN SIGNATURE &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airways1,2,3 and 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scissors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Torch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves S,M,L x 3 of each</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRAWE TWO</th>
<th>PRESENT /IN DATE</th>
<th>RGN SIGNATURE &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pocket mask with oxygen port</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Various syringes x 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety razors x 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Various needle sizes x 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Octopus extension sets x 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Sterets 1 box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorprep x 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face shields x5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tapes x 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butterflies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THIRD DRAWER</th>
<th>PRESENT /IN DATE</th>
<th>RGN SIGNATURE &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection of intravenous cannulae</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannula fixing dressings x 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lancets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable Tourniquets x Box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile Gauze x 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selection of blood bottles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium Chloride Flush ampoules x 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOURTH DRAWER</th>
<th>PRESENT /IN DATE</th>
<th>RGN SIGNATURE &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non re-breath mask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen masks 24%,28%,35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebuliser Mask x 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laryseal masks x 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen tubing 1 box</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIFTH DRAWER</th>
<th>PRESENT /IN DATE</th>
<th>RGN SIGNATURE &amp; DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yankuer suckers x 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Various suction catheters x 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suction tubing x 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous giving sets x 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion giving sets x 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing packs x 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

**BABY / INFANT RESUSCITATION BAG / EQUIPMENT WEEKLY FULL INVENTORY CHECK**

To be completed by a member of the nursing team. Each item is to be checked off against the laminated colour checklist accompanying the Resuscitation bag. Date to be entered when the check takes place. This then needs to be signed off by the person checking. At the end of the week the checklist is to be signed off by the Ward Manager before this is forwarded to the Patient Safety Team for audit purposes.

**Ward/Unit Name: .................................................................**

*Copy to be retained on the ward for audit purposes*

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Equipment Type</th>
<th>No of</th>
<th>Check Date</th>
<th>Expiry Date</th>
<th>TAG NUMBER</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Resus bag Check zip/handles etc.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Child (weight 5-10kg) Resuscitator Bag/valve/mask with oxygen tubing</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Manual Resuscitator (INFANT/PRE TERM weight 0-3kg) with Pressure Limitation Value and Size 0 Round Silicone Face Mask</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Welch Allyn Flexiport Reusable Blood Pressure Cuff</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infant 7 Cuff</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Small Child 8 Cuff</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child 9 Cuff</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Medisavers Nitrile Gloves</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Checking person’s name & signature to be entered in the box*

**Ward Manager: .......................................................... Date: ..................................................**
PROCEDURE FOR CARDIAC ARRESTS WITHIN Basildon Hospital MHU

If there is a cardiac arrest within the MHU, the emergency Pin Point Alarm will be pulled to summon help and then ‘2222’ must be dialled to activate the Basildon Cardiac Arrest team.
See Appendix 1 for signage.

Roles and responsibilities
Senior Nurse: Attends the area immediately.
Security: Opens front doors on Level B to allow access to the unit and directs the cardiac arrest team to location of event.
Unit bleep Holder nominates staff member to:
Opens the doors on Level A between Basildon Hospital and the Mental Health Unit and directs the cardiac arrest team.

EPUT has in place a notice stating ‘In an Emergency Press Green Box’

Nurse in charge of area: Must ensure that:

- Cardiopulmonary resuscitation is initiated.
- Resuscitation equipment has been obtained from the treatment room
- Doors to the area are opened to allow the cardiac arrest team access.
- That the patients’ Health Care Records are available

Assessment unit: Takes the MRX defibrillator and grab bag to the area.

Resuscitation of the patient
Use the Resuscitation Council UK current guidelines.
See Appendix 2 for In-hospital resuscitation algorithm.

Arrival of the cardiac arrest team
The person, who had led the initial resuscitation attempt whilst waiting for the Basildon Cardiac Arrest team, needs to handover to the Cardiac Arrest team leader who will then co-ordinate advanced life support interventions and delegate to the team.

Transfer of the patient
Only when a patient is safe for transfer should this take place.
Senior Nurse: Needs to obtain a trolley from ECT on Level C
The BTUH Team Leader: Will bleep the A&E shift lead on Bleep 9020 to handover and inform them of the imminent transfer.
Complete the 2222 audit form (on the trolley).
Ensure the necessary equipment is ready for transfer.
Obtain necessary patient information.
Organise the team for transfer.

Route of transfer
Take the patient down to Level A via lift.
Transfer through the connecting corridors between the DGH and MHU buildings into the main hospital.
Take the lifts to Level C
Then follow signage to A&E

Post event
The resuscitation equipment must be checked and replaced immediately after use in accordance with the resuscitation equipment list and equipment locators’.
Resuscitation Officer from BTUH will attend the area either during or after an event. To review the clinical documentation, this will be to identify if deterioration had not been identified earlier and / or if DNACPR should have been a consideration. Areas of concern will be incident reported. The Resuscitation Service will when available, provide support and ensure that the resuscitation equipment is checked in line with Resuscitation Policy expectations.
In the event of a cardiac arrest ring 2222

Ask the operator for the Cardiac Arrest Team

State WARD or AREA (NAME) LEVEL MENTAL HEALTH UNIT

Wait for the operator to repeat the information back to you before you end the call.

Please refer to Resuscitation UK algorithm on pages 18 – 23 of this document.
A Report for Management of Emergency Equipment in Essex
Specialist Treatment and Recovery Service (STaRS) and
Marginalised and Vulnerable Adults (MVA)

1.0 INTRODUCTION

1.1 When looking at saving a patient’s life within our client group Naloxone is the most important piece of equipment to carry. The majority of deaths from drug misuse involve opioids. Opioid overdose, most commonly associated with heroin, can be due to the variety and limited awareness of the drug purity being consumed. Overdose is also associated with polysubstance use where the use of alcohol or benzodiazepines alongside heroin increases the depressant effect. Concurrent stimulant use (for example cocaine) can mask the depressant effect resulting in increased heroin dosage which further increases the likelihood of overdose. A recent trend for the use of heroin mixed with fentanyl has been linked to a number of overdose deaths reported late in 2016 and early in 2017. Fentanyl is synthetic opioids which have similar effects to heroin, but are more potent and toxic, meaning using a small amount can result in overdose and death.

1.2 In 2017 there were 2,310 drug misuse deaths in England; a 3.2% decrease on the previous year but still the second highest on record. Of the 1,829 deaths that were attributed to ‘any opiate’ on the death certificate, 59% involved heroin and morphine, 18% involved methadone and 4% fentanyl. This marks the first year that the number of drug misuse deaths has fallen since 2012. Between 2012 and 2017 drug misuse deaths in England increased by 60% and heroin related deaths doubled from 579 to 1164. The rate of drug misuse deaths in 2017 compared to 2016 fell slightly in all age groups except among the over 50s, a trend consistent with the ageing population of people who use drugs. The ageing cohort of heroin users is one of the factors identified as a cause of the rise in drug related deaths, due to deteriorating general health and increased susceptibility to overdose.

1.3 Naloxone is an opioid antagonist which temporarily blocks opioid receptors and reverses respiratory depression and sedation. With training, naloxone can be safely administered as an emergency antidote for opiate overdoses (PHE, 2018).
2.0 SCOPE

2.1 The emergency equipment required for staff to take on home visits/street outreach/satellite clinics are the following:-

- Lone worker device – charged and turned on
- Mobile phone – charged and turned on
- 2 x Take Home Naloxone kits
- Face shield for mouth to mouth

2.2 Carrying lone worker devices and mobile phones allows us to contact the emergency services, 999, immediately. While waiting for the Ambulance to arrive the member of staff can give the Take Home Naloxone, start CPR and mouth to mouth using the face shield. This alone will allow the member of staff to use basic life support while waiting for emergency services to arrive.

2.3 Carrying oxygen in staff cars has greater implications around Health and Safety and Fire risks plus cause issues regarding insurance. The portable oxygen cylinder is not very easy to carry around and impractical this is due to the weight and risks to the individual under the Manual Handling policy.

2.4 The main Essex STaRS sites (Colchester, Basildon, Harlow and Chelmsford) along with MVA (Ipswich) have the Trust approved Emergency bags (Grab bags) except for oxygen as these buildings do not have acceptable ventilation for storing oxygen.

END
PROCEDURE: Cardiopulmonary Resuscitation (CPR)

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<thead>
<tr>
<th>CLINICAL PROCEDURE REFERENCE NUMBER:</th>
<th>CLPG14</th>
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<tr>
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<td>V 8</td>
</tr>
<tr>
<td>REPLACES SEPT DOCUMENT:</td>
<td>CLP14</td>
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<tr>
<td>REPLACES NEP DOCUMENT:</td>
<td>CP8/Resuscitation/02/16</td>
</tr>
<tr>
<td>KEY CHANGES FROM PREVIOUS VERSION:</td>
<td>Merged policies; updated appendices; additional procedure Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Nurse Consultant and Practice Development Lead Nurse</td>
</tr>
<tr>
<td>CONSULTATION GROUPS:</td>
<td>Resuscitation and Deteriorating Patient Group</td>
</tr>
<tr>
<td></td>
<td>Clinical Governance &amp; Quality Sub-committee</td>
</tr>
<tr>
<td>IMPLEMENTATION DATE:</td>
<td>August 2017</td>
</tr>
<tr>
<td>AMENDMENT DATE(S):</td>
<td>February 2018; April '18; May 18, August '18, Sept 18, Nov 18, Dec 18</td>
</tr>
<tr>
<td>LAST REVIEW DATE:</td>
<td>August 2017</td>
</tr>
<tr>
<td>NEXT REVIEW DATE:</td>
<td>August 2020</td>
</tr>
<tr>
<td>APPROVAL BY CLINICAL GOVERNANCE COMMITTEE:</td>
<td>16th Aug 2017</td>
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<tr>
<td>RATIFICATION BY QUALITY COMMITTEE:</td>
<td>14th Sept 2017</td>
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CLINICAL PROCEDURE SUMMARY

The purpose of this procedure is to ensure prompt, safe, early and appropriate cardiopulmonary resuscitation (CPR) within Essex Partnership University NHS Foundation Trust (EPUT). The strategy for resuscitation incorporates the current published guidelines for resuscitation (Resuscitation Council (UK) 2015).

This procedure supports the EPUT Policy for CPR, by providing the Trust arrangements for practice and standards relating to management of the deteriorating patient and CPR. It is anticipated that minor amendments will be made to aspects of this procedure in the near future as part of the on-going work of standardisation across the Trust, for example standardisation of drug and equipment lists.

Please read in combination with the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) clinical procedure and note that DNACPR only applies to CPR and not to other forms of care.

All inpatient service users are monitored for signs of physical deterioration using track and trigger or an early warning scoring system.

This policy makes direct reference to guidance from the British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing, in the document ‘Decisions Relating To Cardiopulmonary Resuscitation’, 3rd Edition (1st revision) 2016, previously known as the “Joint Statement”. https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

The Trust monitors the implementation of and compliance with this clinical procedure in the following ways:

- The resuscitation and deteriorating patient group will be responsible for monitoring implementation and compliance with this procedure through review of audit findings and post cardiac arrest reports.

The Executive Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Nurse.
<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Essex MH&amp;LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td></td>
<td></td>
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</tbody>
</table>
PROCEDURE: Cardiopulmonary Resuscitation (CPR)

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2.0 DEFINITION OF TERMS
3.0 EARLY WARNING SCORES & THE DETERIORATING PATIENT
4.0 PROCEDURE FOR CPR
5.0 POST CARDIAC ARREST REPPORTING PROCEDURE
6.0 PROVISION & MAINTENANCE of EMERGENCY EQUIPMENT & DRUGS
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8.0 RESUSCITATION STATUS & DECISIONS RELATING TO DNACPR
9.0 TRAINING
10.0 REFERENCES

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APPENDIX 2 IN-HOSPITAL RESUSCITATION ALGORITHM
APPENDIX 3 PAEDIATRIC BASIC LIFE SUPPORT ALGORITHM
APPENDIX 4 ADULT CHOKING ALGORITHM
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APPENDIX 6 ANAPHYLAXIS ALGORITHM
APPENDIX 7a CARDIAC ARREST REPORT FORM
APPENDIX 7b POST CARDIAC ARREST REVIEW FORM
APPENDIX 8 COMMUNICATING CONCERNS & DOCUMENTING DISCUSSIONS (SBAR COMMUNICATION TOOL)
APPENDIX 9 MH & LD RESUSCITATION EQUIPMENT STANDARD CHECKLIST
APPENDIX 10 RESUSCITATION BAG & TROLLEY DAILY CHECKLIST
APPENDIX 11 HMP CHELMSFORD ADDITIONAL EQUIPMENT CHECKLIST
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**Appendix 15**  
MANAGEMENT OF EMERGENCY EQUIPMENT IN ESSEX STARS & MVA SERVICE
1.0 INTRODUCTION

1.1 Essex Partnership University NHS Foundation Trust (EPUT) provides community health, mental health and learning disability services for a population of approximately 2.5 million people in a variety of settings ranging from in-patient wards to the patient’s own home. In the event of a cardiac or respiratory arrest in any setting, all EPUT staff should be able to recognise and respond appropriately to maximise the chances of survival.

1.2 Patients cared for in mental health (MH) and learning disability (LD) inpatient settings can be particularly vulnerable to cardiac or respiratory arrest through coexisting physical illness, through self-harm, and through the effects of medication, including rapid tranquillisation, physical intervention, or seclusion in the short term management of disturbed or violent behaviour. Patients in MH & LD inpatient settings are also vulnerable to choking, through dysphagia associated with illnesses like dementia, behaviour such as food bolting, pica (attempting to eat non-food items) or intentional self-harm. (NPSA, 2008)

1.3 The Resuscitation Council (UK) requires all healthcare staff to have ongoing training in basic life support, and additionally suggests that Automated External Defibrillators (AEDs) should be provided in any healthcare setting that might reasonably expect to use them at least once every five years.

1.4 NICE Guideline NG10 (2015) requires that any setting where restrictive interventions may be used can access staff trained to immediate life support (ILS) standards, and access appropriate equipment for ILS (including AEDs).

1.5 The purpose of this procedure is to ensure that:

- Service users are monitored for signs of potential deterioration if they are an inpatient using either track and trigger, the Trusts’ modified early warning tool or national early warning scoring system which may facilitate early intervention to prevent further deterioration resulting in a cardiac arrest;

- In the event of collapse when being seen by a member of Trust staff or when visiting any EPUT sites, service users, carers, staff and the public receive an appropriate response which will maximise their chances of survival;

- All reasonable steps are taken to provide an initial first aid response for medical emergencies and that in all instances there is a referral for subsequent specialist treatment and care.

1.6 In the event of an unexpected cardiac arrest, every attempt to resuscitate the individual will take place in accordance with the advice provided by the Resuscitation Council (UK), unless a valid DNACPR decision or a valid Advance Decision to Refuse Treatment (ADRT), refusing cardiopulmonary resuscitation, is in place. However, there is acknowledgement within the
Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing on Decisions Relating to Cardiopulmonary Resuscitation that there will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded. It is therefore imperative that conversations with patients and their families take place at the earliest opportunity to ensure their wishes are known and taken into consideration when planning care and considering DNACPR orders. Decisions regarding resuscitation status must be clearly communicated to all teams involved in the care of the patient.

2.0 DEFINITION OF TERMS

2.1 **Advance Decisions to Refuse Treatment (ADRT)** An Advance Decision to Refuse Treatment enables someone, aged 18 and over, while still having mental capacity, to document their wish to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment. It is governed by the Mental Capacity Act and is a legally binding decision.

2.2 **Automated External Defibrillator (AED)** is a computerised device used to deliver defibrillatory shocks to a patient in cardiac arrest. They use voice and visual prompts to guide staff. They analyse the heart rhythm to determine the need for a shock. The staff then deliver the shock when it has been ascertained that it is safe to do so.

2.3 **Basic Life Support (BLS)** comprises the following elements: initial assessment, then airway maintenance, chest compression and expired air ventilation (rescue breathing) with or without the use of a mouth-shield or mask.

2.4 **Basic Life Support with Airway Adjuncts and Defibrillation** comprises the following: initial assessment, airway maintenance with or without the use of a naso-pharyngeal, oropharyngeal or laryngeal mask airway, chest compression and bag-valve-mask ventilation (rescue breathing) with or without the use of oxygen and the application of the AED and following of prompts.

2.5 **Cardiac Arrest** is the cessation of effective pumping action of the heart. There is abrupt loss of consciousness and breathing stops. Unless treated promptly irreversible brain damage and death can follow within minutes.

2.6 **Cardio-pulmonary Resuscitation (CPR)** the delivery of chest compressions and ventilation +/- AED.

2.7 **Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)** is an order that can be communicated only following a thorough consultation and assessment which must be recorded on the appropriate form. Evidence of the assessment process must be documented.
2.8 **Early Warning Scoring System (EWSS):** incorporated into the physiological observation chart which highlights potential patient deterioration by assigning a score to vital signs that fall outside of normal parameters.

2.9 Vital signs will be monitored in mental health inpatients by the Modified Early Warning Score (MEWS). EPUT Community Health Services (CHS) use National Early Warning Score (NEWS2) which, like MEWS, is based on a simple aggregated scoring system in which a score is allocated to physiological measurements. For details on how to complete EWSS, refer to the Trust Clinical Guidelines for Use of early Warning Scoring Systems (CG87).

2.10 **Enhanced Emergency Skills (EES)*** incorporates the components of ILS with additional training requirements in emergency skills, as required by the individual clinical services within EPUT.

2.11 **Immediate Life Support (ILS)*** The ILS course teaches participants to identify the causes and promote the prevention of cardiopulmonary arrest; recognise and treat the deteriorating patient using the ABCDE approach; undertake the skills of quality CPR and defibrillation (using AED) and simple airway manoeuvres and utilise non-technical skills to facilitate initial leadership and effective team membership. Where provided ILS follows the guidance as set out by the Resuscitation Council (UK).

### 3.0 EARLY WARNING SCORES & THE DETERIORATING PATIENT

3.1 The Trust operates Early Warning Scoring Systems (EWSS) that are designed to recognise the potentially physically deteriorating patient within an inpatient setting. For more details refer to EPUT Clinical Guidelines for the Use of Early Warning Scoring Systems (CG87)

3.2 In mental health setting baseline clinical observations and calculations of MEWS are to be recorded every 24 hours for the first 72 hours of admission unless more frequently recommended by the admitting doctor. If baseline clinical observations are considered by the multidisciplinary team to be within normal range after 72 hours, observations must then be recorded as a minimum as follows:
- **Once daily** for patients on older people’s wards;
- **Every 7 days** for patients on all other wards until discharged.

3.3 All physical observations should be recorded using the appropriate early warning system and a complete set of observations should be recorded each time i.e. temperature, pulse, blood pressure, respirations, oxygen saturation, and ACVPU, which is alert/confusion/voice/pain/unresponsive. Where an individual parameter or total score identifies potential physical deterioration, this must be escalated to the appropriate medical team and documented in the patient records.

3.4 Clinical observations **must be increased and reviewed** if the patient experiences any of the following: rapid tranquillisation or physical intervention, falls, seizures, the commencement of new/increased medication, signs of
recent confusion or agitation or if the staff, carers or the service user states that they suspect that they may be becoming physically unwell.

3.5 The EWSS is **not** intended to replace clinical judgement; for example a patient may be seriously ill yet **not** score highly on EWSS, staff would be expected to take appropriate steps to ensure the wellbeing of any patient whose condition gave cause for concern.

3.6 When communicating with medical colleagues in relation to the potentially deteriorating patient a communication tool such as SBAR (Situation, Background, Assessment and Recommendation) should be used, to ensure concise and relevant information is relayed in a timely manner. (Appendix 8)

**4.0 PROCEDURE FOR CPR**

4.1 The core procedure for responding to a sudden cardiac arrest and initiating life support is shown in Appendices 1-3. It is recognised that some clinical areas may wish to provide additional information, such as emergency contact telephone numbers and the location of emergency equipment. This should be included in a local service procedure for CPR which must be clearly displayed.

4.2 **Immediate Action to be taken on finding a collapsed individual where no DNACPR order is in place**

- This includes initiation of resuscitation and the system for summoning help.
- It is essential that the person who finds the collapsed individual immediately assesses the safety of the environment, shouts or calls for help and raises an emergency alarm if available, to alert others to the situation.
- The collapsed individual should be assessed for signs of life using the ABC approach and if appropriate, BLS should be commenced immediately if emergency services or a crash team has already been summoned. The single rescuer should normally contact emergency help before commencing BLS.
- Other staff arriving at the scene should bring emergency equipment to assist with the resuscitation attempt as quickly as possible. The AED should be switched on and the instructions followed without delay.
- Minimise interruptions to CPR when attaching the AED pads to the victim. Defibrillation within 3–5 min of collapse can produce survival rates as high as 50–70% (Resuscitation Council, UK)
- Early defibrillation and good quality chest compressions are key to increasing the chances of survival.
- Oxygen should be used with bag-mask-ventilation when available.
- Consideration may need to be given to the surface on which the patient is lying and staff should be familiar with equipment used in their clinical
setting, knowing how to institute the emergency deflation of air mattresses or neutral positioning of profiling beds. Staff should be aware that a greater level of energy will be required to deliver effective chest compressions to a patient lying on a mattress than on a more rigid surface and if effective chest compression cannot be achieved i.e. depression of the chest by 5-6 cm then consideration should be given to moving the patient to the floor if safe to do so. The efficacy of chest compressions should be assessed before considering moving the patient and this should only be attempted following careful assessment of the risks to staff and patient.

- Staff performing chest compressions should rotate approximately every 2 minutes to minimise the effect of fatigue on performance. Changing CPR providers should not interrupt chest compressions and resuscitation attempts should continue until there are signs of life or the crash team or emergency services have arrived and are ready to take over.

- The most senior clinician present will assume the lead role in the coordination of the resuscitation attempt until emergency services (paramedics or Emergency Response team) arrives (in some instances in Community Health Services this may be the Band 3 Healthcare Support Worker). These responsibilities will include ensuring:
  a) The situation is assessed for any specific risks to staff or patient;
  b) The patient is assessed to establish if resuscitation is indicated;
  c) Emergency assistance is summoned;
  d) Management and safety control of the environment;
  e) Ensuring appropriate equipment [see Appendix 9-11] is available for the incident;
  f) Basic life support is commenced if appropriate without any delay by an appropriately trained
  g) That an AED is brought immediately [if available] and set up without any delay;
  h) Tasks are assigned to team members who have the most appropriate skills;
  i) Witnesses, including other patients, staff and relatives who are involved/witness a resuscitation attempt are supported at the time if possible and after the event.
  j) That the appropriate documentation is completed.
  k) That emergency equipment is replenished immediately after the resuscitation attempt

4.3 Contacting Emergency Services

- All non-clinical and clinical staff will be made aware of the process for contacting emergency services in their individual department.

- At Basildon Hospital site the number 2222 - will alert the crash team to cardiac and respiratory arrest/sudden collapse (see Appendix 14)
• **Please note at Basildon MHU only** when a 2222 resuscitation call is made the Site Officer is responsible for:
  
a) ensuring that a staff member is immediately allocated to open the front door on reception level B for the team to gain access

b) allocating staff to open the doors along the level A link corridor to the general hospital (a key fob is located in the site office folder)

c) informing the allocated staff to stand down once the team have arrived

• Where the casualty is in a building or grounds which are not easily or readily accessible to the Crash Team on acute hospital sites, then an emergency ambulance is also to be called in order to ensure that the casualty is promptly assisted and transferred to the medical unit.

• In the event of a cardiac/respiratory arrest/sudden collapse at a non-hospital site/community area the paramedic service must be contacted on 999 (+/-external prefix).

• For areas where community clinics are held and there is a likelihood that a doctor may be present in the building, staff should be aware of formal local systems of summoning emergency assistance such as bells or computer alerts. If available, medical assistance should be summoned either at the same time as 999 or after the 999 call has been made.

• The precise location of the patient must be communicated promptly and clearly to the emergency service switchboard operator, stating the name of the ward/clinical area clearly.

• It is vital to nominate one individual to direct crash teams and emergency services to the casualty on arrival.

• N.B. Switchboard is unable to ring for emergency services on behalf of wards, since they will not have the details of the casualty and circumstances which are necessary to activate the emergency call. Contacting the emergency services is to be done by the staff closest to or handling the event. Switchboard/reception staff should be alerted to the incident so that they can help direct emergency services when arriving on site.

• The Duty Consultant/Doctor should be informed of the cardiac arrest as soon as possible, so that they may contribute to pre-transfer care if time permits, or liaise with the admitting team at the receiving hospital. If occurring at a community location, the responsible doctor or the patient’s GP must be informed.

4.4 **Automatic External Defibrillator (AED)** the algorithm for the use of an AED is included within Appendix 1, although an AED must only be operated by persons specifically trained in their use or following instructions provided by emergency services with respect to a public access AED.
4.5 **Response in the Community (domiciliary services)** - In the event of a cardiac arrest in a patient’s own home or elsewhere in the community there is an expectation that emergency help would be summoned and CPR commenced where appropriate, in the absence of a DNACPR order. Some Trust services provide palliative and End of Life care and it should be acknowledged that in some instances there may not be a DNACPR order in place for a number of reasons. As detailed in section 1.6 there will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded.

4.6 It is recommended that a mouth shield should be provided for community staff to be carried with them at all times.

4.7 If staff are unable to deliver rescue breaths, they should give chest compression only CPR (i.e. continuous compressions at a rate of at least 100–120 min⁻¹) (Resuscitation Council UK, 2015)

4.8 Although community staff would not be expected to have access to additional equipment, they should consider the availability of public access defibrillators (PAD) and may be directed to these by the emergency services. Those regularly meeting patients in public areas should make themselves aware of the location of PAD's.

4.9 **CPR in babies / children** All staff are encouraged to initiate CPR in children even if they haven’t been taught specific paediatric techniques. CPR should be started with the Compression: Ventilation ratio that is familiar and for most, this will be 30:2. The paediatric modifications to adult CPR should be taught to those who care for children but are unlikely to have to resuscitate them. The specific paediatric sequence incorporating the 15:2 ratio (Appendix 3) is primarily intended for those who have the potential to resuscitate children as part of their role (Resuscitation Council UK, 2015).

4.10 **Cross Infection during Resuscitation.** Whilst the risk of cross infection transmission from patient to rescuer during direct mouth-to-mouth resuscitation is extremely rare, isolated cases have been reported. It is recommended that staff use Mouth Shields. The use of a mouth shield is included in training. Chest compressions must be started whilst awaiting the arrival of equipment.

4.11 **Informing Relatives** the patient’s relatives should be informed of the CPR event as soon as is practicable by a staff-member nominated by the person in charge.

4.12 **Post Resuscitation Care:** should the person survive a cardio-respiratory arrest, s/he will be transferred to an acute hospital where post-resuscitation care will be provided.
5.0 POST CARDIAC ARREST REPORTING PROCEDURE

5.1 The outcome of the CPR event must be clearly documented in the patient’s care record by the doctor and the clinician in charge.

5.2 It is imperative that a DATIX Incident Report Form is completed at the earliest possible opportunity.

5.3 The Cardiac Arrest Report Form (Appendix 7a) should be completed for all incidents and attached to the DATIX report. In addition, the Post Cardiac Arrest Review Form should be completed for all inpatients (Appendix 7b) and attached to the DATIX report to provide a full account of the circumstances including early warning scores, actions and outcomes of treatment.

5.4 The senior member of staff on duty at time of the resuscitation incident is responsible for ensuring the Cardiac Arrest Report Form (see Appendices 7a and 7b) is completed accurately.

5.5 Upon receipt of the DATIX report and attached Cardiac Arrest Report and Post Cardiac Arrest Review Form the Head of Clinical Quality & Non-medical Tutor will review to determine if Root Cause Analysis (RCA) should be undertaken.

5.6 Following the conclusion of a CPR event, the clinician in charge or the senior member of staff must ensure that all resuscitation equipment is cleaned, checked and, if necessary, replaced immediately, including all single use equipment, in accordance with infection control procedures.

6.0 PROVISION & MAINTENANCE of EMERGENCY EQUIPMENT & DRUGS

6.1 Basic resuscitation equipment should be held in all clinical areas to enable staff to carry out basic life support. Staff in the community setting (non-Trust properties), will be issued with a mouth shield which should be carried with them at all times whilst on duty.

6.2 Each in-patient ward will have access to the following equipment: pocket masks; an Automatic External Defibrillator (AED) (which will be available during each cardiac arrest incident); a standard grab bag and/or resuscitation trolley, a portable oxygen cylinder and a suction unit. The minimum requirements for emergency equipment are summarised in Appendix 9 - 13.

6.3 In units where additional expertise is available and there is a need for additional equipment to support this, staff are responsible for checking and maintaining this in a ready state, using a local checklist.

6.4 Where restraint and the pharmacological management of acutely disturbed behaviour occur, staff must have access to an AED, oxygen and airway adjuncts.
6.5 Staff must be familiar with the location of all resuscitation equipment within their working area and this must be covered on induction.

6.6 Responsibility for the storage, maintenance and checking of resuscitation equipment resides with the manager of the ward, home or department where the equipment is held.

6.7 The AED must be operationally checked in accordance with Trust’s Medical Devices and Equipment Management Policy and associated Procedure.

6.8 All units will purchase resuscitation equipment from the standardised product list determined by the Medical Equipment and Resuscitation Committee (Appendix 9 - 11) which can be found on the EPUT intranet. The Trust Purchasing department can also assist with codes for ordering items – Telephone 01375 364470 or via 0300 123 0808.

- The crash trolleys at Basildon MHU are owned by Basildon and Thurrock University Hospitals (BTUH) therefore staff must follow guidance on checking equipment and restocking the trolley set in accordance with BTUH check list kept on the crash trolley.

6.9 It is important to ensure that resuscitation equipment is always readily available in the event of a cardio-respiratory arrest. Checking equipment is a requirement that should be undertaken to ensure that resuscitation equipment is maintained in a ready-to-use condition, expiry dates have not lapsed and checks are undertaken and recorded. It is the responsibility of the nurse-in-charge to ensure the following checks are carried out:

Daily checks
The defibrillator must be checked daily to ensure that the machine is rescue-ready, i.e. that the battery is charged and pads are attached, where appropriate. The oxygen cylinder gauge is visible through the resuscitation bag clear panel and should be inspected daily to ensure an adequate supply, i.e. ¾ full.

The numbered tag must also be inspected on a daily basis to ensure that it is the correct serial number and that it has not been broken. Equipment should be replaced one month in advance of its expiry date, (recorded on the checklist).

Where resuscitation equipment is kept on untagged trolley.

Weekly check for grab bag:
In order to ensure that resuscitation equipment is always ready for use, the contents of the resuscitation bag must be checked weekly and the checklist completed to assure that all equipment is present and ready to use. The resuscitation bag must be sealed using a numbered tag, to indicate that it has not been tampered with between these checks. The numbered tag must be replaced weekly.
There is a need for a full check:

- Where resuscitation equipment is kept on untagged trolley;
- When the tag is broken;
- When the tag is missing;
- When the number of the tag is different from the last check;
- Imminent expiry of equipment.

6.10 When checking oxygen cylinders, it is important to note the following:

- **Portable (CD Size) Oxygen Cylinders**: to check the oxygen level in a portable oxygen cylinder, simply take a reading from the gauge rather than turning the cylinder on, as the reading is valid even if the cylinder and valve are both switched off. When a portable oxygen cylinder is full: 460 litres at 10 litres per minute will provide oxygen for 46 minutes, and for 30 minutes if giving 15 litres per minute.

- **Traditional Metal / Large Oxygen Cylinders**: to check the oxygen level, turn open the valve to check and record the available level. Please replace the cylinder when the reading falls to ¼ full (red area) – *do NOT wait until this reaches zero*.

- If a medical equipment item **develops a fault**, call Althea (previously known as TBSGB) on **0844 809 4778** if in South Essex and Bedfordshire, for services in North East and Mid East call **EBME Colchester** (based at Colchester Hospital) - telephone number **01206 742492** (direct line to EBME office). For services in West Essex area call **EBME Harlow** (based at Princess Alexandra Hospital) telephone number **01279 444455** (PAH switchboard-ask to be put through to EBME). More details are available on Input intranet - type the name of company in search box and on **Insite** - type Medical Device and Equipment in search page and provide the following information:
  - The asset code if applicable, if equipment has not been labelled give details of the make and model of the item.
  - The nature of the fault.
  - Name, location and contact telephone number of where they are calling from.
  - Keep the equipment in the department / on site with a notice in red that clearly states that the equipment is “not for use” and that Althea or EBME have been informed.

- In clinical areas where resuscitation equipment trollies are deployed, e.g. Basildon MHU, ECT suites, staff must ensure that appropriate checking procedures are in place to ensure that equipment is ready for use at all times and that the trolley is restocked immediately if equipment is used.
• National Patient Safety Agency (NPSA) Safety guidance on Oxygen in Hospitals state the following robust systems must be in place:
  
a. To ensure reliable and adequate supplies, including checking and stocktaking of cylinders.
  
b. The risks of confusing oxygen and medical compressed air are assessed and action plans developed (e.g. removing the medical air flow meter from the wall outlet when not in regular use).
  
c. In an emergency, oxygen should always be given immediately and documented later. Oxygen is prescribed in all other situations in accordance with British Thoracic Society (BTS) guidelines (these do not cover critical care or children under 16 years).
  
d. It should be noted that oxygen is not kept in areas where it cannot be safely managed e.g. day centres and community areas/units i.e. STARS. Resuscitation equipment would still be available, with a range of airway maintenance, ventilation and defibrillation equipment, all of which can be successfully deployed without using supplementary oxygen.

6.11 Drugs intended for the immediate treatment of cardiac arrest (for example adrenaline 1:10 000 injection, amiodarone 300mg injection) will only be held on wards based on local acute trust sites where an Emergency Response (“crash”) team response is available or where there is additional expertise available. The emergency drugs to be held as part of the Cardiac Arrest Trolley will be determined by the relevant acute trust.

6.12 Other in-patient wards should hold drugs which may be needed in the management of common medical emergencies as part of their normal ward stock. As a minimum:

- Adrenaline injection (1:1000, 1mg/ml)
- Aspirin dispersible (300 mg)
- Glyceryl trinitrate (GTN) 400 microgram spray
- Glucagon injection 1mg
- Glucose solution / tablets / gel / powder
- Midazolam 10mg (buccal)
- Salbutamol aerosol 100 micrograms inhaler

This list will be reviewed as part of the on-going work of standardisation across the Trust.

6.13 Where specialist services are delivered there may be a need for additional equipment or drugs to be held in order to meet local or national guidance. Each service is responsible for ensuring any such guidance is adhered to with regard to procurement, training and regular up-dating of staff.

6.14 In HMP Chelmsford there is additional equipment required to be used in the event of an emergency and all equipment is kept in the bags including items that are for immediate access.

6.15 In Mother and Baby unit, there have two grab bags for adults and babies.

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7.0 POST INCIDENT CARE

7.1 Resuscitation attempts are extremely demanding both physically and emotionally for patients, their relatives, carers and staff. Care should be taken to ensure that those people who may be traumatised by the incident are identified. Every effort should be made to support those involved by listening and offering appropriate support immediately following the incident and at a later stage.

7.2 Debriefing following a cardiac/respiratory arrest must be handled with sensitivity. Team leaders, ward managers, matrons, consultants and senior medical staff are identified to engage with patients, relatives, carers and staff who may have been affected following an incident.

7.3 Many staff will have little experience of dealing with such a traumatic event as a cardiac arrest. The objective is to provide support for those involved and for staff to learn from the incident and allow those involved the opportunity to discuss the event in a constructive way. Debriefing by a person with facilitation experience should take place within seven days of the incident. If the incident happens in a ward or residential setting a meeting with patients / residents should be convened so that support and appropriate aftercare can be offered as necessary.

8.0 RESUSCITATION STATUS & DECISIONS RELATING TO DNACPR

8.1 Please refer to the DNACPR Procedure for more detailed guidance.

8.2 The resuscitation status of each in-patient must be clearly communicated to all staff. As a minimum this must be recorded on the handover sheet. It is imperative that any additional measures to communicate this e.g. list kept in nursing office; red dot against name, must be kept up-to-date with accurate information at all times.

8.3 It must be recognised that a DNACPR Order applies solely to the use of CPR and, in general terms, the following will still be provided: medical treatment; position and comfort; control of any bleeding; analgesia; providing oxygen, if required; providing emotional support; and, liaison with other healthcare providers – for example, a hospice and/or home care.

8.4 In some circumstances, there may be reversible causes of a cardio-respiratory arrest that are either pre-planned or acute, where it would be appropriate to suspend a DNACPR decision. For example: certain pre-planned medical procedures (such as the induction of anaesthesia, surgical operations) or acute events (where the person suffers from an acute, unforeseen, but immediately life threatening situation, such as anaphylaxis or choking) could precipitate a cardio-respiratory arrest. In these circumstances, the individual should receive treatment, unless intervention in these circumstances has been otherwise specified Decisions Relating To Cardiopulmonary Resuscitation 3rd Edition (1st revision) 2016").
8.5 If a DNACPR decision is made on medical grounds, not in relation to a mental health condition and a person attempts to end their life, every reasonable attempt should be made to resuscitate the individual in this situation as the DNACPR form was not completed with the eventuality of suicide in mind.

9.0 TRAINING

9.1 Upon induction, each staff-member must make themselves aware of the availability and location of emergency equipment within the clinical / service area, and reporting procedure.

9.2 There is a requirement for Trust staff to achieve a level of competency in CPR that is appropriate to their role, for which they will be expected to attend for training on an annual basis.

9.3 Training will be provided in accordance with the United Kingdom and European Resuscitation Council’s Guidelines. Training guidelines will be regularly updated in accordance with the Council’s updates, which should be read in conjunction with the Trust’s Induction / Mandatory Training Policy.

9.4 The Trust’s Workforce Development and Training Department will provide training in accordance with the requirements of the clinical service and as set out within the Mandatory Training Policy.

9.5 The service manager/team lead/matron in each clinical service will be responsible for ensuring that simulations of CPR events are undertaken at least three times each year. This may include simulation of emergency situations facilitated in the workplace by Workforce Development. Each ward or unit must record when simulation events occur.

9.6 Regular training updates on how to use emergency equipment safely and effectively will be incorporated within all BLS / CPR training sessions.

9.7 All staff in mental health in-patient areas will undergo training in relation to Early Detection of the Deteriorating Patient incorporating use of EWSS and SBAR tool.
10.0 REFERENCES


5. **Health and Social Care Act** 2008 rev 2015


9. **National Patient Safety Agency** (2009) *Oxygen safety in hospitals (acute, community and mental health)* found at: http://www.nrls.npsa.nhs.uk/resources/?entryid45=62811&q=0%c2%acoxygen%c2%ac


CHECK LIST FOR DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION - DNACPR

WHEN YOU RECEIVE SOMEONE INTO YOUR CARE IT IS YOUR RESPONSIBILITY TO CHECK THE DNACPR STATUS. THIS INCLUDES ENSURING THAT THEY HAVE A VALID FORM THAT HAS BEEN COMPLETED

**Patient details** must be legible and complete – a printed sticker is acceptable

**Date of DNACPR order** must be completed. A document without this is not valid

**REASON**

- **Diagnosis why medically futile**: must be clear. It must clearly state END STAGE and list all co-morbidity.
- **Never accept if states**: dementia, frailty or learning disability.
- **Good examples**: dementia with co-morbidities End stage heart failure and COPD.
- **Why CPR would not be acceptable**: should state something like prolonging suffering.
- **Patient does not want CPR**: it must state the date of conversation and who was present.

**RECORD OF DISCUSSION**

All boxes must be ticked or crossed to indicate yes or no.

There must be a record of the discussion, which includes time, date and who was present at the conversation. This should also be recorded in medical notes. If a discussion has not been had then it is essential that it is recorded the reason why this did not happen.

**HEALTH PROFESSIONALS COMPLETING THE FORM**

The person who has written on the form and had the discussions should sign here as a record that it has happened. If it is the same person who is authorised to sign the form it should still be completed. Some ambulance crews may not accept it not completed

**REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN**

This should always be completed with a signature, date and the position of the senior clinician.

Is DNACPR decision indefinite **Yes or No** must be ticked or crossed

If No is marked it must state a review date. It is not valid without the review date for an indefinite decision and if the review date has passed it is not valid.
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

Name: ____________________________  (OR USE ADDRESSOGRAPH)
Address: __________________________
Postcode: __________________________
NHS number: ________________________  Date of birth: ____________

Date of DNACPR order: ____________

REASON FOR DNACPR DECISION (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful (i.e. medically futile) because: ____________________________________________________________

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because: ________________________________

☐ Patient does not want to be resuscitated as evidenced by: ______________________________________________________________

RECORD OF DISCUSSION OF DECISION (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney (welfare)? Yes ☐ No ☐ If ‘yes’ record content of discussion. If ‘no’ say why not discussed.

Discussed with relatives / carers / others? Yes ☐ No ☐ If ‘yes’ record name, relationship to patient and content of discussion. If ‘no’ say why not discussed.

Discussed with other members of the health care team? Yes ☐ No ☐ If ‘yes’ record name, role and content of discussion. If ‘no’ say why not discussed.

Is DNACPR decision indefinite? Yes ☐ No ☐ If ‘no’ specify review date: __________________________

HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER

Name: ____________________________  Signature: __________________________
Position: __________________________  Date: ____________  Time: ____________

REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN

Name: ____________________________  Signature: __________________________
Position: __________________________  Date: ____________  Time: ____________
Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?

YES

If there is no reason to believe that the patient is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with the patient (or those close to patients who lack capacity) about CPR. If, however, the patient wishes to discuss CPR this should be respected.

NO

Is there a realistic chance that CPR could be successful?

YES

When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient's wishes about CPR. However if a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it unless that would cause them severe distress. Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation. Where the patient lacks capacity and has a LPA health and welfare or CAD, this person should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussions about the patient's care. If a second opinion is requested, this request should be respected, whenever possible.

NO

Does the patient lack capacity and have an advance decision refusing CPR or a LPA health and welfare with relevant authority?

YES

If a patient has made an advance decision refusing CPR and the criteria for applicability and validity are met, this must be respected. If an attorney or deputy has been appointed they should be consulted.

NO

Are the potential risks and burdens of CPR considered to be greater than the likely benefits of CPR?

YES

When there is only a small chance of CPR being successful and/or there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial.

NO

CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.

PLEASE NOTE: Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully. Advice should be sought if there is uncertainty.
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Children less than 16 years of age

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Date of DNACPR decision:</th>
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In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1a. Does the child have capacity to make and communicate decisions about CPR? If “YES” go to 1b. If “NO” go to 1c.

1b. Has the child been involved in the decision-making process? Now go to 1c.

1c. Have the child’s parents (or those holding legal parental responsibility) been consulted and agreed to the application of this decision? If “YES” go to box 2.

1d. Has a Court made an order in respect of this decision? If “YES” go to 1e.

If the answers to both 1c and 1d are “NO”, legal advice must be taken before proceeding. All other decisions must be made in the child’s best interests and comply with current law.

1e. Date, time, location and name of Judge/Court making order:

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child’s best interests:

3. Summary of communication with child. If this decision has not been discussed with the child state the reason why:

4. Name of person(s) holding parental responsibility and summary of communication with them:

5. Names of members of multidisciplinary team contributing to this decision:

6. Healthcare professional recording this DNACPR decision:

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   Signature   Date   Time

7. Review and endorsement by most senior health professional:

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   Review date (if appropriate):

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Paediatric DNACPR Guidance Notes

Resuscitation Council (UK)

This form should be completed legibly in black ball-point ink
All sections should be completed

- The patient’s full name, date of birth and address should be written clearly.
- The date of recording the decision must be recorded.
- This decision will be regarded as “INDEFINITE” unless it is clearly cancelled or a definite review date is specified.
- The decision should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the decision.

1. Child’s capacity: Parental responsibility and decisions
   - Record the assessment (using Fraser guidelines) of the child’s capacity in the clinical notes.
   - If the child is noted to have capacity but not included in the decision process a detailed, reasoned explanation for that should be included in the clinical notes and summarised in section 3.
   - Record all discussions with those holding parental responsibility in the notes. Document all action points discussed with a clear indication of the absence or presence of parental agreement. Any disagreements that cannot be resolved should be discussed with your Trust’s legal department for advice before recording a DNACPR decision.
   - Record all communications with the courts.
   - The date, time and name of the Court must be recorded in section 1e where the Court has been involved or made a formal ruling on the application of this decision. A copy of the Court order should be filed in the patient’s health record.

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the child’s best interests
   Be as specific as possible.

3. Summary of communication with child...
   If this decision was not discussed with a child in capacity summarise the reason why this was inappropriate (Full detail should be recorded in the clinical notes). Otherwise state clearly what was discussed and agreed.

4. Summary of communication with persons holding parental responsibility
   Whether or not the child has capacity their legal guardians (i.e. persons with parental responsibility) must be consulted. If the child has capacity and has been consulted great care must be taken to ensure that discussions do not compromise the clinician-child relationship. If the child and their guardians are not in agreement a legal opinion should be sought.
   State the names and relationships of guardians with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. Members of multidisciplinary team...
   State names and positions. Ensure that the DNACPR decision has been communicated to all relevant members of the healthcare team.

6. Healthcare professional recording this DNACPR decision
   This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7. Review / endorsement ...
   The decision should be discussed with and endorsed by the most senior healthcare professional responsible for the child’s care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.
PROCEDURE: DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

PROCEDURE REFERENCE NUMBER: CLPG14B
VERSION NUMBER: V 1
REPLACES SEPT DOCUMENT: CLP14
REPLACES NEP DOCUMENT: CP8/Resuscitation/02/16
KEY CHANGES FROM PREVIOUS VERSION: Merged policies; updated appendices; additional procedure Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

AUTHOR: Practice Educator
CONSULTATION GROUPS: Resuscitation and Deteriorating Patient Group

IMPLEMENTATION DATE: n/a
AMENDMENT DATE(S): n/a
LAST REVIEW DATE: August 2017
NEXT REVIEW DATE: August 2020
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE: 16 August 2017
RATIFICATION BY QUALITY COMMITTEE: 14 September 2017

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PROCEDURE SUMMARY
This procedure is to provide guidance to all staff working within Essex Partnership University NHS Foundation Trust regarding the process of making, recording and reviewing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
Through the Resuscitation and Deteriorating Patient Group who will review audit findings and clinical incident reports as appropriate.

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The Director responsible for monitoring and reviewing this procedure is Executive Nurse
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DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) PROCEDURE

1.0 INTRODUCTION

1.1 Cardiopulmonary resuscitation (CPR - attempting to restart the heart and breathing) can be attempted on any person in whom cardiac or respiratory functions have ceased (also referred to as a cardiac or respiratory arrest). Failure of these functions is part of dying and thus CPR can theoretically be attempted on any individual as part of an attempt to preserve life. However, because there comes a time when death is inevitable for every person, it is essential to identify patients for whom cardiopulmonary arrest represents a final event in their illness and in whom attempted CPR may be inappropriate. It is also essential to identify those patients who do not want CPR to be initiated.

1.2 It must be emphasised that every patient (and/or their family), for whom a DNACPR decision is considered, must be given the opportunity to be involved in the decision-making process, and be informed of the decision unless this would cause them harm, or they have stated that they do not wish to be involved or informed. This policy does not distinguish between basic and advanced resuscitation since the underlying ethical and legal principles about how decisions should be reached are the same.

1.3 It is most important however, that it is understood that a decision not to commence CPR does not in any way diminish the importance of on-going medical and nursing care. The change of focus of care should be effected by those involved in managing the patient and should be assisted by the appropriate palliative care.

1.4 It must be emphasised that the implementation of a DNACPR decision relates solely to the withholding of artificial ventilation and delivery of chest compressions to a person in cardiac arrest. All other treatments and interventions deemed appropriate will be given. The responsibility for making decisions about resuscitation lies with the Consultant or General Practitioner (GP) in charge of the patient’s care.

1.5 Where a valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is not available in the Medical records (or appropriate location) and the precise wishes of the patient are unknown, cardiopulmonary resuscitation should be initiated if cardiac or respiratory arrest occurs.

2.0 SCOPE

2.1 This procedure applies to all staff (including voluntary workers, students, locum and agency workers) on all sites, within EPUT.
3.0 LEGAL ISSUES

3.1 In order to meet their obligations under the Human Rights Act (1998), health professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempted CPR include:

- The right to life (Article 2).
- To be free from inhumane or degrading treatment (Article 3).
- Respect for privacy and family life (Article 8).
- Freedom of expression, which includes the right to hold opinions and to receive information (Article 10).
- Freedom from discriminatory practises in respect of these rights (Article 14).

3.2 If any concerns arise regarding the application of a DNACPR order, the senior doctor in charge of the patient’s care should be informed. If concerns still exist, the Medical Director should be informed and the advice of the Trust’s legal advisors should be sought.

4.0 DNACPR DECISION

4.1 The British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

- Where the individual’s condition indicates that effective CPR is unlikely to be successful
- When CPR is likely to be followed by a length and quality of life not acceptable to the individual
- Where CPR is not in accord with the recorded, sustained wishes of an individual who is deemed mentally competent or who has a valid applicable ADRT.

4.2 It is recommended that early decisions about CPR status and advance planning about limits of care should be made when patients are at risk of a cardiorespiratory arrest and there should be a clear and explicit resuscitation plan. In particular, consideration of this should be given to patients on older adult wards.

4.3 For situations when CPR might restart the heart and breathing of the individual, discussion will take place with that individual if this is possible (or with other appropriate individuals for people without capacity), although people have a right to refuse to have these discussions.

4.4 If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, health professionals will commence CPR in the event of a cardiac or respiratory arrest as per CPR Policy.
4.5 There may be some situations in which CPR is commenced on this basis, but during the resuscitation attempt further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR decision, or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.

4.6 When considering making a DNACPR decision for an individual it is important to consider the following:

- Is cardiac or respiratory arrest a clear possibility for this individual? If not, it may not be necessary to initiate discussion with the patient.
- If cardiac or respiratory arrest is a clear possibility for the individual, and CPR may be successful, will it be followed by a quality of life that would not be of overall benefit to the person? The person’s views and wishes in this situation are essential and must be respected. If the person lacks capacity, a LPA will make the decision. If a LPA has not been appointed a best interests decision will be made.
- If the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual.

4.7 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:

- The DNACPR decision is made following discussion with patient/others, this must be documented in the patient’s medical notes and a clear and explicit resuscitation plan developed.
- The DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this, then a discussion with relatives/carers should only take place with the patient’s permission. All discussions and decisions, including rationale must be clearly documented in the patient’s records.
- If a discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, the reason for this must be clearly documented in the patient’s medical notes.

5.0 DOCUMENTATION

5.1 Any decision relating to resuscitation must be communicated to the entire team of health professionals caring for that patient. A DNACPR decision should be reviewed on each transfer of care, but remains valid until it is reviewed.

5.2 The senior doctor is responsible for writing and authorising the order, then informing relevant clinical staff (e.g. nursing teams, other departments, and those areas required to be aware) that the order is in existence.

5.3 If a DNACPR decision is made, the doctor in charge of the patient’s care (i.e. Consultant or GP) is responsible for ensuring that the DNACPR form is completed (as per Appendix 2) and the printed, signed original form is retained in the front of
the patient’s notes. Where the facility exists, a copy should be scanned onto the electronic patient record, for audit purposes.

5.4 If the patient is discharged or transferred to another healthcare establishment, whilst still subject to a DNACPR, the original DNACPR form MUST accompany the patient at all times.

5.4.1. Information needed on a DNACPR order:
- Patient’s details.
- Date of decision.
- Assessment of patient’s capacity.
- Clinical reasons for decision.
- Summary of communication regarding the decision with patient or their Attorney.
- Summary of communication with patient’s relatives or significant others.
- Names of multi-disciplinary team members contributing to the decision.
- Name, position and signature of healthcare professional completing the decision.
- Review and endorsement by doctor in charge of the patient’s care (Consultant or GP).

5.5 The original DNACPR form must be stored safely in the most appropriate place for the particular clinical environment. Where a physical set of notes exists, the DNACPR form should be filed at the front, however where electronic patient records are in existence an alternative system such as a ‘DNACPR folder’ should be agreed. Wherever the form is stored it must be immediately available in the case of an emergency.

5.6 In the community the DNACPR form should be kept safely in the patient’s home and be accessible to all staff involved in their care. All staff should be aware of its existence. It is essential that the form goes with the patient when undergoing hospital treatment and is returned to them on discharge.

6.0 REVIEWING A DNACPR

6.1 The DNACPR decision will be regarded as ‘indefinite’ unless:
- A definite review date is specified
- There are improvements in the patient’s condition
- The patient’s express wishes change

The frequency of review should be determined by the health care professional in charge of the individual’s care.

6.2 It is important to note that the patient’s ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR is reviewed, the clinician must consider whether the person can contribute to the decision-making process each time. It is not usually necessary to discuss CPR
with the person each time the decision is reviewed, if they are involved in the initial decision. Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

6.3 Prior to discharge from an in-patient facility, all DNACPR decisions should be reviewed and if the decision is to remain valid on discharge this needs to be communicated to the GP and community staff involved in providing support on discharge.

7.0 CANCELLATION OF DNACPR

7.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision by a doctor ST3 grade or above. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point pen and the word ‘CANCELLED’ written clearly between them, dated and signed by the healthcare professional cancelling the order.

7.2 It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision. The DNACPR form is then folded in half and filed at the back of the patient’s medical notes.

7.3 If a copy of the DNACPR form is kept in the electronic patient records and the DNACPR decision is cancelled or suspended then the record must be updated to reflect this and steps must be taken to ensure that the DNACPR form does not appear to remain as a live document. For example on Mobius a request should be made to move the form to historical alerts via the ‘report a problem’ facility and a reason given. This should be done at the same time as scanning a copy of the ‘cancelled’ document.

8.0 SUSPENSION OF DNACPR

8.1 Uncommonly, some patients for whom a DNACPR decision has been established may have a cardiac or respiratory arrest from a readily reversible cause. In such situations CPR would be appropriate, whilst the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. It may therefore be appropriate and necessary to ignore or override a DNACPR order or an ADRT and give treatment and/or resuscitation in such circumstances such as anaphylaxis or choking.

8.2 Some procedures could precipitate a cardiac or respiratory arrest, for example, induction of anaesthesia, surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the patient where applicable, will need to take place.

8.3 If a DNACPR decision is made on medical grounds, not in relation to a mental health condition and a person attempts to end their life, every reasonable attempt should be made to resuscitate the individual in this situation as the DNACPR form was not completed with the eventuality of suicide in mind.
9.0 LACK OF AGREEMENT

9.1 A patient with Capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an Advanced Decision to Refuse Treatment (ADRT). An ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the ADRT, but it is not essential. If the patient had capacity prior to a cardiac arrest event, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. The verbal refusal should be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented. The patient should be encouraged to make an ADRT to ensure the verbal refusal is adhered to.

9.2 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a DNACPR form in their possession. An appropriate sensitive discussion with the patient should aim to secure their understanding and acceptance of the DNACPR decision. Fully documented discussion with relevant multi-disciplinary team members and family where possible would provide evidence of best practice. Additionally a second opinion may be sought in some circumstances.

9.3 Individuals do not have a right to demand that doctors carry out treatment against their clinical judgment. It may arise in rare cases that a clinical decision is seriously challenged and agreement cannot be reached, in these circumstances legal advice may be indicated.

10.0 PATIENTS WHO LACK CAPACITY

10.1 A person must be assumed to have the capacity to make a decision, unless it can be established that they lack capacity.

10.2 All decisions made on behalf of a person who lacks capacity must be made in that person’s best interests. In the absence of a valid ADRT, DNACPR order, decision from a Court Appointed Deputy (CAD) or Lasting Power of Attorney (LPA), the person’s best interests will be served by performing CPR, in an emergency.

10.3 If a decision relating to resuscitation is to be made, a ‘decision-specific’ assessment of the person’s capacity must be made specifically relating to the DNACPR decision. Please refer to the Mental Capacity Act Policy and chapter 4 of the MCA Code of Practice for detailed information around assessing capacity. Assessments of Capacity should be clearly recorded on the Trust’s Mental Capacity Assessment Form 1.
10.4 If the patient has an LPA in place, or a CAD, authorised to make decisions in respect of CPR, then the decision of the LPA/CAD should be respected.

10.5 If the assessment shows that the person lacks capacity to make a decision relating to DNACPR, the decision must be made on their behalf using the best interest guidelines. These are set out in the MCA Code of Practice. In some cases not all of these factors will be relevant, and in others additional factors may need to be considered. Please refer to the Mental Capacity Act Policy and chapter 5 of the MCA Code of Practice for further guidance when determining best interest decisions. Best interest decisions should be made with involvement from the multidisciplinary team where possible and clearly documented, including as much information as possible on the Trust’s Best Interest Decision Form, Form 3.

10.6 Lasting Powers of Attorney
An LPA is someone nominated by the patient to make decisions about health and welfare when he or she had capacity. For an LPA to be valid, it must be in a prescribed form, registered with the Court of Protection. For the LPA to be able to make decisions relating to CPR the patient must lack capacity and must have given authority under the LPA to give or refuse consent to life-sustaining treatment on their behalf. The LPA must act in the patient’s best interests at all times.

10.7 Family and friends
It is a statutory requirement that family and friends are consulted if a patient lacks capacity and clinicians wish to act in his or her best interests. Friends or relatives of patients often believe that they will be the decision maker for the patient, however no person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision-making capacity, except where there is a LPA in place.

Clinicians have authority to act in the patient’s best interests where consent is unavailable. People close to the patient should be kept informed and may be asked to reflect the patient’s views and preferences, but it must be made clear to them that their role is not to make decisions on behalf of the patient. It is helpful for the clinician to ascertain known wishes of the patient, prior to the loss of capacity, from family and friends whilst making a best interest decision. Details of discussions and those involved should be recorded on the MCA form and within the patients records.

11.0 CHILDREN AND YOUNG PEOPLE

11.1 A child is someone under the age of 18. The MCA applies to anyone aged 16 and over but they cannot make an ADRT or give an LPA until the age of 18.

11.2 As a general rule, the wishes of a ‘Gillick competent’ child, who has sufficient understanding and intelligence to understand what is proposed by way of treatment, should be respected. Decisions relating to resuscitation should be made in full consultation between all relevant professionals and the parents. Staff should not rely solely on the wishes or directions of parents. Parents or anyone with parental responsibility must, however, be consulted as to whether the
The proposed contents of the Personal Resuscitation Plan (PRP) seem appropriate. Where feasible, the child’s wishes should be obtained. (See http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html for basic information on ‘Gillick competence’)

11.3 It will normally be the case that the overall responsibility for drafting and reviewing PRPs rests with the Consultant Paediatrician. S/he should draft and review the PRP in consultation with the relevant nursing teams. The PRP must be recorded in the documentation.

11.4 If agreement cannot be reached as to whether CPR or other emergency treatment would be in the best interests of the child, e.g. there is an issue between staff and parents about the application of a PRP, a Court declaration should be sought.

11.5 The consultant and nursing team must ensure the plan is communicated to all those involved in the child’s care. It must be ensured that schools where children subject to a PRP attend are fully aware of the PRP, are issued with copies and updates as necessary and that there is full and effective communication between all medical and nursing teams working with that particular child and school.

11.6 If a child is incompetent, in the absence of a PRP, staff should provide emergency treatment in child’s best interests, using the same principles that apply to adults.

11.7 In an emergency situation, any doubt should be resolved in favour of preserving life.

12.0 COMMUNICATION

12.1 If the individual has capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family and friends must be respected. Where individual’s lack capacity and their views on involving family and friends are unknown, health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individuals ‘care and is not contrary to their interests’

12.2 Effective communication concerning the individual’s resuscitation status will occur between all members of the multidisciplinary healthcare team involved and across the range of healthcare settings.

12.3 For in-patients a DNACPR decision should be recorded on the handover sheet and resuscitation status should be verbally handed over at the start of each shift.

12.4 Any additional measures used to communicate resuscitation status must be accurate and used consistently in the clinical area e.g. red dots on whiteboard, lists of patient resuscitation status.
13.0 TRANSFERRING PATIENTS

13.1 When transferring a patient, the original DNACPR form should be seen by the ambulance crew and remain filed in the accompanying medical notes or patient care record. Photocopied DNACPR forms or Personal Resuscitation Plan (PRP) should not be sent unless they are acceptable to the transferring ambulance service and receiving healthcare provider. They may accept a copy which they should sign to say they have seen the original.

13.2 Internal transfers and all accompanied visits off Trust premises
If the patient is transferred to another ward or hospital, the DNACPR order will remain in place until reviewed by the new consultant.

13.3 If a patient is taken off Trust premises and accompanied by a Trust member of staff, the original DNACPR order or PRP must travel with the patient and be adhered to if necessary.

13.4 Transfers into EPUT Services
Where a patient is transferred into an EPUT service with a current and applicable East of England unified form of DNACPR, this decision will be upheld until it is reviewed by the receiving consultant.

13.5 Where a patient is transferred with an existing DNACPR form, this should be checked for accuracy and completeness (See appendix 1), particularly with regard to discussion with relatives. If this discussion has not taken place, then arrangements should be made to address this as soon as possible with the patient’s consent or as part of a best interest decision if they lack capacity.

13.6 Transfers out of EPUT Services
When a patient is transferred out of EPUT services with a DNACPR order, the original order must accompany them and should be reviewed by the GP or consultant taking charge of the patient.

14.0 REFERENCES


7. **National Patient Safety Agency** (2008) Resuscitation in mental health and learning disability settings [http://www.nrls.npsa.nhs.uk/resources/healthcare-setting/mental-health-service/?entryid45=59895&q=0%c2%accardiac+arrest%c2%ac](http://www.nrls.npsa.nhs.uk/resources/healthcare-setting/mental-health-service/?entryid45=59895&q=0%c2%accardiac+arrest%c2%ac)


END
TEN ESSENTIAL SHARED CAPABILITIES – DEPARTMENT OF HEALTH

A framework for the whole of the Mental Health Workforce

1. **Working in Partnership** - Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

2. **Respecting Diversity** - Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3. **Practicing Ethically** - Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

4. **Challenging Inequality** - Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in communities they come from.

5. **Promoting Recovery** - Working in partnership to provide care and treatment that enable service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. **Identifying People’s Needs and Strengths** - Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.

7. **Providing Service User Centred Care** - Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

8. **Making a difference** - Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

9. **Promoting Safety and Positive Risk Taking** - Empowering the person to decide the level of risk they are prepared to take with their health and safety and positive risk taking including assessing and dealing with possible risks for service users, carers, family members and the wider public.

10. **Personal Development and Learning** - Keeping up to date with changes in practice and participating in lifelong learning, personal and professional development for one’s self and colleagues through supervision, appraisal and reflective practice.
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<tr>
<td>AUTHOR:</td>
<td>[redacted] Associate Director, Community Mental Health Services</td>
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<td>AD’s, Service Managers and Community Teams Community Quality and Safety Group Members Workforce Development Policy Group (North)</td>
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<td>26 May 2017</td>
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<td>RATIFICATION BY QUALITY COMMITTEE:</td>
<td>15 June 2017</td>
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## POLICY SUMMARY

- This policy outlines the implementation of the Care Programme Approach (CPA) and Non-CPA for Essex Partnership University NHS Foundation Trust (EPUT). The policy must be applied together with other relevant legislation, and should be read in conjunction with the CPA Procedure which provides detailed reference for staff and advice regarding care under CPA and Non-CPA.

- The CPA is a process which describes the approach used in secondary mental health services to assess patients, develop a personalised care plan, manage risk, review and coordinate care to address patient needs.

- This policy applies to, and is mandatory for, all staff working within mental health services and learning disability provided by the Trust. It sets out the policy governing the operation/delivery of CPA & Non-CPA within the Trust.
The commitment of the Trust and responsibility of all staff in everything we do is not to discriminate on any grounds. In drawing up this policy aspects of discrimination have been considered so that particular groups are not disadvantaged.

The Trust monitors the implementation of and compliance with this policy in the following ways:

Performance Standards, KPI’s, Audit, Supervision, 1-1s and Trust wide CPA Steering Group.

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<td>Essex MH&amp;LD</td>
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The Director responsible for monitoring and reviewing this policy is Executive Director of Corporate Governance & Strategy
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA POLICY

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1.0 INTRODUCTION
2.0 SCOPE OF THE CARE PROGRAMME APPROACH
3.0 CPA PROCESS
4.0 TRAINING
5.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION
6.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

APPENDICES

Appendix 1 – Ten Essential Shared Capabilities
1.0 INTRODUCTION

1.1 The Care Programme Approach was introduced by the Department of Health (DoH) in 1991 to provide a framework for effective mental health care to all patients and carers regardless of age, disability, race, ethnic origin, nationality, gender, gender reassignment, sexual orientation, marital status, religion, culture, belief, spirituality, pregnancy and maternity.

1.2 CPA is a framework for assessing, planning, implementing/delivering care, and then evaluating the effectiveness of that care/intervention.

1.3 The patient/carer is put at the centre of care planning and delivery. Comprehensive information is given to patients so they can make informed choices with regards to their care and treatment based on their diverse needs, strengths and preferences.

1.4 Values and principles of person-centred care include:
   - Focussing on the individual and recovery.
   - Assessing and planning the care for the person as a “whole”.
   - Promoting and supporting self-care.
   - Recognising the role and needs of carers.
   - Services based on fulfilling therapeutic relationships and partnerships between the people involved.

1.5 The CPA process promotes safety, positive risk taking, and recovery/living well through a whole life focused approach and draws specifically on the Ten Essential Shared Capabilities (ESC).

1.6 The term ‘Patient’ will be used throughout this CPA Policy. This refers to service users, clients, residents.

2.0 SCOPE OF THE CARE PROGRAMME APPROACH

2.1 Following the initial assessment, service users will be placed on either CPA or Non-CPA. The decision to provide care under CPA or Non-CPA is a clinical decision.

- **CPA**: An individual deemed to have complex needs, a higher risk profile and/or requiring multi agency input should be placed on CPA.

- **Non-CPA**: An individual with more straightforward needs, one agency input or no problems with access to other agencies/support and lower risks should be placed on Non- CPA.
2.2 CPA or Non-CPA is applicable to all individuals (adults, older adults and younger people) receiving secondary mental health services in whatever setting that care is delivered. Therefore, throughout this policy, reference to the CPA framework includes the two levels (CPA & Non-CPA).

2.3 The following key groups will automatically be considered to require the support of CPA. Those:

- Who are admitted to a mental health hospital as an inpatient.
- Who have parenting responsibilities.
- Who have caring responsibilities.
- Who are unsettled in their accommodation.
- Who have a history of violence or self-harm.
- Who have known history of suicide attempts/ideations.
- Who have co-morbid drug and alcohol or physical health conditions.
- Who have complex physical, psychological and social needs.
- Who have learning disabilities.
- Who are accepted for treatment (as opposed to just assessment) by the Home Treatment Team.
- Who are under the care of the Early Intervention Team.
- Who are supported under S117 of the Mental Health Act.
- Who are subject to a Community Treatment Order (CTO) under the Mental Health Act.
- Who are under a Guardianship Order under the Mental Health Act (Section 7).
- Who are subject to safeguarding procedures.

### 3.0 CPA PROCESS

3.1 **Referral**
Referrals are received from a range of sources including GP’s, local authority social services, the voluntary sector, probation services, police service, carers, family members, neighbours, other organisations, any other professionals (e.g. district nurse, pharmacist, etc.) and in some instances individuals user may self-refer.

3.2 **Components of CPA**
The main components of the CPA framework are:

- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Reviewing
- Co-ordinating care
- Transitions
3.3 **Assessment**
Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical health and social care needs (in line with the Care Act 2014) and this must always include an assessment of risk.

3.4 **Risk**
Risk assessment is an essential and on-going part of the CPA process and there must be a specific assessment of the level of risk posed to self and/or others using the Trust’s approved risk assessment tool.

3.5 **Care Plan**
A care plan is intended to provide a shared understanding of care being provided for each individual. It is a written record outlining who is doing what, when and where, how and why, and must be written using language and terminology that the patient and their family or carer (if appropriate) are able to understand.

3.6 **Coordinating Care**
Care co-ordination is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care.

- The term Care Co-ordinator is used for those working with individuals supported by the CPA Process.
- The term Lead Professional is used for those working with individuals on Non-CPA.

3.7 **Review**
Review is the way we find out if the care plan is working, look at the progress the patient has made and the ways in which their needs may have changed. On review, consideration must be given to whether or not care should continue to be delivered under CPA.

3.8 **Transitions**
Individuals can experience any number of transitions during their contact with our service, such as discharge from services, transfer between services, or transfer of care to another provider.

3.9 **Carers**
Carers play an important role in the support required in helping to contribute to a person’s recovery and wellbeing. Carers are entitled to a holistic assessment of their own needs in order to continue their caring role, even if the person they are caring for refuses support from the mental health service.
4.0 TRAINING

4.1 All staff who undertake the role of care co-ordinator will complete eLearning training every three years

5.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

- Department of Health 1991, Care Programme Approach
- Department of Health 2008, Refocusing the Care Programme Approach
- Department of Health 1994, Ten Essential Shared Capabilities
- Mental Health Act 1983 (amended 2015)
- Mental Capacity Act 2005
- The Care Standards Handbook 2014 (Care Co-ordination Association)
- Care Act 2014

6.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Advance Decisions
- Carers Strategy
- Clinical Risk Assessment and Management
- Discharge Procedure
- Equality & Diversity Policy
- Information Governance Policy
- Records Management Policy
- Safeguarding Children & Adults Policy
- S117 Protocol
- 7 Day Follow up Policy
- Induction and Mandatory Training Policy and Procedure

END
Your Care and the Care Programme Approach (CPA)

Information for Patients and Carers

Name of your Care Co-ordinator/Lead Professional:

........................................................................................................

Their Contact Details:

Office No: ......................... Mobile No: .................................
What Is the Care Programme Approach?
The care you receive from our Mental Health Service is organised under the framework called the Care Programme Approach (CPA).

What does it involve?
- You telling us about your needs
- Planning your care
- A professional who will coordinate your care
- Receiving a regular review of your care

The Process
YOU are the most important person in the CPA process and will be involved at all stages. A named professional will work with you

- **ASSESSMENT** of your health and social care needs
- **CARE PLAN** of help and support you will receive
- **REVIEW** of the help and support you are receiving

- When you are referred to the Trust you will receive a full assessment of your health and social care needs. Your assessment is a *discussion* about your health and social situation; it is **not** a test.

- All areas of your health and social situation will be considered, including your physical health, cultural and religious needs and any problems arising from age, gender and race. We also look at your medical and physical health because all of these can have an effect on your mental wellbeing.

- In your assessment we look at things that affect your mental wellbeing, such as your housing, employment, benefits needs and your family situation. We will look at what is going well for you as well as the ways in which you are experiencing difficulties and how we can work together to resolve these.

- The assessment will look at any identifying any risks and look at ways of maintaining safety for you and others around you.
With your permission other people who know you well (family / friends/ carer) can be included in the assessment process.

**Carers**

All carers are entitled to an assessment of their needs while they are supporting and looking after you. This is known as a carers’ assessment.

Your carer is the person who provides regular unpaid help to support you to manage your daily life. Your carer may be a parent, your son or daughter, a relative, a partner, a neighbour or a friend. The support they provide to you may be physical, practical or emotional. Carers can ask for a review of your care at any time.

**CPA or Non-CPA**

After your assessment, we will allocate your care to either CPA or Non-CPA. This will depend upon your needs.

- If your needs are straightforward and there may only be one Professional involved in your care, you will receive your care under Non-CPA.
- If your needs are more complex and there are a number of professionals involved, you will receive your care under CPA.

**Who co-ordinates your care?**

The person responsible for co-ordinating your care will be a lead professional for those on Non-CPA or your care co-ordinator for those on CPA. He or she is a qualified mental health professional and may be a psychiatrist, nurse, social worker, occupational therapist or other member of the mental health team.

This is the person who works closely with you. He or she plans your support and keeps in contact with all the other people who are helping you. He or she will be your central point of contact and will be responsible for:

- Fully assessing your needs alongside you.
- Working together with you to put together a care plan that you agree with.
- Making sure you get the help and care you need, as agreed with you (or explaining why this is not available).
- Meeting with you regularly to have a full discussion about your health and wellbeing (your family/carer can be involved in this), to make sure the care plan is working and reviewing this if necessary.
- Keeping contact with you as long as you need our help, and telling others if contact is lost.

- Ensuring, if you have spent time in hospital, that you will be visited within 7 days of your discharge.

- Ensuring anyone living with you must be offered a carers needs assessment and care plan.

What if I can’t contact my care co-ordinator?

Your crisis plan will tell you what to do and who to contact in an emergency, and include what to do if you have an urgent problem out of office hours.

If your situation is not an emergency and it is within working hours you will be offered the chance to leave a message for the person co-ordinating your care.

If your situation is more urgent, then your care plan will state another name and / or number to contact if your care co-ordinator or lead professional is not available.

Care Plan

Your care plan is a written agreement about how we can work together to help improve your situation. It will include:

- Your needs and how we aim to help you meet these needs.

- What we have agreed to do to help you, and support your carer or family.

- The name and contact number of your Care Co-Ordinator or Lead Professional who will be working with you.

- Details of when you will meet with your care coordinator or other professionals.

- A review date.

Everyone who receives care from Essex Partnership University Trust (EPUT) should have a care plan. If you disagree with any area of your care plan, this will be recorded on the plan.
Crisis Plan
Your care plan will include a ‘crisis’ plan that will tell you what you should do if things are not going well. It will include:

- Things that can trigger a crisis for you, including any key life events.
- Signs you are becoming unwell.
- Particular difficulties you have had in the past.
- What has happened to you in the past when unwell.
- Who you are most responsive to, or who you would turn to for help and their contact details.
- Information about any advance decisions you may have (this is an expression of your wishes about future care if you become unwell; please discuss this with your care co-ordinator).

Review

You will have a review of your care plan regularly (this is usually six monthly for those under CPA and yearly for those under Non-CPA but this may be sooner if things change). You will be told when the review is going to happen and will be given time to prepare for this. The purpose of reviewing your care plan is:

- To discuss your care plan with everybody involved in your care. This is to make sure the care you are receiving still meets your needs. You can always ask for a review at any time especially if you think your needs have changed.
- To check that the support you are getting is helping you, and will consider if you need any other help.
- To discuss about whether you need to continue to receive support through the CPA process, and if the people present feel you no longer need the support, then CPA will end. When CPA ends, any support you need to keep you well will continue and you will be told who to contact if there are any problems in the future.

Questions you could ask about your care:

- How do I know whether I am receiving CPA or Non-CPA?
- Can I have more information about my wellbeing?
- Are there any local support groups which could help me?
- Could I be helped by other treatments?
- Is there any self-help information available?
- Who can come to my care review?
- Will I be told about my medication?

Complaints, Comments, Compliments and Concerns
We want to provide high quality community health and social care services that meet your needs. We care about getting it right for you, first time and every time. If you have any concerns or comments, please speak to your care co-ordinator or lead professional in the first instance. He or she will be able to give you details of how to get in touch with our Patient Advice and Liaison Service (PALS).
This Procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust (EPUT).

The main components of the CPA Framework outlined in this procedure are:
- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Co-ordinating care
- Reviewing
- Transitions
This procedure applies to, and is mandatory for, all staff working within mental health services and learning disability provided by the Trust. It sets out the procedures governing the operation/delivery of CPA & Non-CPA within the Trust.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

Monitoring of implementation and compliance with this policy and associated procedural guideline will be undertaken by the Trust Safeguarding Group and the Mental Health and Safeguarding Committee.

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The Director responsible for monitoring and reviewing this procedure is Executive Director of Corporate Governance & Strategy
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA PROCEDURE

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2.0 COMPONENTS OF CPA
3.0 ASSESSMENT
4.0 RISK ASSESSING AND PLANNING
5.0 CARE PLANNING
6.0 CO-ORDINATING CARE
7.0 REVIEWS
8.0 TRANSITIONS

APPENDICES

APPENDIX 1 – CPA INFORMATION LEAFLET
1.0 INTRODUCTION

1.1 This Procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust.

1.2 A CPA INFORMATION LEAFLET (See Appendix 1) should be given to all patients at the start of their journey.

2.0 COMPONENTS OF CPA

2.1 The main components of the CPA framework are:

- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Co-ordinating care
- Reviewing
- Transitions

3.0 ASSESSING

3.1 What is an Assessment?

The assessment is the starting point for all patient care. Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical health and social care needs (in line with the Care Act 2014) and this must always include an assessment of risk.
3.2 **Who can undertake an Assessment?**

All assessments are undertaken by a qualified clinician, including nurses, occupational therapists, social workers, psychologists and medical staff. On occasions, it may be appropriate to organise a joint assessment, for example where there are complexities and/or high risks.

3.3 **Confidentiality**

All those assessed (and those with parental responsibility for those young people seen in our service) must be informed at their initial assessment that information that is collected about them will be stored electronically and may need to be shared with other Trust staff, in particular the rest of the multi-disciplinary team involved in providing care or service to them. They must be advised that all our staff are required to abide by a strict code of conduct on confidentiality.

3.4 **Purpose of an assessment**

The purpose of an assessment is to:

- Provide an initial assessment of needs and how they may be met (including identifying any S117 health or social care needs).
- Evaluate the individual’s strengths.
- Identify their goals, aspirations and choices.
- Assess the level of risk and safety.
- Ascerten carer’s involvement.
- Identify any safeguarding issues.
- Identify the need for specialist assessment, i.e. personality disorder, substance misuse, and where appropriate, refer to relevant service, agency or profession.
- Determine whether intervention from services is appropriate.
- Identify the person’s need for CPA, Non-CPA or other care process that can support them.
- Establish an information base.
3.5 **The full assessment should take into account the following:**

<table>
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<tr>
<th>Psychiatric &amp; Psychological Functioning</th>
<th>Personal Circumstances</th>
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<tbody>
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<td>Patients views on strengths &amp; aims</td>
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<tr>
<td>Presentation</td>
<td>Personal circumstances</td>
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<tr>
<td>Impact on daily life</td>
<td>Family including Genogram</td>
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<td>Recent life event</td>
<td>Caring responsibilities</td>
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<td>Precipitating factors</td>
<td>Childcare issues</td>
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<td>Psychiatric history</td>
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<td>Pre-morbid personality</td>
<td>Gender, sexuality, sexual orientation</td>
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<td>Team/Specific Assessment</td>
<td>Statement of wishes</td>
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<td>Experience of violence &amp; abuse</td>
<td>Lasting Power of Attorney</td>
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<td>Family history</td>
<td>Veteran (Armed Forces Covenant)</td>
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<td>Risks to individual or others</td>
<td>Personalised budget</td>
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<td>Learning Disability</td>
<td>Consent to seek or share information with other agencies</td>
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<table>
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<td>Support network</td>
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<td>Financial status &amp; needs</td>
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<td>Weight/Height/BMI</td>
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<td>Smoking status</td>
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<td>Training &amp; education</td>
<td>Current Medications</td>
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<td>Leisure</td>
<td>Disabilities</td>
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<td>Social function &amp; social needs</td>
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<tr>
<td>Communication &amp; cultural needs</td>
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</tbody>
</table>
3.6 **Outcome Scale**

Outcome measures, as required by the service, must be completed at the point of assessment and at review.

3.7 **Assessment Outcome**

All assessments should conclude with the assessment outcome and a summary of what happens following the assessment. This could include advice, information and guidance given or the formulation and plan for what happens next. All assessments must be dated and include the name and designation of the assessor.

3.8 **Discharge back to the GP following Assessment**

If following the assessment, the person is deemed not to require any further intervention from our secondary mental health service; they should be discharged back to their GP with a copy of the assessment outcome and personalised advice, information and guidance on re-direction or signposting to other services if required.

---

**4.0 RISK ASSESSING AND PLANNING**

4.1 **Assessing Risk**

The assessment and management of risk provides the services the structure to anticipate and prepare for foreseeable dangerous behaviour, whether to self or others. Risk is dynamic and is constantly changing in response to circumstances, in particular treatment and management decisions are likely to influence the risks.

4.2 **Risk Assessment Tool**

The risk assessment must be carried out using the Trust's approved Risk Assessment tool.

4.3 **Gathering Risk Information**

Risk assessments must take into account all the available information from the patient, and other sources, such as the GP, carers, family members, forensic, other professionals and agencies that have knowledge of the individual. It is essential to seek information on the patient’s past behaviour and any previous potential triggers for dangerous behaviour, and to consider the information in the context of the patient’s present circumstances, as well as considering what previous strategies have worked.
### 4.4 Risk Categories & Indicators

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<th>Self-harm</th>
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<td>▪ Previous attempts</td>
<td>▪ Current/recent episodes of self-harm</td>
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<td>▪ Threats</td>
<td>▪ Deliberate self-harm</td>
</tr>
<tr>
<td>▪ Opportunity</td>
<td>▪ History of self-harm</td>
</tr>
<tr>
<td>▪ Means</td>
<td>▪ Accidental harm</td>
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<tr>
<td>▪ Internet (access to information &amp; suicide promoting groups)</td>
<td>▪ Alcohol/drug/substance misuse issues</td>
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<td>▪ Expressed intent</td>
<td>▪ Food issues</td>
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<td>▪ Plans</td>
<td>▪ Cutting</td>
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<tr>
<td>▪ Chronic suffering of persistent pain</td>
<td>▪ Binge drinking</td>
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<td>▪ Recent diagnosis of life changing/threatening illness</td>
<td>▪ Degree of dependence/withdrawal problems</td>
</tr>
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<td>▪ Recent discharge from hospital</td>
<td>▪ Change in method</td>
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<tr>
<td>▪ Recent discharge from the services</td>
<td>▪ Increase in severity/Frequency</td>
</tr>
<tr>
<td>▪ Family history of successful or attempted suicide</td>
<td>▪ Deliberate promiscuous sexual behaviour</td>
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<tr>
<td>▪ Red Flag Alerts from Connecting with People / STORM Training</td>
<td>▪ Deliberate avoidance of prescribed meds or treatment</td>
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<tr>
<td>▪ Rational decision</td>
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<td>▪ Sleep disturbances</td>
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<tr>
<th>Aggression &amp; Violence</th>
<th>Vulnerability &amp; Neglect</th>
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<tbody>
<tr>
<td>▪ Violence to others</td>
<td>▪ Inability to care for self</td>
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<tr>
<td>▪ Domestic violence</td>
<td>▪ Lack of carer support</td>
</tr>
<tr>
<td>▪ Access to potential victims</td>
<td>▪ Falls</td>
</tr>
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<td>▪ Specific threats made</td>
<td>▪ Cognitive impairment/confusion</td>
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<td>▪ History of sexual assault</td>
<td>▪ Capacity issues</td>
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<td>▪ Paranoid delusion</td>
<td>▪ Fire risk</td>
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<td>▪ Verbal aggression</td>
<td>▪ Social isolation</td>
</tr>
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<td>▪ Escalation of threats</td>
<td>▪ Social media</td>
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<tr>
<td>▪ Response associated to withdrawal symptoms</td>
<td>▪ Recent discharge from hospital</td>
</tr>
<tr>
<td>▪ Aggressive behaviours whilst under the influence</td>
<td>▪ Impaired eyesight and/or hearing</td>
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<tr>
<td>▪ Predatory towards vulnerable individuals</td>
<td>▪ Physical ill health</td>
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<td>▪ History of violence to family/staff/other people &amp; degree of harm caused</td>
<td>▪ Recent discharge from prison or the services</td>
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<td>▪ Lack of health education</td>
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<td>▪ Poverty or lack of resources</td>
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<td>▪ Recent bereavement</td>
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<td>Safeguarding</td>
<td>Hazards</td>
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<td>▪ Exploitation from others</td>
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<td>▪ Domestic abuse</td>
<td>▪ Hoarding</td>
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<td>▪ Risk of being radicalized</td>
<td>▪ Hazardous surroundings</td>
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<tr>
<td>▪ Financial abuse</td>
<td>▪ Unsafe buildings</td>
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<td>▪ Aggressive pets</td>
</tr>
<tr>
<td>▪ Sexual abuse</td>
<td>▪ Inadequate information on patient</td>
</tr>
<tr>
<td>▪ Physical abuse</td>
<td>▪ Location</td>
</tr>
<tr>
<td>▪ Female Genital Mutilation (FGM)</td>
<td>▪ Bad lighting</td>
</tr>
<tr>
<td>▪ Patient is carer of their own relatives</td>
<td>▪ No mobile phone network</td>
</tr>
<tr>
<td>▪ Patient is directly or indirectly providing support to a child</td>
<td>▪ Parking difficulties/issues</td>
</tr>
<tr>
<td>▪ Being cared for by carers with mental illness/addiction problems</td>
<td>▪ Other members of the household have aggressive/intimidating behaviour</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health history</th>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Previous admissions to hospital</td>
<td>▪ Age</td>
</tr>
<tr>
<td>▪ Previous risk taking behaviour</td>
<td>▪ Gender</td>
</tr>
<tr>
<td>▪ Detention under the Mental Health Act</td>
<td>▪ Social situation (for example Redundancy, Divorce)</td>
</tr>
<tr>
<td></td>
<td>▪ Key life events</td>
</tr>
<tr>
<td></td>
<td>▪ Relapse indicators</td>
</tr>
<tr>
<td></td>
<td>▪ Triggers</td>
</tr>
<tr>
<td></td>
<td>▪ Anniversary date of death of loved one (or pet)</td>
</tr>
<tr>
<td></td>
<td>▪ Non-compliance with medication</td>
</tr>
<tr>
<td></td>
<td>▪ Failure to attend appointments</td>
</tr>
<tr>
<td></td>
<td>▪ Incidents involving the Criminal Justice system</td>
</tr>
<tr>
<td></td>
<td>▪ Reluctance to engage with services</td>
</tr>
<tr>
<td></td>
<td>▪ Substance misuse</td>
</tr>
</tbody>
</table>
4.5 Documenting Risks

All risks identified in the risk assessment and at every review must be clearly documented and evidenced in the patient’s clinical record.

4.6 Planning & Sharing of Risks

All risks must be shared with all professionals involved with the patient. It is essential to record all considerations and risk plans and ensure that the relevant professionals are kept informed. All members of the multi-disciplinary team have a responsibility to consider risk and how these risks will be planned and managed. The outcome of the risk assessment must form the basis of a clear crisis and contingency plan.

4.7 Reviewing Risk

The assessment of risk is an essential and continuous ongoing part of the CPA process and must be considered on an individual basis. It is an essential mandatory requirement whenever a review takes place, or an individual’s circumstances change (e.g. through admission to an inpatient unit or on transfer back to the community) to consider all the risk implications and how these will be planned and managed.

5.0 CARE PLANNING

5.1 Person-Centred Care

Person centred care planning is about listening to the patient and finding out what he/she wants and needs. It is about helping patients to think and plan what they want from their life now and in the future, and to enable friends, family & professionals to work together with the person to achieve these goals.

5.2 Jargon-free

In developing care plans in partnership with the patient and their family and/or carers, it is important that they must be created using language and terminology that the patient and their family or carer is able to understand.

5.3 Wellbeing and Recovery

The care plan is a record of the agreed care and treatment for the patient and should focus on their well-being and recovery.

5.4 Specialist Care Plans

When a range of services are identified in the overarching personalised care plan, each service, in partnership with the service user, must agree their specialist care plan which outlines the specific care a person, team or service will deliver. All those involved with specialist care plans must ensure that progress is communicated to the care coordinator/lead professional.
### 5.5 What should be considered in the Care Plan?

Consideration needs to be given to everything outlined in the table below.

<table>
<thead>
<tr>
<th>Need</th>
<th>Actions/Goals/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Diverse needs and preferences</td>
<td>▪ Interventions</td>
</tr>
<tr>
<td>▪ Translation/interpretation requirements</td>
<td>▪ Contributions of all agencies involved (include their contact details)</td>
</tr>
<tr>
<td>▪ Specific needs arising from co-existing physical disability, sensory impairment, learning disability/autism</td>
<td>▪ Agreement of each professional or service to undertake their aspect of the care delivery</td>
</tr>
<tr>
<td>▪ Physical healthcare</td>
<td>▪ SMART goals</td>
</tr>
<tr>
<td>▪ Parenting or caring needs</td>
<td>▪ Patients actions necessary to achieve the agreed goals</td>
</tr>
<tr>
<td>▪ Specific needs arising from drug, alcohol or substance misuse</td>
<td>▪ Agree desired outcomes with patient and carer</td>
</tr>
<tr>
<td>▪ Consideration of self-directed support (SDS)/personalised budgets</td>
<td>▪ Arrangements for measuring and reviewing outcomes</td>
</tr>
<tr>
<td>▪ S117 Aftercare needs</td>
<td>▪ An estimated timescale by which the outcomes and goals will be achieved or reviewed</td>
</tr>
<tr>
<td>▪ Social, cultural or spiritual needs</td>
<td>▪ Date of next planned review</td>
</tr>
<tr>
<td>▪ Any unmet needs and service deficits</td>
<td>▪</td>
</tr>
<tr>
<td>▪ Easy read format care plans</td>
<td>▪</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk, Contingency &amp; Crisis</th>
<th>Patient/Carers &amp; Staff Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Triggers &amp; Relapse indicators</td>
<td>▪ Patients/carers responsibility to achieve the agreed goals</td>
</tr>
<tr>
<td>▪ Key events</td>
<td>▪ Patients comments</td>
</tr>
<tr>
<td>▪ Contingency plans</td>
<td>▪ Carers comments</td>
</tr>
<tr>
<td>▪ Advance decision &amp; Statement of wishes</td>
<td>▪ Copy given to the patient</td>
</tr>
<tr>
<td>▪ Crisis contact details</td>
<td>▪ Copy given to the carer (where appropriate)</td>
</tr>
<tr>
<td>▪ Outline of who the patient best responds to in a crisis</td>
<td>▪ A note if the patient disagrees with the care plan and the reasons for the disagreement</td>
</tr>
<tr>
<td>▪ Crisis plans</td>
<td>▪ Dated and timed</td>
</tr>
<tr>
<td>▪ Contact Numbers to ring in a crisis</td>
<td>▪ A note if the patient does not wish to receive a copy</td>
</tr>
<tr>
<td>▪ Identified risks and safety issues</td>
<td>▪</td>
</tr>
</tbody>
</table>
Things to take into account when a crisis happens (children, elderly relatives, animals etc.)

5.6 **Copy of the Care Plan given to Patient**
A copy of the care plan must be offered to the patient, and made available to all those involved in the care plan. It is essential that practitioners maximise the extent to which the patient knows and understands their care plan and agrees with it. Any disagreements should be recorded.

5.7 **Care Plan for Patients on Non-CPA**
For those patients who are placed on Non-CPA, their care plan will often be in letter format (for example a copy of the letter from the consultant/clinician sent to their GP is copied directly to them).

5.8 **Copy of the Care Plan sent to GP**
The care plan must always be shared with the patient’s GP.

### 6.0 CO-ORDINATING CARE

6.1 Co-ordinating care is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care by the appropriate agency or provider.

- The term Care Co-ordinator is used for those working with individuals supported by the CPA Process.
- The term Lead Professional is used for those working with individuals on Non-CPA.

6.2 **Who can co-ordinate?**
The role of the CPA care co-ordinator or Lead Professional will be allocated to the practitioner who, after consideration of the initial assessment, is best qualified to oversee and to support the care needs of the individual. Care co-ordinators will be qualified professionals who are employed by or seconded to EPUT.

6.3 The responsibilities of the care co-ordinator remain in place whatever the setting, especially during the period of inpatient treatment or when the patient is receiving intensive support from specialist services, such as community teams or residing in a residential home.

6.4 **Absence/Leave arrangements**
When a care coordinator/lead professional is on leave, arrangements must be made as to who will cover their absence.
6.5 Co-ordinating Care – Main Responsibilities

The main duties and responsibilities for the care co-ordinator are outlined in the table overleaf and have been divided into the following categories:

- Assessing
- Planning
- Co-ordinating
- Reviewing

<table>
<thead>
<tr>
<th>Assessing</th>
<th>Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry out a thorough assessment of the person’s physical, social, emotional and psychological needs</td>
<td>Agree goals with the patient</td>
</tr>
<tr>
<td>Assess any immediate risk to the person or others</td>
<td>Identify and agree actions and interventions</td>
</tr>
<tr>
<td>Assess the impact on others in the household (particularly children)</td>
<td>Develop risk management plans to support the individual’s independence and daily living</td>
</tr>
<tr>
<td>Ensure the identified carer has been informed of their rights to a Carer’s Needs Assessment, and where relevant undergo this assessment</td>
<td>Work with the person, their families and carers to identify measures to be taken to prevent a crisis developing and develop a personal crisis and contingency plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-ordinating/Implementing</th>
<th>Reviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure regular contact is maintained to monitor the person’s progress (whether at home/in hospital or prison) taking into account their needs &amp; risks</td>
<td>Review the effectiveness of the therapeutic interventions and recovery/living well strategies with all involved</td>
</tr>
<tr>
<td>Ensure the patient understands the care co-ordinator role and knows how to make contact and who to contact in their absence</td>
<td>Review where there is deterioration in the patient’s mental health or where problems may arise in the delivery of the care plan or if significant new risk factors are identified in the course of delivering the care plan</td>
</tr>
<tr>
<td>Ensuring all those involved understand and are implementing their identified responsibilities</td>
<td>Discuss the options for transfer of care or discharge</td>
</tr>
<tr>
<td>Work with the patient &amp; their families/carers during times of crisis, ensuring crisis situations are responded to timely, effectively and safely</td>
<td>Agree transfer/discharge plan and the arrangements including the support needs upon transfer/discharge</td>
</tr>
</tbody>
</table>
- Arrange advocacy for those unable to represent their own interests
- Care plans are revised and updated after a review and re-issued to those involved
- Support patients on their caseload to have an annual health check
- Review of S117 needs at every review
- Work in collaboration with carers and ensure information, advice or signposting to services is given

6.6 **Recording**

It is essential that information collected is recorded in line with legal and operational requirements.

### 7.0 REVIEWING

7.1 Review is the way we find out if the care plan is working, look at progress the patient has made and the ways in which their needs may have changed.

7.2 **Who attends the review?**

The level of complexity of each case will determine who needs to be present at the review. It may not be practical to have all those individuals involved in the care plan attend the review meeting, and it is essential that the patient’s feelings and views are taken into account, as large meetings can be intimidating. In some cases, the review may consist of just the patient and the care co-ordinator. However, the care co-ordinator should ensure the views of others are represented.

7.3 **Where the review takes place?**

The patient’s wishes about the location and timing of the review and the number of people attending should be respected wherever possible.

7.4 **How often does a review take place?**

All patients on CPA must have their care reviewed no less than once every six month, in response to any change and prior to any transition (e.g. discharge from hospital).
7.5 **The review process**

The review process is outlined in the table on the next page and has been divided into the following categories:

- **Purpose of a review**
- **Preparation for a review**
- **During the review**
- **Outcome of the review**

7.6 **The table below outlines the review process**

<table>
<thead>
<tr>
<th>Purpose of Review</th>
<th>Preparation for Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any person involved in the care plan, including the patient or carer, can ask for a review to be held at any time (if refused, this must be recorded in the patient's notes)</td>
<td>Reviews should be prepared for in advance</td>
</tr>
<tr>
<td>Ensure the patient’s personal details are up-to-date and correct</td>
<td>Respect the patient’s wishes for the location and timing of the review and who attends the review</td>
</tr>
<tr>
<td>Review the consent to share agreement</td>
<td>Invite all those involved in the patient’s care plan</td>
</tr>
<tr>
<td>Discussion of any progress the person has made</td>
<td>Where appropriate carers should be involved in the review</td>
</tr>
<tr>
<td>Whether they continue to or now need the support of CPA, S117 aftercare, and/or a Community Treatment Order (CTO)</td>
<td>Care co-ordinator/lead professional must ensure they obtain the views of those involved in the care plan who are unable to attend the review</td>
</tr>
<tr>
<td>The extent to which the care plan (including crisis and contingency plan) needs amending</td>
<td></td>
</tr>
<tr>
<td>Reassessment of risk factors</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During the Review</th>
<th>Outcome of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record all present and apologies received</td>
<td>Change the amount of support required</td>
</tr>
<tr>
<td>Determine views of the patient, carer and professionals</td>
<td>Move from or to CPA</td>
</tr>
</tbody>
</table>
- Decide upon the best plan of care and setting approximate timescales based on the above discussions
- Discharge from the service back to the GP or transfer to another system of care
- Consider whether someone continues to have S117 aftercare needs, or if they continue to require a CTO under the MHA & the impact of any user led document (such as an Advance Decision) has on the care plan
- Update the care plan, risk plan, crisis and contingency plan and draw up the modified care plan
- Any changes must be agreed by all parties and disagreements recorded
- Ensure everyone receives a copy of the updated care plan even if they were unable to attend the review

7.7 Date of the Next Review
At every review the date of the next review must be planned and appropriately recorded.

7.8 Professionals Meetings
It may be necessary on occasions to hold a multi-disciplinary professionals meeting to discuss and decide on the support and treatment of patients who may present with complex needs, high risks and probable non-concordance with their care plan, and where there maybe differences of opinion within the multi-disciplinary group.

8.0 TRANSITIONS

8.1 Individuals can experience any number of transitions during their contact with our service, such as discharge from the services, transfer between services, or transfer of care to another provider.

8.2 Examples of transitions:
- Admission to hospital
- Discharge to community from hospital
- Move to a residential home/nursing home
- Imprisonment or release from jail
- Change of geographical area
- Change of care co-ordinator
- Move from the child & adolescent service to the adult service
- Move from the adult service to the older adult service

8.3 At the time of transfer it is essential that:
- The process is co-ordinated by the care co-ordinator/lead professional
- The patient and all relevant members of the multi-disciplinary team are involved in the planning of any transition
- Handovers of care are clearly documented with transfers of responsibility agreed in a timely manner
- There are clear plans which have been agreed with all concerned
- Information is shared with all the relevant people
Inpatient transitions – communication

8.4 If it becomes necessary for the patient to have a period of inpatient care, the care co-ordinator will maintain contact with the patient throughout.

8.5 During the period of inpatient care, the care co-ordinator and the inpatient team will maintain open communication to facilitate full assessments of needs and appropriate plans of care.

8.6 The care co-ordinator will retain his/her responsibility for actively overseeing the patient's CPA care plan in close liaison with the inpatient team throughout the period of the inpatient stay.

8.7 Care Planning for leaving inpatient care

It is the responsibility of the care co-ordinator in conjunction with the inpatient team and others involved in the care package, to oversee all arrangements for transfer out of the inpatient setting into the community. At the time of leaving inpatient care, the patient must have a current and coherent care plan that includes any changes in need or circumstances and risk factors that were not considered or included in the previous care plan.

8.8 Follow up arrangements when leaving inpatient care

The care plan must include details of follow-up arrangements and these should be in line with the 7 day follow up policy.

8.9 Change of care co-ordinator

If a change of care co-ordinator/lead professional is necessary, either within the existing team or to another team within the Trust or outside the Trust, the current co-ordinator must arrange to hold a formal CPA review with the patient, any carers if applicable and the new co-ordinator. The care co-ordinator will not discharge the person from their caseload until the person has been accepted fully by the receiving professional/team/service.

8.10 Transfer to residential homes/nursing homes/prisons

When a patient is removed from their normal place of residence (e.g. they go into a prison, residential home, nursing home or children being placed into out-of-area foster care), it remains the responsibility of the care co-ordinator to review the quality and appropriateness of their care in accordance with Trust Policy. The care co-ordinator must always ensure that they remain in contact with the patient and ensure that reviews are still carried out in accordance with Trust policy.

8.11 Change of geographical area

The national Care Co-ordination Association (CCA) has outlined the procedure for the transfer of patients between Trusts and Local Authority Areas.

END
POLICY FOR THE USE OF SECLUSION & LONG-TERM SEGREGATION

<table>
<thead>
<tr>
<th>PROCEDURE NUMBER:</th>
<th>CLP41</th>
</tr>
</thead>
<tbody>
<tr>
<td>VERSION NUMBER:</td>
<td>7</td>
</tr>
<tr>
<td>REPLACES SEPT DOCUMENT</td>
<td>Seclusion &amp; Long-Term Segregation Policy CPL41 V6</td>
</tr>
<tr>
<td>REPLACES NEP DOCUMENT</td>
<td>Seclusion &amp; Long-Term Segregation Policy</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Consultant Psychiatrist - Forensic</td>
</tr>
<tr>
<td>CONSULTATION GROUPS:</td>
<td>Service Management Teams Quality Groups Trust Solicitor Seclusion Task and Finish Group Restrictive Practice Steering Group</td>
</tr>
<tr>
<td>IMPLEMENTATION DATE:</td>
<td>August 2010</td>
</tr>
<tr>
<td>AMENDMENT DATE(S):</td>
<td>May 2014 (Director Change), July 2014, June 2015, March 2016</td>
</tr>
<tr>
<td>LAST REVIEW DATE:</td>
<td>March 2016</td>
</tr>
<tr>
<td>NEXT REVIEW DATE:</td>
<td>March 2019</td>
</tr>
<tr>
<td>APPROVAL BY CLINICAL GOVERNANCE &amp; QUALITY SUB-COMMITTEE:</td>
<td>October 2017</td>
</tr>
<tr>
<td>RATIFICATION BY QUALITY COMMITTEE</td>
<td>16 November 2017</td>
</tr>
</tbody>
</table>

POLICY SUMMARY

This policy aims to ensure that all staff are provided with the information required to enable them to adhere to the principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive practices within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (Code of Practice, 1983) current best practice guidance.

The Trust monitors the implementation of and compliance with this policy in the following ways:

Datix reporting system, Manager’s sign of, Restraint and Seclusion Review Group and Restrictive Practice Steering Group as part of the Quality Account.

<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essex MH&amp;LD</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Director responsible for monitoring and reviewing this policy is Executive Medical Director for Patient Safety
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2.0 DEFINITIONS

3.0 DUTIES

4.0 MONITORING OF IMPLEMENTATION

5.0 MONITORING AND COMPLIANCE

6.0 POLICY REFERENCES/ASSOCIATED DOCUMENTATION
Assurance Statement

Essex Partnership University NHS Foundation Trust (EPUT) aims to ensure that any patient who presents with behaviour that challenges in-patient services to such an extent that they cause a risk to themselves or others around them, must be cared for in accordance with guidelines as set out within the Mental Health Act 1983 Code of Practice (Department of Health, 2015).

This policy aims to ensure that all staff are provided with current information and the underlying principles considered by the Trust to be essential regarding the use of Seclusion and Long-Term Segregation.

The principles contained within this policy and associated documents will aim to ensure the physical and emotional safety and wellbeing of the patient by promoting the use of effective communication, respectful and dignified approaches to Restrictive Interventions including Seclusion and Long Term Segregation.

This policy must be read in conjunction with Adverse Incidents including Serious Incidents (SI) Policy and Procedure (CP3, CPG3), Safeguarding Adults Policy and Procedure (CLP39, CLPG39) and Clinical Guideline for Engagement and Formal Observation (CG8).

1.0 INTRODUCTION

1.1 This policy and associated procedure outline the processes for the use of Seclusion and Long-Term Segregation (LTS).

1.2 The revised Mental Health Act (MHA) Code of Practice (COP) issued in 2015 identifies changes to the safe and therapeutic responses to disturbed behaviour. This has required the Trust to review the historic terms “segregation & restricted access”. These terms no longer exist within the COP and are covered by the terms “Seclusion” and Long-Term Segregation.

1.3 Seclusion and Long-Term Segregation are restrictive interventions. The Trust acknowledges this and the significant ethical and practical dilemmas. This policy and the associated document titled “Use of Seclusion and Long-Term Segregation Procedure – CPG41” set out when
such restrictive interventions shall be used and this will be kept under ongoing review.

1.4 Staff must be aware of the rights of a secluded patient to freedom, choice and autonomy and the rights of others to protection from harm.

1.5 Any decision to seclude a patient in accordance with this policy must be for the containment of severe behavioural disturbance which is likely to cause harm to others and where the professionals involved are satisfied the need to protect others outweighs any increased risk to the patient’s health or safety.

1.6 Seclusion itself is an emergency measure of last resort.

1.7 The Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DOLS) cannot be used to authorise seclusion. Seclusion should ordinarily be used on patients who are detained under the Mental Health Act 1983. For emergency situations, please refer to 3.1 of the Seclusion and Long-Term Segregation Procedure.

1.8 If a patient requests seclusion or has an Advance Statement which meets the seclusion definition set out in the COP, seclusion processes must be followed. (COP 26.104)

2.0 DEFINITIONS

2.1 The definition for seclusion and long-term segregation is set out in the MHA COP 2015.

2.2 Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. (COP 26.103)

2.3 Long-Term Segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis (COP 26.150)
3.0 DUTIES

3.1 Executive Medical Director for Patient Safety

- Ensure policy and procedures are embedded into clinical practice and that these procedures are implemented and monitored.

3.2 Directors and Senior Management:

- Ensure this policy and accompanying procedure is complied with.
- Monitor the implementation of this policy via clinical audit and supervision.
- Ensure that Trust Risk Management Team is appropriately notified on all incidents of seclusion and long term segregation.
- Be able to evidence that EPUT policies have been followed.

3.3 Team Managers, Clinical Leads and other Persons in Charge:

- Ensure policy and procedures are adhered to in accordance with the MHA Code of Practice.
- Ensure that all requirements in relation to the seclusion and long-term segregation of a patient are followed and implemented.
- Ensure that all seclusion and long-term segregation incidents are recorded and reported through the Datix Incident Reporting System.
- Ensure staff receive training and are competent in managing seclusion and long term segregation.
- Ensure that risk assessment is reviewed and support plans reflect current risks.
- Ensure that staff wellbeing is maintained following the incident and incident analysis is carried out and takes forward lessons learned.

3.4 Individual Staff Members

- All staff must ensure that they are competent in the seclusion and long term segregation processes as set out in the MHA Code of Practice.
- Ensure that all required documentation and reporting processes are implemented and adhered to.
- Staff must be aware of the rights of a secluded patient to freedom, choice and autonomy and the rights of others to protection from harm.
- Staff must ensure that the patient receive the care and support rendered necessary by their seclusion both during and after it has taken place.
- All staff will have a good working knowledge of the risks and care plan requirements of a patient in seclusion or long term segregation.
All staff have the duty of care to act on changes to a patient’s presentation and mental state whilst in seclusion or long term segregation and ensure these are reported and documented.

4.0 MONITORING OF IMPLEMENTATION

4.1 This policy will be made available across the organisation via the Trust Intranet site.

4.2 All incidents surrounding seclusion and long term segregation must be reported in line with the MHA Code of Practice, 2015.

4.3 Screening of staff will be in accordance with Disclosure and Barring Service (DBS) and Recruitment of Ex-Offenders Policy HR26.

4.4 Training in relation to the Mental Health Act is part of the Mandatory Training Portfolio.

4.5 Any additional training needs in relation to seclusion and long term segregation will be identified by team managers and should be referred to the Restrictive Practice Group to ensure that they are addressed promptly.

5.0 MONITORING AND COMPLIANCE

5.1 The Executive Medical Director for Patient Safety will be responsible for overall monitoring and review of this policy.

5.2 All incidents of seclusion must be recorded on Datix.

5.3 All ward sisters/charge nurses will scrutinise the Seclusion and LTS paperwork and processes as it happens for compliance using Appendix 1g for seclusion and Appendix 2h for LTS. This will be signed off by the relevant services lead (Clinical Lead, Matron, etc.)

5.4 Compliance will be monitored via the restraint/seclusion review group with a monthly report from the reviewers re process compliance and standard of reporting in line with the MHA code of practice 2015. This will be reported into the Restrictive Practice Steering Group for learning and oversight.

5.5 Annually there will be an audit of seclusion and LTS paperwork and processes to provide assurances to the wider Trust. The Clinical Audit Department will ensure that annual audits are carried out as part of the annual audit programme.
5.6 This policy will be reviewed every 3 years taking into account emerging research, local audit recommendations and lessons learnt from reports, enquiries and positive practice initiatives.

### 6.0 POLICY REFERENCES/ASSOCIATED DOCUMENTATION

- Adverse Incidents including Serious Incidents (SI) Policy and Procedure (CP3, CPG3)
- Safeguarding Adults Policy and Procedure (CLP39, CLPG39)
- Disclosure and Barring Service (DBS) and Recruitment of Ex-Offenders Policy (HR26)
- Clinical Guideline for Engagement and Formal Observation (CG8)
- Induction/Mandatory Training Policy (HR21)
- Advance Directive (CLP6 and CLPG6)
- Dealing with Criminal Behaviour Policy (CP22)
- Mental Health Act 1983 (amended 2007)
- Mental Health Act Code of Practice, 2015
- Children Act 2004
- Positive and Proactive Care: reducing the need for restrictive interventions. DH (2014)
- A positive and proactive workforce. Skills for Care / Skills for Health (2014)
- Francis Report (2013)
- Deprivation of Liberty Safeguards: Supreme Court Judgements (2014)
- Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings. NHS Protect: (2014)
USE OF SECLUSION AND LONG-TERM SEGREGATION POLICY - CLP41

- Statement on CQC’s roles and responsibilities for safeguarding children and adults, 2015
- Guidance on prevention and management of physical assaults in mental health settings - NHS Protect
- Mental Capacity Act, 2005
- Royal College of Nursing consultation - Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools, December 2013
- Culture of Care Barometer, March 2015
- Safewards; making psychiatric wards more peaceful places
- R (Munjaz) v Mersey Care NHS Trust (2008) UKHL 58
- Public Sector Equality Duty (s.149 Equality Act 2010)

END
# USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41

**Appendix 1a (September 2017)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
</tr>
</thead>
</table>

## SECLUSION - COMMENCEMENT FORM

### RESPONSIBLE CLINICIAN

**Name:** ..................................................
(Block Capitals)

### NURSE IN CHARGE

**Name:** ..................................................  **Signature:** ..................................................
(Block Capitals)

### SECLUSION DETAILS

**DATE OF SECLUSION:** ..................................  **TIME COMMENCED:** ..................................

**Area of Seclusion**

- [ ] Designated Seclusion Room
- [ ] Bedroom
- [ ] Intensive Care Suite
- [ ] Other

**Date and time of change to Area of Seclusion:**

**REASONS FOR SECLUSION** (including patient’s mental state, details of incident)

- ...........................................................................................................................
- ...........................................................................................................................
- ...........................................................................................................................
- ...........................................................................................................................

**AUTHORISING DOCTOR** (where decision is taken to seclude by a senior nurse, doctor must attend within the first hour to authorise it. The person authorising seclusion should have seen the patient immediately prior to authorising the seclusion)

**Name:** ..................................................  **Signature:** ..................................................
(Block Capitals)

**Role/ Grade:** (On-call doctor, RC etc.): ..........................................................

**Time Notified:** ..................................  **Time of Arrival:** ..................................

**If delayed please comment:** ............................................................

**REASONS FOR AGREEING SECLUSION**

- ...........................................................................................................................
- ...........................................................................................................................
- ...........................................................................................................................
- ...........................................................................................................................
### Consultant informed Date and Time:
- The patient must be continually monitored at all times throughout the period of seclusion and a record made of the patient's behaviour every fifteen (15) minutes by a suitably skilled nurse. This should include the patient's appearance; what they are doing and saying; their mood; level of awareness and any evidence of physical ill health, especially with regard to their breathing, pallor or cyanosis.
- Two (2) hourly reviews by two RMN's/RNLD's (one not involved in the decision to seclude)
- Four (4) hourly reviews by a Doctor (either the ward or duty doctor)
- Out of hours and weekends continuation of the four hourly medical reviews should be carried out until the first MDT has taken place. Different review arrangements can be agreed and applied locally when patients in seclusion are asleep the doctor must be informed and visit as soon as possible after the patient has woken and the detail of the revised review recorded in the care plan.
- Following the first internal MDT review, further medical reviews should continue at least twice in every 24 hour period. At least one of these should be carried out by the patient’s responsible clinician.
- If the Seclusion continues for more than eight (8) hours consecutively or for more than twelve (12) hours intermittently over a period of forty eight (48) hours, an independent review must take place by an MDT not involved in the decision to seclude.
- A Datix must be completed for each episode of seclusion.
- Family members should be notified as per what has been agreed in the patient’s positive behaviour support plan (or equivalent) with the agreement/consent of the patient to share information.

### Date Family Informed:

### CARE PLANNING

<table>
<thead>
<tr>
<th>Mental Health Needs</th>
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</thead>
<tbody>
<tr>
<td>Managing Risks</td>
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<td>Physical Health Needs</td>
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<td>Clothing</td>
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<tr>
<td>Bedding</td>
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<tr>
<td>Dietary Needs</td>
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<tr>
<td>Verbal De-escalation</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
# USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41

<table>
<thead>
<tr>
<th>Last Name</th>
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<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
</tr>
</thead>
</table>

- **Patients Views**
  - Date: ........................................
  - Comments:

- **IMHA Informed**
  - Date: ........................................

- **Safeguarding Team Informed**
  - Date: ........................................

- **Commissioner**
  - Date: ........................................

  *(Please speak to service lead or commissioners contact details)*

## FAMILY INVOLVEMENT

- Name of the Family member / Carer informed / Contacted
  - Date Family Informed/contacted: ____________________________ Time: ____________________________

  Comments:

## MONITORING

**UNIT MANAGER’S Clinical Lead / Matron/ Ward Sister / Charge Nurse / Nurse in Charge**

- **NAME**: __________________________________________________________
  - (Block Capitals)
- **SIGNATURE**: ____________________________ DATE: ____________________________
- Responsible Clinician __________________________________________
- Signature: __________________________________________ DATE: ____________________________

## OUT OF HOURS

- **NAME OF SENIOR MANAGER INFORMED**: ____________________________
  - Date: ____________________________ Time: ____________________________

- **NAME OF CONSULTANT ON CALL INFORMED**: ____________________________
  - Date: ____________________________ Time: ____________________________
<table>
<thead>
<tr>
<th>TIME</th>
<th>CLINICAL OBSERVATIONS (i.e. Physical Condition, Mental State, Mood and Behaviour)</th>
<th>DETAILS OF CARE PROVIDED (i.e. drinks/food offered, bedding, books, engagement)</th>
<th>NAME AND STATUS</th>
<th>SIGNATURE</th>
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<td>Unit / Ward</td>
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(1hr 45)

(2hr 00)
## USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 1c (September 2017)

### SECLUSION - NURSING REVIEWS

<table>
<thead>
<tr>
<th>Date and Time of Review (e.g. this must be 2 hourly)</th>
<th>CLINICAL OBSERVATIONS AND CARE GIVEN</th>
<th>DETAILS OF REASONS TO CONTINUE OR DISCONTINUE SECLUSION, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN</th>
<th>SECLUSION CONTINUED/ DISCONTINUED (Please state)</th>
</tr>
</thead>
</table>

**EXPLAINED TO PATIENT**

YES/NO
## USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41

**Appendix 1c (September 2017)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
</tr>
</thead>
</table>

### Patients Views

**Comments:**

### IMHA

**Comments:**

<table>
<thead>
<tr>
<th>NAME AND ROLE OF 1st RMN/RNLD</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME AND ROLE OF 2nd RMN/RNLD</td>
<td>SIGNATURE</td>
</tr>
<tr>
<td>NAME AND ROLE OF INDEPENDENT MDT PROFESSIONAL (8 hourly review)</td>
<td>SIGNATURE</td>
</tr>
</tbody>
</table>
## SECLUSION - DOCTORS REVIEW FORM

<table>
<thead>
<tr>
<th>Date and Time of Review (eg 4 and 8 hourly)</th>
<th>CLINICAL OBSERVATIONS CARE GIVEN</th>
<th>DETAILS OF REASONS TO CONTINUE OR DISCONTINUE SECLUSION, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN</th>
<th>SECLUSION CONTINUED/ DISCONTINUED (Please state)</th>
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</thead>
<tbody>
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</table>

**EXPLAINED TO PATIENT** YES/NO
### Patient Views
Comments:

### IMHA
Comments:

<table>
<thead>
<tr>
<th>NAME AND ROLE OF DOCTOR</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME AND ROLE OF INDEPENDENT MDT PROFESSIONAL (8 hourly review)</td>
<td>SIGNATURE</td>
</tr>
</tbody>
</table>
**SECLUSION - MDT REVIEWS**

If the patient is secluded for more than 8 hours consecutively or 12 hours over a period of 48 hours Independent MDT Review is required

<table>
<thead>
<tr>
<th>Date and Time of Review (first review to be held as soon as practicable)</th>
<th>DISCUSSION AND REASSESSMENT OF SECLUSION</th>
<th>DETAILS OF REASONS TO CONTINUE OR DISCONTINUE SECLUSION, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN</th>
<th>OUTCOME OF REVIEW SECLUSION CONTINUED/DISCONTINUED (Please state)</th>
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<tbody>
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</table>

**EXPLAINED TO PATIENT**: YES/NO
# USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 1e (September 2017)

<table>
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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
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</table>

## Patient Views
Comments:

## IMHA
Comments:

<table>
<thead>
<tr>
<th>NAME OF SENIOR NURSE IN CHARGE/WARD SISTER</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF DOCTOR</td>
<td>SIGNATURE</td>
</tr>
<tr>
<td>NAME OF RESPONSIBLE CLINICIAN</td>
<td>SIGNATURE</td>
</tr>
<tr>
<td>NAME OF MATRON/ICL</td>
<td>SIGNATURE</td>
</tr>
<tr>
<td>NAME AND ROLE OF OTHER PROFESSIONALS (i.e. OT/Psychology/Social Work)</td>
<td>SIGNATURE</td>
</tr>
</tbody>
</table>
(Where agreed by the patient family members should be informed of the review outcome)
USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 1f (September 2017)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
</tr>
</thead>
</table>

SECLUSION - DISCONTINUATION FORM

RESPONSIBLE CLINICIAN

Name: ........................................ (Block Capitals)

NURSE IN CHARGE

Name ........................................ Signature ...................................... (Block Capitals)

SECLUSION DETAILS

DATE: ........................................... TIME: .....................................

REASON FOR DISCONTINUING:

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Is patient now being managed under long-term segregation Yes/No (if yes please complete appendix 2a)

PATIENT Views: Comments:

IMHA Views: Comments:
Person Authorising Discontinuation of Seclusion

Name: .................................................. Role/ Grade ..........................................

Signature: ......................................... Date: ........................................

RISK MANAGEMENT PLAN: (i.e. level of observation, care plan)
SECLUSION - MONITORING AND SCRUTINY FORM

Clinical Lead/Charge Nurse/Sister must review records of each episode of seclusion using this monitoring form to ensure the seclusion process has been completed in line with the Trust Policy and Procedure.

Once completed this form must be scrutiny checked by the Matron/Integrated Clinical Lead and scanned onto electronic records in legal document section.

<table>
<thead>
<tr>
<th>DATE TIME (24 Hour Clock)</th>
<th>MONITORING</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient been prevented from leaving an area? If yes was Appendix 1a initiated and fully completed?</td>
<td></td>
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<tr>
<td>Was NIC, AC or Doctor on call contacted to complete authorisation of seclusion as soon as practicable?</td>
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</tbody>
</table>
  
  *(Note the authorising person must have seen patient immediately prior to seclusion)* |
<p>| If the seclusion was not initiated by a doctor, was this authorised by a doctor within one hour of commencement of Seclusion? | | | | |
| Was the reason to commence seclusion recorded? | | | | |
| Was a care plan devised? | | | | |
| Was a family member notified of the Care Plan? <em>(where patient has agreed/consented)</em> | | | | |
| Was the Out of Hours Senior Manager on Call contacted <em>(where applicable)</em> | | | | |
| Was the patient continuously observed and monitored by a suitably skilled professional and records of Physical Condition, Mental State, Mood and Behaviour made every 15 minutes in Appendix 1b | | | | |
| Is it recorded that at intervals throughout the 15 minute intervals that the reasons for seclusion were explained to the patient taking into | | | | |</p>
<table>
<thead>
<tr>
<th>DATE (24 Hour Clock)</th>
<th>MONITORING</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>account the current clinical presentation?</td>
<td></td>
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<tr>
<td></td>
<td><strong>Rapid Tranquillisation:</strong> If Rapid Tranquillisation has taken effect discontinuation of seclusion must be considered.</td>
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<tr>
<td></td>
<td>Was the nursing review completed using designated seclusion form <strong>Appendix 1c</strong> every two (2) hours by x 2 RMNs, one of which must not have been involved in the original seclusion decision?</td>
<td></td>
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<tr>
<td></td>
<td>Was the Doctors Review completed using designated seclusion form <strong>Appendix 1d</strong> every 4 hours by a Doctor?</td>
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<tr>
<td></td>
<td>Was the first internal MDT review completed as soon as practicable using designated seclusion form <strong>Appendix 1e</strong>?</td>
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<tr>
<td></td>
<td>Were further MDT reviews completed at least twice in every 24 hours if the patient continued seclusion?</td>
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</tbody>
</table>
|                      | **Was an independent MDT review undertaken promptly where the patient has either been secluded 8 hours consecutively or for 12 hours intermittently during a 48 hour period?**  
  - By clinicians who were not involved in the original decision to seclude the patient?  
  - Did this involve the patients IMHA?  
  - Did the independent MDT consult with those involved in the original decision? |     |    |          |
<p>|                      | <strong>Did the seclusion immediately end when a MDT review or NIC determine that it was no longer warranted?</strong> |     |    |          |</p>
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME (24 Hour Clock)</th>
<th>MONITORING</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Discontinue Seclusion using designated seclusion discontinuation form <strong>Appendix 1f</strong> An entry must also be made in the patient notes and Datix</td>
</tr>
<tr>
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<td>Yes</td>
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<td>Comments</td>
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Monitoring Form completed by:

<table>
<thead>
<tr>
<th>Name</th>
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<td>Date</td>
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<td>Signature</td>
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**ISSUES FOUND/LESSONS LEARNT**

<table>
<thead>
<tr>
<th>ACTIONS TAKEN</th>
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Monitoring Form Scrutiny Checked by:

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<th>Name</th>
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<td>Designation</td>
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<td>Date</td>
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<td>Signature</td>
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</table>
USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 2a (September 2017)

LONG-TERM SEGREGATION (LTS) - COMMENCEMENT FORM

AUTHORISING RESPONSIBLE CLINICIAN

Name: ........................................ Signature: ........................................
(Block Capitals)

NURSE IN CHARGE

Name: ........................................ Signature: ........................................
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE OF LTS: ........................................ TIME COMMENCED: ..................

Area of LTS
☐ Intensive Care Suite
☐ Bedroom
☐ Other (please name area) ........................................

Reasons or LTS (including patients mental state, details of incident):

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- The patient must be continually monitored at all times throughout the period of LTS and a record made of the patients behaviour hourly by a suitably skilled professional.
- The patients must be reviewed at least once every 24 hours by RC or Approved Clinician
- There should be an MDT review at least weekly and include RC and IMHA where appropriate
- Arrangements should be made for a Senior professional not involved in the case to review
- Where LTS continues or 3 month and longer reviews of the patient’s circumstances and care should be undertaken by an external hospital, this should include discussions with the patients IMHA and commissioner.
- The local Safeguarding team should be made aware of any patient being supported in longer term segregation.
- A Datix must be completed for each episode of LTS
- The views of the patients’ family should be elicited and taken into account with the agreement/consent of the patient.
USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 2a (September 2017)

<table>
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<th>Last Name</th>
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<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
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CARE PLANNING
Care Plan & Socialisation Plan: (Physical and mental health needs, managing risks, utilising verbal de-escalation, clothing and bedding provided, dietary needs)

☐ Patients Views
   Date: ..............................................
   Comments:

☐ IMHA Informed
   Date: ..............................................
   Comments:

☐ Safeguarding Team Informed
   Date: ..............................................

☐ Commissioner
   Date: ..............................................
   (Please speak to service lead or commissioners contact details)

FAMILY INVOLVEMENT
Family Informed/contacted:
Date
Time:
Comments:

MONITORING
Unit Manager’s Clinical Lead / Matron / Ward Sister / Charge Nurse / Nurse in Charge
Name: ........................................................................................................
(Block Capitals)
Signature................................................................. Date: ....................

OUT OF HOURS
Name of Senior Manager informed:
Date: .......................................................... Time: ................................

Name of Consultant On Call Informed: ..........................................................
Date: .......................................................... Time: ................................
## USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 2b (September 2017)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
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</thead>
</table>

### LONG-TERM SEGREGATION (LTS) - RECORD OF OBSERVATIONS

**DATE:**

<table>
<thead>
<tr>
<th>TIME (Hourly)</th>
<th>CLINICAL OBSERVATIONS (i.e. Physical Condition, Mental State, Mood and Behaviour)</th>
<th>DETAILS OF CARE PROVIDED (i.e drinks/food offered, bedding, books, engagement)</th>
<th>NAME AND STATUS</th>
<th>SIGNATURE</th>
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<td>Date and Time of Review (e.g. once every 24 hours)</td>
<td>CLINICAL OBSERVATIONS AND CARE GIVEN</td>
<td>DETAILS OF REASONS TO CONTINUE OR DISCONTINUE LTS, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN</td>
<td>LTS CONTINUED/ DISCONTINUED (Please state)</td>
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**Patients Views**

Comments:

**IMHA**

Comments:

<table>
<thead>
<tr>
<th>PRINT NAME (RC/Approved Clinician)</th>
<th>DATE:</th>
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| SIGNATURE: | TIME: |
### LONG-TERM SEGREGATION (LTS) - MDT WEEKLY REVIEW

<table>
<thead>
<tr>
<th>Date and Time of Review (at least weekly)</th>
<th>DISCUSSION AND REASSESSMENT OF LTS</th>
<th>DETAILS OF REASONS TO CONTINUE OR DISCONTINUE LTS, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN</th>
<th>OUTCOME OF REVIEW LTS CONTINUED/DISCONTINUED (Please state)</th>
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<tr>
<th>EXPLAINED TO PATIENT</th>
<th>YES/NO</th>
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(Where agreed by the patient family members should be informed of the review outcome)
USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 2d (September 2017)

Last Name: 
First Name: 
NHS No.: 
Date of Birth: 
Unit / Ward: 

Patients Views
Comments:

IMHA
Comments:

PRINT NAME: RESPONSIBLE CLINICIAN SIGNATURE DATE:
PRINT NAME: NURSE SIGNATURE DATE:
PRINT NAME: OTHER PROFESSIONALS (i.e. Psychology) SIGNATURE DATE:
PRINT NAME: OTHER PROFESSIONALS (i.e. Occupational therapist) SIGNATURE DATE:
PRINT NAME: OTHER PROFESSIONALS (i.e. Social Work) SIGNATURE DATE:

(Where agreed by the patient family members should be informed of the review outcome)
USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 2e (September 2017)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
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</table>

LONG-TERM SEGREGATION (LTS) – PERIODIC REVIEW FORM

RESPONSIBLE CLINICIAN

Name: ........................................ Signature: ........................................
(Block Capitals)

NURSE IN CHARGE

Name: ........................................ Signature: ........................................
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE OF LTS: ........................................ TIME COMMENCED: ........................................

Area of LTS
☐ Intensive Care Suite
☐ Bedroom
☐ Other (please name area) ........................................

SENIOR PROFESSIONAL (not involved with the case)

Name: ........................................ Signature: ........................................
(Block Capitals)

Designation: ........................................

Address:
........................................................................................................................................
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CONSULTED WITH

☐ Discussed with patient
Comments:

☐ Discussed with family
Comments:

☐ Other
Comments:
**USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41**  
Appendix 2e (September 2017)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
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<tbody>
<tr>
<td>NHS No.</td>
<td>Date of Birth</td>
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</table>

**RECOMMENDATIONS**
LONG-TERM SEGREGATION (LTS) – EXTERNAL REVIEW FORM

RESPONSIBLE CLINICIAN

Name: ....................................................
(Block Capitals)

NURSE IN CHARGE

Name: ....................................................
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE OF LTS: ........................................ TIME COMMENCED: ........................................

Area of LTS
☐ Intensive Care Suite
☐ Bedroom
☐ Other (please name area) ....................................................

EXTERNAL REVIEWING TEAM

Name/s: ....................................................
(Block Capitals)

Designation: ....................................................

Address:
........................................................................
........................................................................

CONSULTED WITH

☐ Discussed with Patient
  Comments:

☐ Discussed with IMHA
  Comments:

☐ Discussed with Family
  Comments:

☐ Discussed with Commissioner
  Comments:
USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41
Appendix 2f (September 2017)

<table>
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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
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RECOMMENDATIONS

Review Team

Name: ........................................ Signature: ........................................ Date: ............

Name: ........................................ Signature: ........................................ Date: ............
LONG-TERM SEGREGATION (LTS) - DISCONTINUATION FORM

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<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
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**RESPONSIBLE CLINICIAN**

Name: ................................................ Signature: ................................................

(Block Capitals)

**NURSE IN CHARGE**

Name: ................................................ Signature: ................................................

(Block Capitals)

**LONG-TERM SEGREGATION DETAILS**

DATE: .................................................. TIME: ................................................

**REASON FOR DISCONTINUING:**

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(If patients requires seclusion, please complete appendix 1a)

**RISK MANAGEMENT PLAN (e.g. level of observation, care plan)**
LONG TERM SEGREGATION (LTS) - MONITORING FORM

This monitoring form is for the Nurse in Charge (NIC) of the ward to complete once Long Term Segregation has been discontinued to ensure the process has been completed in line with the Trust policy and procedure.

Once completed this form must be scrutiny checked by the Matron/Integrated Clinical Lead and scanned onto electronic records in legal document section.

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<thead>
<tr>
<th>DATE</th>
<th>TIME (24 Hour Clock)</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tr>
<td></td>
<td>Is there evidence of clear clinical judgement indicating the decision to implement LTS? (Appendix 2a)</td>
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<td></td>
<td>Was the decision to implement LTS as an MDT communicated with the Responsible Commissioning Authority?</td>
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<td></td>
<td>Were the patient views and relevant family / carers sought &amp; IMHA where applicable? (Appendix 2a)</td>
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<td></td>
<td>Was the local Safeguarding Team made aware of patient being supported in LTS? (Appendix 2a)</td>
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<td>Have hourly observations been carried out and recorded in the patient records? (Appendix 2b)</td>
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<td>Has a Care Plan for LTS been developed which includes informing the patient what is required of them so that the period of LTS can be brought to an end? (Appendix 2a)</td>
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<td>Has a review been carried out at least once every 24 hours by Approved Clinician (may or may not be a Doctor)? (Appendix 2c)</td>
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<td>Has a review been carried out at least weekly by MDT including RC and IMHA (where appropriate)? (Appendix 2d)</td>
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<td>Have periodic monthly reviews been carried out by a Senior Professional? (Appendix 2e)</td>
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<td>Has a review been carried out if LTS is for longer than 3 months by an External Hospital? (Appendix 2f)</td>
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Date to be completed by

Date completed
## USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE – CLPG41

### Appendix 2h (September 2017)

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<tr>
<td>Have the outcomes of each review been clearly documented with the patient’s records?</td>
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<td>Where successive MDT reviews determined that LTS continues to be required is there evidence to explain why the patient cannot be supported in a less restrictive manner?</td>
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<td>Has the decision to discontinue LTS been undertaken by a MDT in consultation with the patients IMHA (where appropriate)? (Appendix 2d)</td>
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<td>Is it evident that the discontinuation took into account a thorough risk assessment and review of observation from staff of the patient’s presentation during close monitoring of the patient with others?</td>
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<td>Does the care plan and patient records clearly document that LTS has ended? (dated and timed) (Appendix 2g)</td>
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### Monitoring Form completed by:

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### ISSUES FOUND/LESSONS LEARNT | ACTIONS TAKEN
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Monitoring Form Scrutiny Checked by:

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<td>NB: This should be Matron/Integrated Clinical Lead</td>
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LONG TERM SEGREGATION FLOW CHART

LTS may be used after a period of seclusion
*Use CLP41 Appendix 2a to commence, complete care planning.

Start Hourly Observations without delay
Appendix 2b

- Continuous visual observations without delay
- Record every hour
- Observing staff will be present with the patient

Once every 24 hours
*Review Appendix 2c

- Approved Clinician may or may not be a doctor
- Out of hours/weekend, use on call doctor/consultant
- Should include patients RC wherever possible
- Should include the patient IMHA where appropriate

Weekly MDT
*Review Appendix 2d

- Should include patients RC
- Should include IMHA where appropriate

Periodic
*Review Appendix 1e

- Senior professional which is not involved in the case
- Could include clinical lead, site/unit coordinator/senior clinician from other ward e

External
*Review Appendix 2f

- Regularly three monthly reviews
- Must review patient circumstances
- Review must be undertaken by external hospital
- Must include discussion with patients IMHA and Commissioner

Termination

Terminating LTS is a MDT decision with IMHA where appropriate

Use Appendix 2g to record

Monitoring and Scrutiny

Monitoring and scrutiny form (Appendix 2h) to be completed by Clinical Lead/Charge Nurse/Sister to ensure compliance with process.
SECLUSION FLOW CHART

Seclusion should be used as a last resort and for the least possible time.
*Use CLP41 Appendix 1a to commence seclusion, complete care plan.

- Continuous visual observations without delay
  - Record every 15 minutes
  - To be reviewed without delay if seclusion not authorised by a doctor and if patient is not known or has a significant change from usual presentation.

- If seclusion is not authorised by the Responsible Clinician, a consultant psychiatrist, ward doctor or duty doctor (or equivalent) should attend to undertake the first medical review.
  - This can be the doctor authorising seclusion
  - If a consultant psychiatrist authorised the seclusion, their medical review immediately prior to the seclusion satisfies this requirement and no further medical review within the first hour is required.

- These will be undertaken by two registered nurses
  - One of whom was not involved directly in the decision to seclude.

- Review by RC
  - Where RC is not immediately available, a “duty doctor” can deputise for RC. Where the duty doctor is not an Approved Clinician, they should at all times have access to an on call doctor who is an Approved Clinician.
  - Night time - if the patient is asleep different medical review arrangements should be agreed and recorded in the patient’s records.

- MDT Review
  - Continuing medical reviews every 4 hours until MDT review
  - First MDT review can include, Senior Nurse; Psychologist; Occupational Therapist; Clinical Lead/Matron

- Further medical reviews should continue at least twice in every 24 hour period.
- At least one of these should be carried out by the patient’s RC or an alternative approved clinician.

- Subsequent Independent MDT Review
  - If the patient is secluded for more than 8 hours consecutively, or 12 hours over a period of 48 hours an independent multi-disciplinary review must be undertaken by clinicians who were not involved in the original decision to seclude the patient. This process should involve the patient’s IMHA where there is one in place.
  - The independent MDT should consult with those involved in the original decision.

Seclusion can be terminated using Appendix 1f at any time when the clinical team assess that seclusion is no longer necessary. Seclusion is only to be considered formally discontinued when the service user is informed that they are able to leave the room if they so wish.
PROCEDURE FOR THE USE OF SECLUSION & LONG-TERM SEGREGATION

<table>
<thead>
<tr>
<th>PROCEDURE NUMBER:</th>
<th>CLP41</th>
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<tr>
<td>VERSION NUMBER:</td>
<td>7</td>
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<tr>
<td>AUTHOR:</td>
<td>Consultant Psychiatrist - Forensic</td>
</tr>
<tr>
<td>CONSULTATION GROUPS:</td>
<td>Service Management Teams, Quality Groups, Trust Solicitor, Seclusion Task and Finish Group</td>
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<tr>
<td>IMPLEMENTATION DATE:</td>
<td>August 2010</td>
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<td>AMENDMENT DATE(S):</td>
<td>May 2014 (Director Change), July 2014, June 2015, March 2016, July 2016</td>
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<td>LAST REVIEW DATE:</td>
<td>March 2016</td>
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<td>NEXT REVIEW DATE:</td>
<td>March 2019</td>
</tr>
<tr>
<td>APPROVAL BY CLINICAL GOVERNANCE &amp; QUALITY COMMITTEE:</td>
<td>October 2017</td>
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<tr>
<td>RATIFICATION BY QUALITY COMMITTEE:</td>
<td>16 November 2017</td>
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PROCEDURE SUMMARY

This procedure aims to provide staff with guidance and practices for seclusion and long term segregation following the changes to the Mental Health Code of Practice in 2015. This procedure applies to all members of staff working within Mental Health, Learning Disability, Child and Adolescent and Secure Services for EPUT whether on a temporary or permanent basis.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

Datix reporting system, Manager’s sign of, Restraint and Seclusion Review Group and Restrictive Practice Steering Group as part of the Quality Account.

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The Director responsible for monitoring and reviewing this policy is Executive Medical Director for Patient Safety
1.0 INTRODUCTION

2.0 SCOPE

3.0 SECLUSION

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USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE –
CLPG41

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE FOR THE USE OF SECLUSION AND LONG-TERM SEGREGATION

Assurance Statement
This procedure sets out the arrangements for the management of Seclusion and Long-Term Segregation for inpatients within EPUT.

The purpose of this procedure is to ensure that all staff take appropriate steps to promote the physical and emotional well-being and the health and safety of patients where the clinical presentation of the patient indicates that the use of seclusion or long-term segregation is warranted. These procedures are intended to be supported by a safe and therapeutic culture that is focused on individualised, positive and proactive care approaches in the management of disturbed behaviour.

This procedure must be read in conjunction with Adverse Incidents including Serious Incidents (SI) Policy and Procedure (CP3, CPG3), Safeguarding Adults Policy and Procedure (CLP39, CLPG39) and Clinical Guideline for Engagement and Formal Observation (CG8).

1.0 INTRODUCTION

1.1 The revised MHA Code of Practice (COP) issued in 2015 identifies changes to the safe and therapeutic responses to disturbed behaviour. This has required the Trust to review the historic terms “segregation & restricted access”. These terms no longer exist within the COP and are covered by the terms “Seclusion” and Long-Term Segregation (LTS).

2.0 DEFINITIONS

2.1 Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. (COP 26.103)

2.2 Long-Term Segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. (COP 26.150)

2.3 Time Out is an intervention used in children and young people’s mental health services ONLY.
Time-out is a specific behaviour change strategy which is delivered as part of a behavioural programme and this may prevent a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time.

If at any time “time-out processes” have the features of seclusion, this should be treated as seclusion and comply with the requirements of seclusion processes and the Code. (COP 26.58)

### 3.0 SECLUSION

#### 3.1 Introduction to Seclusion

Seclusion must only be used as a last resort and for the shortest possible time.

Seclusion must never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion must be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient’s health or safety and that any such risk can be properly managed.

In order to ensure that seclusion measures have a minimal impact on a patient’s autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient’s circumstances.

Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward.

Seclusion should only be used in hospitals and in relation to patients detained under the Mental Health Act. (COP 26.106)

If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately (COP 26.106). – i.e. holding powers under S.5(2) or S.5(4) must be considered as an immediate response whilst MHA assessment is coordinated.
3.2 Seclusion Environments

If a patient is confined in any way that meets the definition for seclusion (point 1.2) even if they have agreed to or requested such confinement (i.e. they have requested or agreed to be nursed in an area away from other patients), if they have been prevented from leaving it is seclusion.

Despite the use of any alternative local terminology or the condition of the immediate environment it does not change the fact that the patient has been secluded and as such the seclusion process must be followed (COP 26.104)

The following factors should be taken into account in the design of rooms or areas in which the patient is secluded to, must (COP 26.109):

- Allow for clear observation with no blind spots
- Have no apparent safety hazards and be ligature free
- Have clear vision of a clock for the patient to identify the time of day
- Have a bed area with pillow, mattress and blanket or covering
- Be fit for purpose and be able to withstand attack/damage
- Have robust doors which open outwards
- Provide privacy from other patients
- Not contain anything which could cause harm to the patient or others
- Be appropriately furnished, heated, lit (and externally controlled where possible), well insulated and ventilated with natural light.
- Have externally controlled temperature that those observing patient can monitor and maintain
- Be quiet, but not sound proofed and will contain some means of calling for attention and allow for communication with the patient; the means of operation will be explained to the patient
- Access to toilet/washing facilities available within the intensive care area

Staff may decide what a patient may take into the seclusion room, but the patient must always be clothed.

3.3 Authorising Seclusion

<table>
<thead>
<tr>
<th>Seclusion may be authorised by either:</th>
<th>Additional considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A psychiatrist</td>
<td>If the psychiatrist who authorises seclusion is neither the patient’s responsible clinician (RC) nor an Approved Clinician (AC), the RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.</td>
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</tbody>
</table>
The professional in charge of ward (i.e. nurse in charge of the ward, RMN) & The patient’s RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.

An Approved Clinician (AC) who is not a doctor & The patient’s RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.

The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

Family members should be notified as per what has been agreed in the patient’s positive behaviour support plan (or equivalent).

3.4 Level of Observation

Patients in seclusion require monitoring “within eyesight” and sound as per levels of observation (level 3) throughout their period of seclusion by a suitably skilled and competent staff member utilising therapeutic engagement to aid in resolving the situation.

In this instance “suitably skilled” and “competent staff member” can include any band 2 Health Care Assistant/Support Worker or above who is TASI trained and have completed the Engagement and Formal Observation competency checklist.

The staff member should have the means to summon urgent assistance from other staff at any point.

Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Different review arrangements can be applied during the night when patients in seclusion are asleep. These arrangements must be agreed by the professional in charge of the ward and/or a doctor and the revised schedule should be recorded in the seclusion care plan.

Delegation of staff must take into account patients’ gender and consider cultural background.

The aim of observation and engagement is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

3.5 Seclusion Review Process

A series of review processes should be instigated when a patient is secluded.
<table>
<thead>
<tr>
<th>WHEN</th>
<th>BY WHOM</th>
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<tbody>
<tr>
<td><strong>Without delay</strong></td>
<td>If the seclusion was not authorised by a doctor and the individual is not known or has a significant change from usual presentation, the patient should be reviewed by a doctor without delay (26.116).</td>
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</tbody>
</table>
| **First hour** | • If the seclusion is not authorised by a consultant psychiatrist, the Responsible Clinician or duty doctor (or equivalent) should attend to undertake the first medical review.  
• This can be the doctor authorising seclusion  
• If a consultant psychiatrist authorised the seclusion, their medical review immediately prior to the seclusion satisfies this requirement and no further medical review within the first hour is required. |
| **Every two hours** | • Two registered nurses (i.e. RMN/RNLD)  
• One of whom was not involved directly in the decision to seclude. |
| **Every four hours** | • These will be undertaken by the Responsible Clinician.  
• Where the Responsible Clinician is not immediately available for whatever reason, a “duty doctor” can deputise for the Responsible Clinician. Where the duty doctor is not an Approved Clinician, they should at all times have access to an on call doctor who is an Approved Clinician.  
• During the night if the patient is asleep different medical review arrangements should be agreed and recorded in the patient’s records/seclusion care plan. |
| **First Internal MDT review**  
i.e. Responsible Clinician; Approved Clinician; Senior Nurse; Psychologist; Occupational Therapist; Integrated Clinical Lead/Matron | As soon as practicable |
Twice daily following internal MDT review | Following the first internal MDT review, further medical reviews should continue at least twice in every 24 hour period. At least one of these should be carried out by the patient’s RC or an alternative approved clinician.

Subsequent Independent MDT review | - If the patient is secluded for more than 8 hours consecutively; or 12 hours over a period of 48 hours an independent multi-disciplinary review must be undertaken by clinicians who were not involved in the original decision to seclude the patient. This process should involve the patient’s IMHA where there is one in place.
- The independent MDT should consult with those involved in the original decision.

3.6 Seclusion Reviews OUT OF HOURS and WEEKENDS

The on-call senior Manager and Consultant on call must be notified of any periods of seclusion and details of this should be recorded on Appendix 1.

Nursing reviews will continue at least every 2 hours.

Medical reviews can be designated / delegated to the “Duty Doctor/Consultant on call”; however this must be pre-arranged.

MDT review may be limited to medical and nursing staff, in which case the on-call senior site manager/unit coordinator (or equivalent) must also be involved. Further MDT reviews should take place once in every 24-hour period of continuous seclusion.

3.7 Pharmacological Management of Acutely Disturbed Behaviour (CG52) (Rapid Tranquilisation COP 26.91 – 26.102) whilst in Seclusion (moved from 3.9 to 3.7)

Any patients secluded will have staff present all the time and physical health observation monitoring must be undertaken using Modified Early Warning System (MEWS).

Where patients have received pharmacological intervention to manage the disturbed behaviour a skilled professional positioned outside of the door is to monitor and record physical health signs for any adverse reaction to medication for at least the first hour after administration or until the effect of the sedation has entirely worn off, whichever is the later.

A skilled professional can be a qualified nurse or suitably experienced Associate Practitioner (Band 4).
3.8 Record Keeping

On commencement of seclusion Appendix 1a should be fully completed.

Following this a suitably skilled and competent staff member must document a summary of the patient's mental and physical state and behaviour every 15 minutes, on the designated seclusion form (Appendix 1b). This will include details of any nursing interventions given and, where applicable:

- The patient’s appearance;
- What they are doing and saying
- Their mood
- Their level of awareness; and
- Any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.

Nursing reviews – will be noted in Appendix 1c

Medical reviews - will be noted on Appendix 1d

MDT reviews – will be noted in Appendix 1e

Care Planning for any seclusion should set out how the individual care needs of the patient will be met whilst in seclusion and the steps that will be taken to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan must include:

- a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient’s dietary needs are to be provided for, and
- details of any family or carer contact/communication which will be maintained during the period of seclusion in accordance with the requirements of paragraph 26.16 of the MHA CoP. The care plan should also provide details of the support that will be provided when the seclusion comes to an end.

3.9 Discontinuation of Seclusion

Termination of seclusion should be recorded on Appendix 1f.
Seclusion should immediately end when:

- A MDT review, a medical review or the independent MDT review determines it is no longer warranted
- Where the professional in charge of the ward feels that seclusion is no longer warranted
- Following consultation with the patient’s responsible clinician or duty doctor (this consultation may take place in person or by telephone)
- A patient is allowed free and unrestricted access to the normal ward environment

Staff should be aware that opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.

3.10 Where seclusion must not be used

- Where increased staffing could deal with the problem
- Where managing the risk of suicide or self-harm is the priority
- Where the risk presented is towards property and not towards people. However, if in the view of the nurse in charge, the situation is escalating to a degree where harm to others could easily be caused then seclusion could be considered.
- Where it is seen as a punishment or threat
- As part of a treatment programme (however this can be part of an Advance Decision)
- A pregnant woman must not be secluded after rapid tranquillisation
- Any patient who is heavily sedated or using illicit drugs/alcohol must not be secluded

4.0 LONG-TERM SEGREGATION

4.1 Introduction to Long-Term Segregation

The MHA COP 2015 acknowledges that for a small number of patients it may be necessary to initiate periods of LTS in order to reduce the sustained risk of harm posed by the patient to others and the risk would not be ameliorated by a short period of seclusion combined with any other form of treatment.

The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. (COP 26.150)

4.2 Environment

The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risks considerations allow. (COP 26.151)
Although isolated from the general ward population for reasons of safety, patients must not be isolated from contact with general ward staff or deprived access to therapeutic interventions.

Patients in long term segregation must have access to bathroom facilities, a bedroom, relaxing lounge area, secure outdoor area and a range of activities of interest and relevance to the person. (COP 26.151)

4.3 Authorising Long-Term Segregation

It may be the case that following a period of seclusion, long term segregation is considered.

When this decision is agreed, Appendix 2a must be completed.

The decision to care for a patient under conditions of long-term segregation must be taken by the MDT in conjunction with the responsible commissioning authority representative.

The patient’s views and that of relevant family or carers will be sought in addition to the patient’s IMHA if this is appropriate.

The local safeguarding team should be made aware of any patient being supported in longer term segregation.

4.4 Level of Observations

Appendix 2b must be completed to record hourly observations.

As a minimum the patient must be monitored “within eyesight” levels of observation (level 3) by suitably skilled and competent staff utilising therapeutic engagement to aid in resolving the situation.

The aim of observation and engagement is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which long term segregation can end.

Allocation of staff should take into account patients’ gender and cultural consider cultural background.

4.5 Long Term-Segregation Review Process

<table>
<thead>
<tr>
<th>When</th>
<th>By Whom</th>
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</thead>
<tbody>
<tr>
<td>Hourly records Appendix 2b</td>
<td>Observing staff</td>
</tr>
<tr>
<td>At least once in every 24 hour period</td>
<td>Approved Clinician (May or may not be a doctor). Out of</td>
</tr>
</tbody>
</table>
### Appendix 2c

<table>
<thead>
<tr>
<th>Appendix 2c</th>
<th>hours/weekends the delegated duty doctor for this review would be the on call Approved Clinician/Consultant on call.</th>
</tr>
</thead>
</table>

### At least weekly

<table>
<thead>
<tr>
<th>Appendix 2d</th>
<th>MDT (Should include patients RC and IMHA where appropriate)</th>
</tr>
</thead>
</table>

### Periodic monthly reviews

<table>
<thead>
<tr>
<th>Appendix 2e</th>
<th>Senior professional who is not involved with the case</th>
</tr>
</thead>
</table>

### 3 months or longer

<table>
<thead>
<tr>
<th>Appendix 2f</th>
<th>Regular three monthly reviews of the patients circumstances and care to be undertaken by an external hospital. This should include discussion with the patients IMHA and commissioner</th>
</tr>
</thead>
</table>

These should all be recorded within the patient’s records.

### 4.6 Record Keeping

Written records should be made on at least an hourly basis (COP 26.154) within the patient’s records.

The outcome of all reviews and the reasons for continued long term segregation should be recorded within the patient’s records and the responsible commissioning authority should be informed of the outcome.

Where successive MDT reviews determine that long term segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.

**Care/Treatment Plans** – The patients care plan should clearly state the reasons why long-term segregation is required and should outline how they are to be made aware of what is required of them so that the period of long-term segregation can be brought to an end.

### 4.7 Discontinuation of Long-Term Segregation

Appendix 2g must be completed for discontinuation of LTS.

The decision to end long-term segregation should be taken by the MDT (including consultation with the patient’s IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient’s presentation during close monitoring of the patient in the company of others (COP 26.157). The decision to discontinue long-
term segregation should be clearly recorded within the patient’s records and care plans.

5.0 DEPRIVATION OF ACCESS TO NORMAL DAYTIME CLOTHING WHILST IN SECLUSION AND LONG-TERM SEGREGATION

5.1 Individuals must never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living. (COP 26.161)

5.2 It may be appropriate, in some instances, for individuals to be asked to wear special tear-proof clothing and this decision should be authorised by the patient’s Responsible Clinician (out of hour’s consultant after hours) and Nurse in Change. An MDT should undertake an individualised risk assessment before this decision is taken. (COP 26.162).

5.3 Special tear-proof clothing should only be used for as long as absolutely necessary. Positive behaviour support plans should detail primary preventative strategies that will aim to avoid the ongoing need for such restrictions.

5.4 The nurse in charge of the shift and the RC (out of hour’s consultant) will make the decision to terminate the use of special tear-proof clothing and return to usual clothing.

6.0 FOLLOWING ACUTE BEHAVIOURAL DISTURBANCE

6.1 Following use of seclusion or long-term segregation, a post-incident review or debrief should be undertaken so that all involved parties, including patients, have appropriate support and there is opportunity for learning. It is important that patients are helped to understand what has happened and why.

6.2 Methods should be put in place to assess the effect of the seclusion or long-term segregation on the patient.

This should all be recorded within the patient’s positive behaviour support plan.

6.3 Discussion with the patient about the experience should be used in the future to determine what did and did not help and what could be done differently in the future. The patient’s accounts of the incident and their feelings following it should be recorded in the patient’s notes. Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions they would or would not like to be used in an advance statement.
7.0 Auditing & Governance

7.1 All incidents of seclusion and long term segregation must be recorded on Datix.

7.2 All ward sisters/charge nurses will scrutinise the seclusion paperwork and processes as it happens for compliance using Appendix 1g for seclusion and Appendix 2h for LTS. A. This will be signed off by the relevant services lead (ICL, matron, etc.) and scanned into the electronic record.

7.3 Compliance will be monitored via the restraint/seclusion review group with a monthly report from the reviewers re process compliance and standard of reporting in line with the MHA code of practice 2015. This will be reported into the Restrictive Practice Steering Group for learning and oversight.

7.3 Annually there will be an audit of seclusion and LTS paperwork and processes to provide assurances to the wider Trust. The Clinical Audit Department will ensure that annual audits are carried out as part of the annual audit programme.

7.4 If patients wish to formally raise a concern

- They will be reminded of how to access the local complaints process and independent advocacy services.
- They will also be made aware of how to request an accessible version of the Trust policy on restrictive interventions.
- The safeguarding team will be informed whenever a patient raises concerns about restrictive interventions.
- Patients who need alternative support will be offered this support to access and use the complaints procedure.

8.0 TRAINING

The Trust have a policy on workforce development and training for staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions.

All Trust staff that support people who are liable to present with acute behavioural disturbance will be competent in physical monitoring and emergency resuscitation techniques to ensure the safety of patients following administration of rapid tranquillisation and during periods of physical restraint or seclusion.

All clinical staff undertaking training in the recognition, prevention and management of violence and aggression and associated physical restraint must attend annual refresher training.
9.0 POLICY REFERENCES/ASSOCIATED DOCUMENTATION

- Mental Health act 1983 (amended 2007)
- Mental Health Act Code of Practice, 2015
- Children Act 2004
- Positive and Proactive Care: reducing the need for restrictive interventions. DH (2014)
- A positive and proactive workforce. Skills for Care / Skills for Health (2014)
- Francis Report (2013)
- Deprivation of Liberty Safeguards: Supreme Court Judgements (2014)
- Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings. NHS Protect: (2014)
- Statement on CQC’s roles and responsibilities for safeguarding children and adults, 2015
- Guidance on prevention and management of physical assaults in mental health settings - NHS Protect
- Mental Capacity Act, 2005
• Royal College of Nursing consultation - Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools, December 2013

• Culture of Care Barometer, March 2015

• Safewards; making psychiatric wards more peaceful places

• R (Munjaz) v Mersey Care NHS Trust (2008) UKHL 58

• Public Sector Equality Duty (s.149 Equality Act 2010)

END
Equality Impact Assessment Template

Section 1: Your details

(1.1) Department/ team:

(1.2) Locality/Directorate:

(1.3) Assessment Lead/person:

(1.4) Contact details:

(1.5) Email:

(1.6) Who else will be involved in the process?

(1.7) Please sign & date this form ………………………….. (signed) …………………. (date)

Guidance Note 1:

For Initial EIA’s it is best practice to involve the service / clinical manager, and relevant frontline staff.

For Full EIA’s it is best practice to involve the service / clinical manager, relevant frontline staff, service users/ carers, appropriate external agencies, and the voluntary and community sector.

Section 2: What is to be assessed?

(2.1) Name of service / function / project / strategy / policy to be assessed (see guidance note 2)

(2.2) Is this a new or existing service / function / project / strategy / policy? (please state)

(2.3) Has it been assessed before and if so please attach the existing assessment.
### Guidance Note 2:

Service = your department / service area and its employees  
Functions = your department / service area’s activities  
Projects = your department / service area’s work programmes  
Strategy = a plan of action intended to accomplish a specific goal  
Policy = a plan of action to influence and determine decisions, actions and other matters  
Procedure = a series of steps taken to implement a policy

### Section 3: Let’s do the Initial Equality Impact Assessment (Screening)

3.1 Could a particular group of people be affected differently in either a negative or positive way by the service / function / project / strategy / policy?

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Positive Impact (benefits)</th>
<th>Negative Impact (disadvantage) or potential negative impact</th>
<th>Please rate each negative impact ‘low’, ‘medium’ or ‘high’</th>
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<tbody>
<tr>
<td>Disabled People</td>
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<td>Lesbian, Gay &amp; Bisexual People</td>
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<td>Women</td>
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<td>Men</td>
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<tr>
<td>Equality Group</td>
<td>Positive Impact (benefits)</td>
<td>Negative Impact (disadvantage) or potential negative impact</td>
<td>Please rate each negative impact ‘low’, ‘medium’ or ‘high’</td>
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<tr>
<td>Transgendered People</td>
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<td>See guidance note 3</td>
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<tr>
<td>Black &amp; Racial Minority People (please state which group)</td>
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<td>Older People (60+)</td>
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<td>Younger People (17-25) and Children</td>
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<td>Please state male or female</td>
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<td>Religious / Faith Groups</td>
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<td>Pregnancy and maternity</td>
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<td>Marriage and civil partnership</td>
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<tr>
<td>Deprived Groups</td>
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</table>

If you have rated any negative impact(s) as ‘High’ please go straight to Section 4 to complete a full assessment.

If you have rated any negative impact as ‘Low’ or ‘Medium please complete the rest of this section on pages 5 and 6.
Guidance Note 3: How to assess negative impacts

Low = It is not discriminatory according to current legislation. However, it might not be seen as being in line with best practice.

Medium = It is not discriminatory according to current legislation. However, it is not in line with the Trust or Department Equality Policy and/or Strategy and requires attention.

High = It is discriminatory according to current anti-discrimination legislation (i.e. it is unlawful), and therefore requires immediate action.
3.2 Please list below any actions that you plan to take as a result of any negative impact

**EIA Action plan**

<table>
<thead>
<tr>
<th>Low or medium negative impact</th>
<th>Action required to remove or minimise the impact</th>
<th>Lead person</th>
<th>Timescale</th>
<th>Resource implications</th>
<th>Any other comments</th>
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3.3 Could you improve the positive impact(s)? Please explain how

3.4 If you have identified no negative impact, then please explain how you reached that decision and provide reference to evidence (for example reviews undertaken, surveys, feedback, patient data verified etc)

Thank you for completing the initial assessment (please email a copy of this report to the compliance function.

Please note that the lead assessment person is responsible for ensuring the actions on pages 9 and 10 are incorporated into your departmental plan.
Section 4: Full Equality Impact Assessment

4.1 Looking back at pages 2 & 3, in which equality areas are there concerns?

- Disability
- Sexual Orientation
- Gender
- Race
- Age
- Religion & Faith
- Deprivation
- Marital status
- Pregnancy and maternity

4.2 Please summarise the negative impact (s) or potential negative impacts

4.3 What consultation has taken place with local people / patient groups in order to complete this full EIA?
4.4 What consultation has taken place with EPUT staff / stakeholders / those we work in partnership with / those we contract with in order to complete this full EIA?

4.5 What equality research / studies / reports have you referred to in order to complete this full EIA?

4.6 What monitoring / evaluation process do you use to collect equality group data (quantitative and qualitative)?
4.7 Please list below any actions that you plan to take as a result of this full equality impact assessment

**EIA Action plan**

<table>
<thead>
<tr>
<th>Negative Impact</th>
<th>Action to be taken</th>
<th>Lead person</th>
<th>Timescale</th>
<th>Resource implications</th>
<th>Any other comments</th>
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Thank you for completing the full assessment. Now email a copy of this report to compliance function.

Please note that the lead assessment person is responsible for ensuring the above actions are incorporated into your departmental plan or organisation-wide plan.
EQUALITY, INCLUSION & HUMAN RIGHTS POLICY

PROCEDURE REFERENCE NUMBER  CP24
VERSION NUMBER  V1
REPLACES SEPT DOCUMENT  CP24
REPLACES NEP DOCUMENT  Corp/Equality/10/14
KEY CHANGES FROM PREVIOUS VERSION  Not applicable
AUTHOR  Associate Director for Social Care and Partnerships
CONSULTATION GROUPS  Equality and Inclusion Steering Group (NEP/SEPT), Employee Experience Lead, Workforce, Development and Training, Patience Experience Team, Operational services (MH and Community) Quality Committee

IMPLEMENTATION DATE  April 2017
AMENDMENT DATE(S)  Not applicable
LAST REVIEW DATE  Not applicable
NEXT REVIEW DATE  April 2020
APPROVAL BY  Interim Board
RATIFICATION BY  Not applicable

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POLICY SUMMARY
The Essex Partnership University NHS Foundation Trust has (EPUT) has a statutory obligation to ensure that all practices within the Trust are carried out in a fair, reasonable and consistent manner in line with the Equality Act, 2010. This procedure aims to promote equality of opportunity between people who share a protected characteristic and those who do not, prevent discrimination and foster good relationships.

EPUT has produced this policy to regulate and monitor the Trust’s compliance with the Equality Act, 2010 and general and specific Public Sector Equality Duty (PSED).
The Trust monitors the implementation of and compliance with this procedure in the following ways;

Equality and Inclusion Committee will ensure that compliance is monitored regularly against:

- The Equality and Inclusion Committee Annual Work plan and schedule
- the Equality Delivery System (2) action plan
- annual review of its effectiveness to ensure it meets requirements as set out in its terms of reference

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The Director responsible for monitoring and reviewing this procedure is Executive Director of Community Services and Partnerships
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EQUALITY, INCLUSION AND HUMAN RIGHTS POLICY

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4.0 PUBLIC SECTOR EQUALITY DUTY
5.0 DEFINITIONS AND TYPES OF DISCRIMINATION
6.0 GUIDING PRINCIPLES
7.0 ROLE OF THE TRUST
8.0 ROLE OF THE DIRECTOR OF EXECUTIVE DIRECTOR OF COMMUNITY SERVICES AND PARTNERSHIPS
9.0 ROLE OF THE SERVICE MANAGER
10.0 ROLE OF THE INDIVIDUAL
11.0 MONITORING
1.0 POLICY STATEMENT

1.1 The purpose of this policy is to ensure that all practices within the Trust are carried out in a fair, reasonable and consistent manner.

1.2 The Trust is committed to providing a service that promotes equality, inclusion and human rights, and does not discriminate against any Trust workers, potential Trust workers, service users, relatives, carers or anyone that deals with the Trust in any way.

1.3 This policy is at the heart of enabling the Trust to deliver its Core Values. Through the implementation of this policy Essex Partnership University NHS Foundation Trust (EPUT) will ensure that commitment to fairness and equality competence is evident in every department and every level throughout the Trust and that everyone has equal access within EPUT, regardless of background or personal characteristics.

1.4 The Policy introduces the Trust’s Principles in relation to ensuring equality in employment practices, service provision and respecting diversity among staff, service users and carers.

1.5 The Trust will promote equality and integrate an anti-discriminatory approach into all areas of its work. It will ensure that barriers to accessing services and employment are identified and removed, and that no person is treated less favourably on the grounds of their race, ethnicity, religion or belief, age, gender, marital status, transgender status, disability, sexual orientation, disability (protected characteristics defined by Equality Act 2010). The Trust also commits to providing equal access to services and employment regardless of mental health status, caring responsibilities or socio-economic background.

1.6 The Trust recognises the importance of this policy in both the employment relationship and service provision, and will reflect these commitments in all Trust policies.

1.7 Trust staff have the right to be treated in a fair, reasonable and consistent way with dignity and respect and without the fear of discrimination, harassment or victimisation.

1.8 Service Users, their relatives and their carers have the right to be treated in a fair, reasonable and consistent way with dignity and respect and without the fear of discrimination, harassment or victimisation.

1.9 Anyone that deals with the Trust, including Partners and stakeholders will receive equitable treatment whether they are receiving a service, providing a service, tendering for a contract or any other relationship.
1.10 The Trust will uphold the Human Rights of all service users, carers and staff and anyone else with a relationship to the Trust. These include practices which reflect the principles of the right to a fair trial, respect for private and family life and freedom of thought, conscience and religion. Any restriction placed on the rights of service users, for example those detained under the Mental Health Act 1983 or Mental Capacity Act 2005, will be considered and proportionate. The ‘least restrictive principle’ will always be applied.

1.11 The Trust is committed to the ongoing development of staff awareness of Equality & Inclusion, and Human Rights issues throughout an individual’s relationship with the Trust.

1.12 The Trust is committed to monitoring, evaluating and reporting on issues of Equality and Inclusion in services, carers and the workforce.

1.13 The Trust recognises these benefits which will arise from implementation of the Equality and Inclusion and Human Rights policy:

- Flexible provision of service that meets individual service users’ and carers’ needs and ensures high levels of satisfaction with services.

- Employing staff from diverse backgrounds allows a better understanding of the needs of all service users and carers, and creates a diverse workforce that reflects the wider community.

- A diverse workforce provides greater flexibility within working practices.

- Valuing staff and ensuring they have been treated fairly improves morale, motivation and job satisfaction, and reduces staff turnover.


1.15 The Trust will work to reduce health inequalities for service users and carers.

1.16 The Trust will continue to be transparent and report on regulatory requirements to report on disciplinary, grievances, harassment.

2.0 RELEVANT LEGISLATION

2.1 The key statutory frameworks that supports this policy are:

- The Human Rights Act 1998
- The Equality Act 2010
- Care Act, 2014
3.0 SCOPE OF POLICY

3.1 This policy applies to substantive and fixed term contract staff, and all Agency and Bank Workers who work for this organisation.

3.2 The policy also applies to service users, their families and carers, throughout their relationship with the Trust.

3.3 This is not an exhaustive list. The policy applies to anyone that has dealings with the Trust.

4.0 PUBLIC SECTOR EQUALITY DUTY

4.1 The Equality Act 2010 places a Public Sector Equality Duty on all public authorities in the form of General and Specific Duties.

The General Duty requires that we:

- Eliminate discrimination.
- Promote and advance equality of opportunity.
- Foster good relation between protected characteristics.

The Specific Duty requires that we:

- Set out and publish our Equality Objectives.
- Report on the progress on meeting those objectives, using our Equality and Diversity System 2 framework.
- Publish its equality objectives and an annual progress report on those objectives. The annual publication of equality information. This includes collecting, analysing and publishing statistics on workforce equality data and service user equality data.
- Gather and analyse data to improve equality outcomes.
- Consult and involve service users.
- Pay due regard to the Personal Protected Characteristics.*
- Review the trust’s approach every 4 year.

*Protected Characteristics: The Equality Act 2010 provides protection for individuals with the following “protected characteristics”:

- race,
- gender,
- disability,
- age,
- sexual orientation,
- gender reassignment,
- religion or belief,
- pregnancy and maternity and
- marriage and civil partnership.
5.0 DEFINITIONS & TYPES OF DISCRIMINATION

5.1 **Direct Discrimination** occurs when a person or group is treated less favourably than others are, or would be, treated in the same or similar circumstances due to no other reason other than a protected characteristic e.g. gender, ethnicity, disability, age, sexual orientation, religion, etc.

5.2 **Indirect discrimination** occurs when a provision, criterion or practice is applied, whether intentionally or not, which adversely affects one group of persons more than another and cannot be justified.

5.3 **Genuine Occupational Requirement** occurs in limited circumstances when jobs can be legally ring-fenced to a particular gender, race, religion, or sexual orientation on the grounds of authenticity or to preserve privacy and dignity.

5.4 **Victimisation** occurs when a person or group is treated less favourably because they have: brought proceedings in relation to this policy; or provided information in support of a third party claim in relation to this policy; or made an allegation that a breach of this policy has taken place. (See policy on **Whistleblowing**

5.5 **Harassment** is the violation of dignity or creation of an offensive environment (see also the **Grievance Policy**). Harassment is largely subjective, the individual will decide on whether they feel conduct is either acceptable or offensive.

5.6 **Vicarious Liability** means that the Trust can be held responsible for the discriminatory actions of its workers, even if they are carried out without the Trust's knowledge or approval, if due care is not provided in upholding this policy within working practices and raising staff awareness of the Trust's position on equality and human rights.

5.7 **Burden of Proof** now falls on the respondent, once the applicant has proven facts that could be interpreted as discriminatory.

5.8 **Unconscious Bias** ‘Unconscious bias refers to a bias that we are unaware of, and which happens outside of our control. It is a bias that happens automatically and is triggered by our brain making quick judgments and assessments of people and situations, influenced by our background, cultural environment and personal experiences.

6.0 GUIDING PRINCIPLES

6.1 All new Trust policies, procedures and practices will be Equality Impact Assessed to ensure that everyone affected will receive equal treatment.

6.2 Service users and carers should be involved in the development of new policies, services and the monitoring of progress to achieve actions plans, where appropriate.
6.3 Trust employees will receive equitable treatment in all relevant aspects of the employment relationship in line with Trust with Trust HR policy and procedures.

6.4 Training in equality and inclusion will be provided to all staff in accordance with the Trust’s approved training matrix.

6.5 The Trust will aim to ensure that there are no barriers to opportunity within the Trust for people potentially at a disadvantage e.g. providing reasonable adjustment that will allow persons with a disability to carry out their duties or receive an equitable service.

6.6 Everyone has the right to seek redress of any perceived injustice. This will ordinarily be through the Grievance Policy for Trust workers, or the Complaint Policy for Service Users or any other non-Trust workers.

6.7 The Equality Duty requires that the Trust, in the exercise of its functions have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

7 ROLE OF THE TRUST

7.1 The Trust has legal and moral responsibility for ensuring equality of opportunity and respect for diversity.

7.2 The Chief Executive Officer (CEO) has overall responsibility for ensuring that the policy is implemented in a co-ordinated manner and that it is effectively monitored.

7.3 There will be an Equality and Inclusion workplan that will be monitored by the Trust’s Equality and Inclusion Committee.

8.0 ROLE OF THE EXECUTIVE DIRECTOR OF COMMUNITY SERVICES & PARTNERSHIPS

8.1 The Executive Director of Community Services & Partnerships has overall responsibility for the co-ordination of this policy and the Trust Wide Equality and Inclusion Committee.

9.1 ROLE OF THE LINE MANAGERS

9.1 All managers will be responsible for ensuring that principles of equality, inclusion and human rights are understood and applied within their areas of responsibility, and that legal requirements are observed.
9.2 All managers have a responsibility for ensuring any allegations of discrimination, harassment or victimisation are fully investigated and appropriate action taken in line with policy.

9.3 Managers should deal with Equality & Inclusion issues raised by the families and carers of Service Users in an open and approachable manner.

9.4 Operational managers should deal with equality and inclusion issues raised by families and carers of service users in an open, transparent and approachable manner. Service users and carers with a concern should use the EPUT PALS or complaints procedure.

10.0 ROLE OF THE INDIVIDUAL

10.1 Every employee has a duty to comply with this policy and Equality legislation.

10.2 It is everyone’s responsibility to inform their manager (or the Human Resources Directorate) if they suspect that discrimination, harassment or victimisation is taking place, anywhere within the Trust.

11.0 MONITORING

11.0 In order to assess the effectiveness of its Equality, Inclusion and Human Rights policy the Trust will maintain, analyse and publish the following information for staff:

11.1 Gender, age, disability, sexual orientation, religion or belief and ethnic origin of:
• Job applicants
• Short-listed candidates;
• Existing and new employees and their deployment within the Trust.

11.2 Details of selections decisions for recruitment, redeployment, promotion, transfer and training and reasons for these decisions.

11.3 The Trust will maintain, analyse and publish anonymous/ statistical information on the protected characteristics of service users/ carers.

11.4 Statistical information will be used for measuring the achievement of the Trust’s Public Sector Duty, and effectiveness of the Trust’s Equality and Inclusion Steering Group.

11.5 Where information is collated in line with the Equality & Diversity Policy, it will be published using established communication mechanisms (in line with confidentiality guidelines).

END
EQUALITY, INCLUSION & HUMAN RIGHTS PROCEDURE

PROCEDURE REFERENCE NUMBER: CPG24
VERSION NUMBER: 1
REPLACES SEPT DOCUMENT CPG24
REPLACES NEP DOCUMENT Corp/Equality/10/14
KEY CHANGES FROM PREVIOUS VERSION Not applicable
AUTHOR: Associate Director of Social Care & Partnerships
CONSULTATION GROUPS: Equality and Inclusion Steering Group (NEP/SEPT), Employee Experience Lead, Workforce, Development and Training, Patience Experience Team, Operational services (MH and Community) SEPT Quality Committee
IMPLEMENTATION DATE: April 2017
AMENDMENT DATE(S): Not applicable
LAST REVIEW DATE: Not applicable
NEXT REVIEW DATE: April 2020
APPROVAL BY: Interim Board
RATIFICATION BY: Not applicable
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PROCEDURE SUMMARY
The Essex Partnership University NHS Foundation Trust (EPUT) has a statutory obligation to ensure that all practices within the Trust are carried out in a fair, reasonable and consistent manner in line with the Equality Act, 2010. This procedure aims to promote equality between people who share a protected characteristic and those who do not, prevent discrimination and foster good relationships.

EPUT has produced this procedure to regulate and monitor the Trust’s compliance with the Equality Act, 2010 and general and specific Public Sector Equality Duty (PSED).

The Trust monitors the implementation of and compliance with this procedure in the following ways:

- The Equality and Inclusion Committee Annual Work plan and schedule
- the Equality Delivery System (2) action plan
- annual review of its effectiveness to ensure it meets requirements as set out in its terms of reference
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The Director responsible for monitoring and reviewing this procedure is Executive Director of Community Services and Partnerships
1.0 INTRODUCTION

2.0 HUMAN RIGHTS ACT, 1998

3.0 EQUALITY ACT, 2010
   3.1 Compliance with Public Sector Equality Duties (PSED)
   3.2 Protected Characteristics
   3.3 The NHS Equality Delivery System (2)
   3.4 Equality Impact Assessments

4.0 Workforce Race Equality Standard (WRES)

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6.0 How do we implement our Public Sector Equality Duties (PSED)?
   6.1 Equality and Inclusion Committee
   6.2 Recording of information
   6.3 Training and Development
   6.4 Faith and Spirituality Advisory Group
   6.5 Equality and inclusion networks/forums
      6.5.1 Personal, Fair and Diverse (PFD) Equality champions
      6.5.2 Equality networks
      6.5.3 Equality and inclusion in practice – role of staff

7.0 Monitoring
QUALITY, INCLUSION & HUMAN RIGHTS PROCEDURE

1.0 INTRODUCTION

The purpose of this procedure is to ensure that all practices within the Trust are carried out in a fair, reasonable and consistent manner. The Trust is committed to providing a service that promotes human rights and equality, inclusion and does not discriminate.

In order achieve this the Trust will implement systems and processes to comply with national legislation, Department of Health, NHS England and NHSI requirements and good practice set out in this procedure below.

2.0 THE HUMAN RIGHTS ACT, 1998

The Human Rights Act 1998 brought the European Convention on Human Rights (ECHR) into UK law. As a result key human rights applicable for healthcare include:

- Article 2, the right to life, which has implications for treatment decision-making and providing access to services and places a positive obligation on the government and public bodies, to preserve life.
- Article 3, the right not to be tortured or treated in an inhuman or degrading way, which protects patients over poor conditions, lack of regard to dignity, neglect or abusive treatment, excessive force and treatment without consent.
- Article 5: The right to liberty and security of person. This article has led to the Deprivation of Liberty Safeguards amendment to the Mental Capacity Act 2005 and forms the grounds for many challenges to the Mental Health Act 1983
- Article 8: the right to respect for private and family life, home and correspondence, which protects patients over issues of consent, privacy and access to records, ensures that people are involved in decisions made about their treatment and care and that there is respect for diverse families and access to family visits;
- Article 14, the right not to be discriminated against in the enjoyment of other human rights, which means we must not deny treatment solely on the basis of age and must commit to improving mental health services for people from black and minority ethnic groups.

High quality care services that respect people’s dignity should:

- Have a zero tolerance of all forms of abuse
• Support and care for people with the same respect you would want for yourself or a member of your family
• Treat each person as an individual by offering a personalised service
• Enable people to maintain the maximum possible level of independence, choice and control
• Listen and support people to express their needs and wants
• Respect people’s right to privacy
• Consider their religious beliefs
• Treat people equally without discrimination
• Ensure people feel able to complain without fear of retribution
• Engage with family members and carers as care partners
• Assist people to maintain confidence and a positive self-esteem.

3.0 THE EQUALITY ACT, 2010

As a public sector organisation, EPUT has a statutory duty to ensure that equality, inclusion and human rights are embedded into all its functions and activities as required by the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution.

The Equality Act 2010 replaces all previous equality legislation, such as the Race Relations Act, the Disability Discrimination Act, the Sex/Gender Discrimination Act, Religion and Belief Regulations and Sexual Orientation Regulation.

The Equality Act is a key part of the legal framework that underpins the way the Trust provides its services and supports its staff.

The Trust will ensure compliance with the requirements of the Equality Act 2010 specifically as follows:

3.1 Compliance with Public Sector Equality Duties (PSED)

The Equality Act 2010 places a Public Sector Equality Duty on all public authorities in the form of General and Specific Duties.

3.1.1 The General Duty requires that we:
• Eliminate discrimination.
• Promote and advance equality of opportunity.
• Foster good relation between protected characteristics.

3.1.2 The Specific Duty requires that we:
• Set out and publish our Equality Objectives.
• Report on the progress on meeting those objectives, using our Equality and Diversity System 2 framework.
• Publish its equality objectives and an annual progress report on those objectives. The annual publication of equality information. This includes collecting, analysing and publishing statistics on workforce equality data and service user equality data.
• Gather and analyse data to improve equality outcomes.
• Consult and involve service users.
• Pay due regard to the Personal Protected Characteristics.
• Review the trust’s approach every 4 year.

3.2 Protected Characteristics

The Equality Act 2010 provides protection for individuals with the following “protected characteristics”:

- race,
- gender,
- disability,
- age,
- sexual orientation,
- gender reassignment,
- religion or belief,
- pregnancy and maternity and
- marriage and civil partnership.

It will be unlawful for the Trust to discriminate against an individual with a “protected characteristic” in any of the following ways:

- **Direct discrimination** – treating somebody less favourably because of a protected characteristic

- **Associative discrimination** – treating somebody less favourably or harassing them because of their connection with a person who has a protected characteristic
- **Perceptive discrimination** – treating somebody less favourably because they are believed to have a protected characteristic even if that perception is mistaken

- **Combined discrimination** – treating somebody less favourably because they have a combination of protected characteristics

- **Indirect discrimination** – applying a provision, criterion or practice that has the effect of disadvantaging somebody with a protected characteristic

- **Harassment** - unwanted conduct that has the purpose or effect of creating an intimidating, hostile, degrading, humiliating or offensive environment for an individual, or violating an individual’s dignity

- **Third party harassment** – Harassment of an employee related to a protected characteristic under the Equality Act 2010 (other than marriage and civil partnership, and pregnancy and maternity) by third parties, for example service users or customers.

- **Victimisation** – treating somebody badly because they have made or supported a complaint under the Act

- **Failure to make reasonable adjustments (for disability only)** – The Act extends the duty to make reasonable adjustments.

### 3.3 The NHS Equality Delivery System (EDS2):

The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. This was replaced in October 2013 by EDS2 in order to systematise and support how NHS organisations implement equality, inclusion and human rights.

The EDS2 is a mandatory tool and from April 2015 implementation by NHS provider organisations is mandated in the NHS standard contract.

The Trust undertakes with key stakeholders an annual self-assessment against the EDS2 domains and areas identified for improvement are included within the Trust objectives, and service operational action plans where appropriate. These action plans are monitored via the EDS2 framework by the Equality and Inclusion Committee.

The Trust also publishes an annual Equality and Inclusion report on our progress on the NHS England website and our own Trust website, which are mandatory requirements.

### 3.4 Equality Impact Assessments

3.4.1 An Equality Impact Assessment (EIA) is a process designed to ensure that a policy, project, service development or scheme does not discriminate against any disadvantaged or vulnerable people. Whilst this is not a legal requirement, the Trust strongly believes that Equality Impact Assessment
process improves and promotes equality therefore should be standard practice in everything that we do.

3.4.2 Staff are required to undertake an impact equality assessment when developing any new Trust policy and procedure. Where a full assessment is undertaken this should be presented to the Equality and Inclusion Committee for review.

3.4.3 Templates together with guidance have been developed to enable staff to undertake either EIA screening or full assessment set out in appendix 1.

3.4.4 This also links to the Quality Impact Assessment Process which is completed for all Cost Improvement Programmes.

3.4.5 The Trust is required to reference Equality Impact Assessments within the Annual Governance Statement signed off by the Chief Executive Officer as part of NHSI Annual Reporting Requirements.

4.0 WORKFORCE RACE EQUALITY STANDARD (WRES)

Implementing the Workforce Race Equality Standard (WRES) is a requirement for all NHS commissioners and NHS provider organisations and forms part of the annual NHS Standard Contract.

Each year the Trust will produce and review its performance across the relevant workforce metrics and an action plan will be developed to address and reduce the gaps in Black, Asian and Minority Ethnic groups and white staff experience. This will be shared with commissioners, and published.

5.0 ACCESSIBLE INFORMATION STANDARD

5.1.1 The Accessible Information Standard aims to ensure that people who have a disability or sensory loss receive information that they can access and understand, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter.

5.1.2 The Accessible Information Standard recommends a specific and consistent approach towards identifying, recording, flagging, sharing and meeting information and communication needs of patients, service users, carers and parents (from now on referred to as ‘service-users’) that relate to disability.
5.1.3 There are five basic steps making up the Accessible Information Standard:

**Ask**: identify if a service user has any communication/information needs relating to a disability or sensory loss.

**Record**: record these needs in a clear, unambiguous and standardised way; electronically within Trust electronic records.

**Alert/flag/highlight**: the Trust will ensure that recorded needs are ‘highly visible’. Whenever a service user’s records are accessed by other staff members, they should be prompted to take action to communicate appropriately with the service user.

**Share**: include information about a service user’s communication needs as part of existing data sharing processes and in accordance with existing information governance frameworks.

**Act**: take steps to ensure the service user receives information they can access and are able to understand, because it has been delivered in the way that was requested.

### 6.0 HOW DO WE IMPLEMENT OUR PUBLIC SECTOR DUTIES?

#### 6.1 EQUALITY AND INCLUSION COMMITTEE (EIC)

The Equality and Inclusion Committee is a sub-committee of the Quality Committee and has delegated responsibilities to:

- Ensure that the Trust remains complaint with Public Sector Equality duties
- Provide assurance and support in respect of compliance and delivery of the Equality Delivery System (**EDS2** Framework) and work plan. The EDS2 provides the Trust with a framework to monitoring our progress on our PSED.

The EIC is chaired by an Executive Director and Non-Executive Director who are executive leads for Equality and Inclusion.

The EIC meets regularly to monitor the equality work plan and is accountable for ensuring that the Trust delivers on our Public Sector Equality duties, and our mandatory reporting and publication requirements, as outlined above.

#### 6.2 RECORDING OF INFORMATION

6.2.1 In order to assess the effectiveness of its Equality, Inclusion and Human Rights policy and procedure the Trust will maintain, analyse and publish the following information for staff:

a. Gender, age, disability, sexual orientation, religion or belief and ethnic origin of:
• Job applicants
• Short-listed candidates;
• Existing and new employees and their deployment within the Trust.

b. Details of selections decisions for recruitment, redeployment, promotion, transfer and training and reasons for these decisions.

6.2.2 The Trust will maintain, analyse and publish anonymous/statistical information on the protected characteristics of service users/carers.

6.2.3 Statistical information will be used for measuring the achievement of the Trust’s Public Sector Duty, and effectiveness of the Trust’s Equality and Inclusion Steering Group.

6.2.4 Where information is collated in line with the Equality & Diversity Policy, it will be published using established communication mechanisms (in line with confidentiality guidelines).

6.2.5 Although Staff do not have to declare their equality information, the Trust encourage staff to share this with us to ensure we can reflect their needs at work.

6.3 TRAINING AND DEVELOPMENT

It is essential that all employees understand and appreciate their responsibilities in relation to equality and inclusion. It is therefore mandatory for all employees to undertake Equality and Inclusion training, as new employees, as part of the Trust’s Corporate Induction Programme, and on an annual refresher basis through the OLM E-learning module.

6.4 FAITH AND SPIRITUALITY ADVISORY GROUP (FSAG)

The Faith and Spirituality Advisory Group is a sub-committee of the Equality and Inclusion Committee (EIC), and its terms of reference include term of reference at appendix 3:

- Support and Advise the Trust on its Public Sector Equality duties in relation to Religion/Belief/Spirituality.
- Support the Trust’s Equality Objectives as described within our Equality Delivery System (EDS2 Framework and work plan)
- Take forward recommendations from faith and spirituality events, reviews, and policy guidance.

6.5 EQUALITY AND INCLUSION NETWORKS/ FORUMS
6.5.1 **Personal, Fair and Diverse (PFD) Equality champions**

The purpose of the PFD equality champion role is to share lived experiences with other staff and colleagues to the benefit of staff, patients and the organisation as a whole.

This includes;

- Sharing good practice
- Recording experiences to share with others
- Providing advice and support to Advising a colleagues who want to know more about specific equality issues.
- Give opinions and suggestions about work practices.
- Draw attention to matters of concern so that the organisation can take action to address them.
- Participate in equality accreditations and charter marks
- Promote the champions scheme across the organisation
- Take part in forums and works shops

6.5.2 **Equality networks and forums** that supports the Trust’s delivery on its Equality objectives. Examples include a Black, Asian, Minority Ethnic group network (BAME network)

6.6 **Equality and Inclusion in practice – the role of staff**

The success of this procedure requires the active commitment of everyone in the organisation from Board to front-line service delivery.

All staff play a vital role in delivering a service which promotes equality and inclusion:

- Recognise discrimination and identify risks of discrimination - whether direct discrimination, indirect discrimination or harassment;
- Understand the potential consequences of discrimination;
- Be able to identify and respond to the specific needs of diverse patients, service users and carers which arise from their personal, social or cultural background;
- Support a service which demonstrates good equality and diversity practice; and
- Support the empowerment of patients, service users and their carers so that they may be involved in their own care and health improvement.

Good equality and inclusion practice involves:

- Communicating with patients, service users and carers in a way that is accessible to them;
- Making reasonable adjustments in the way we do our work and deliver our services to take account of the particular needs of disabled people;
- Understanding the role that cultural and religious beliefs play in health care and peoples’ experiences of the health service;
- Ensuring that everyone gets care which takes account of their individual needs;
- Treating everyone with dignity and respect at all times

7.0 **MONITORING**

The Equality and Inclusion Committee has responsibility for overseeing the implementation of the Equality, Inclusion and Human Rights Policy and associated procedure. The committee will ensure that progress is monitored regularly against:
- The Equality and Inclusion Committee Annual Work plan and schedule
- the EDS2 action plan

and that the Quality Committee are kept informed of any issues or significant risks through regular assurance reports.

The Equality and Inclusion Committee will also undertake an annual review of its effectiveness to ensure it meets requirements as set out in its terms of reference and provides robust assurance to the Quality Committee.

The Trust through its approved governance structure and arrangements will receive a range of reports detailing complaints, compliments and serious incidents and will challenge these for evidence of any actual or potential non-compliance with the Human Rights or Equality Act.

END
USE OF MOBILE PHONES POLICY

POLICY REFERENCE NUMBER: CP54
VERSION NUMBER: 6
REPLACES SEPT DOCUMENT CP54 Use of Mobile Phones Policy
REPLACES NEP DOCUMENT IT3 ICT Mobile Computing Device Policy
KEY CHANGES FROM PREVIOUS VERSION N/A
AUTHOR: Practice Development Lead Nurse
CONSULTATION GROUPS: Practice Development
IMPLEMENTATION DATE: 01 April 2017
AMENDMENT DATE(S): 13 March 2017; May 2018
LAST REVIEW DATE: March 2017
NEXT REVIEW DATE: March 2020
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE: Chairs Action following August 2017 meeting
RATIFICATION BY FINANCE AND PERFORMANCE COMMITTEE: 21st September 2017
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POLICY SUMMARY

The purpose of this policy and accompanying procedural guidelines is to set out working arrangements for the use of Mobile Phones within all areas of Trust premises for Staff, Patients and Visitors.

The use of Mobile Phones within patient settings must include a local individual risk assessment which considers whether use would represent a threat to patients', staff and/or visitors safety or that of others. Risk Assessments must include the consideration of the operation of individual phones together with any surrounding electrically sensitive medical devices in critical care situations and privacy and dignity. 'Patient' will be the terminology used throughout this document and will refer to a patient, resident or service user.

The Trust monitors the implementation of and compliance with this policy in the following ways:

This policy and procedural guideline will be reviewed and monitored for compliance initially for a minimum of 1 year and thereafter 3 yearly or as required by legislation/best practice guidelines. Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

Following an incident where a mobile phone interferes with medical equipment this must be reported on an Incident Reporting Form and returned to the Integrated Risk Team. The Integrated Risk Team will then be responsible for reporting this to the MHRA and NPSA as required.

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The Director responsible for monitoring and reviewing this policy is

Executive Director of Nursing
### USE OF MOBILE PHONES POLICY

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6.0 REFERENCES  
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USE OF MOBILE PHONES POLICY

1.0 INTRODUCTION

1.1 Communication with family and friends is an essential element of support and comfort for patients either in hospital or whilst receiving care as an outpatient. Modern technology has made communication relatively easy particularly with the widespread use of mobile phones, text messaging and email. The use of mobile phones by staff, patients and visitors presents an increasing challenge due to new and continually developing technologies, potential connection and interaction to other hardware devices and portability. (DOH January 2009)

1.2 Mobile Phones commonly have extended functionality which can include email, internet, camera, audio or video recording capability and music players. Therefore, there is a potential for patients and visitors to use these functions to take inappropriate photographs, recordings or videos. This has a potential to present the greatest interference with patient dignity and privacy.

1.3 NHS Protect has produced the good practice advice in the May 2016 Patients Recording NHS staff in Health and Social Care Settings document which covers both covert and overt recording of consultations. Clarification of this document is cited in the Trust Mobile Phone Procedure CPG54.

1.4 Ring tones or music played via mobile phones could disturb others who are trying to recuperate and constant ‘chatter’ of staff, other patients or visitors on mobile phones would be equally disruptive.

1.5 Mobile phones could equally interfere with medical equipment and affect their use.

1.6 In addition charging mobile phones requires the use of a length of electrical wire which may provide ligature risks.

1.7 Consideration of these issues is essential in regards to where mobile phones should and should not be used on Trust premises.

2.0 SCOPE

2.1 This Policy and associated procedural guidelines applies to all staff, patients and visitors in all Trust areas, including in community residential areas, day hospitals, resource centers and inpatient settings.

2.2 The possession or use of mobile phones is strictly prohibited to all staff, patients, contractors and visitors entering clinical areas at Edward House, Christopher Unit, Larkwood Unit, Hadleigh Unit, Brockfield House, Robin Pinto Unit, Woodlea Clinic. When entering patient areas in these units, mobile phones should either be left in staff vehicle, at home or placed in the lockers.
within the reception area. However where someone needs use of a mobile phone for work related tasks then permission must be requested via security or in their absence one of the integrated clinical leads/unit coordinator for their authority. Those not working in any clinical areas of the secure wards at Edward House, Christopher Unit, Larkwood Unit, Hadleigh Unit, Brockfield, Robin Pinto and Wood Lea are able to take their mobile phone into non patient areas only. Staff in Larkwood Unit and on Poplar Ward in Rochford must read this policy in conjunction with the Unit’s protocols on the use of Mobile phones.

2.3 The use of camera phones within patient areas or patient’s own home risks infringing patient confidentiality. Given the difficulty in detecting usage, the consent for taking photographs on a mobile phone of either patients or their confidential information is prohibited. The only exception to this is for staff where a job role or function demands this use for example in community health services staff take wound photographs for monitoring healing.

3.0 RESPONSIBILITIES

3.1 All staff are responsible for adhering to this policy and associated procedural guidelines and for reporting any breaches on Datix reporting incident system. (please see Corporate Policy CP3 for further details)

3.2 All Managers have a responsibility to ensure that standards are maintained as set out in this policy and accompanying procedural guidelines.

3.3 All Managers are responsible for ensuring that information about this policy and procedure is available in their areas to staff, patients and visitors.

3.4 The responsibility for using a mobile device remains with the authorised user.

3.5 All operational support issues must be reported to the ITT Service Desk for resolution.

3.6 All mobile ITT equipment must be approved by ITT Services and will only be issued for the sole use of the recipient individual.

3.7 Mobile devices must be returned to ITT Services when their intended use by the recipient individual no longer applies. Devices must not be passed on to other members of staff.

4.0 LEGAL CONSIDERATIONS

4.1 Patient Privacy and Dignity

There is a legal duty to respect a patient’s private life. The Human Rights Act 1998 (HRA) enshrines the right to respect for private and family life and states “there shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interest of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for
the protection of health or morals or for the protection of the rights and freedoms of others."

The European Commission has found that the collection of medical data and maintenance of medical records fall within the sphere protected by the HRA. This would, therefore, apply to personal medical information including information which identified a patient such as a photograph.

Permitting the use of mobile phones with cameras in hospitals may not sufficiently ensure medical confidentiality or protect an individual’s right to respect for their private life.

Cameras and voice recording facilities should not be used in any way that could cause harm or offence to an individual (member of staff or client) or bring the Trust into disrepute. Under no circumstances should photos or voice recordings be taken without the prior consent of those involved. Such misuse may be subject to the Trust’s disciplinary procedures and could also be subject to civil and criminal proceedings.

The risk of breaching confidentiality and dignity must be assessed against patients’ rights to communicate with the outside world whilst in hospital, including access to alternative forms of communication where the use of mobile phones is not allowed.

4.2 Patient Confidentiality

The Information Commissioner’s Office states that all public and private organisations are legally obliged to protect any personal information that they hold. In relation to this, any individual who takes a photograph of another individual will be processing personal data and must comply with the General Data Protection Regulation 2016.

The use of mobile phones can result in the creation of sensitive personal data and therefore consideration must be given to how effective confidentiality is by monitoring.

4.3 Child Protection

The Children Act 2004 places a duty on the Trust for ensuring the need to safeguard and promote the welfare of children. As such it must be taken into account that mobile phones are a potential risk in that inappropriate photographs/information could be taken, including confidential information pertaining to the child.

4.4 Health and Safety

Mobile phones need to be charged via the mains power supply. Only approved chargers compatible with the make and model of the phone may be used when charging mobile phones on Trust premises. Whether Trust or personal property, the charger must be up to date in relation to Portable appliance testing (PAT) before permitted for use. Failure to observe this
requirement will contravene Health and Safety Regulations and could place individuals at risk.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 This policy and procedural guideline will be reviewed and monitored for compliance initially for a minimum of 1 year and thereafter 3 yearly or as required by legislation/best practice guidelines.

5.2 Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

5.3 Following an incident where a mobile phone interferes with medical equipment this must be reported on an Incident Reporting Form and returned to the Integrated Risk Team. The Integrated Risk Team will then be responsible for reporting this to the MHRA and NPSA as required.

6.0 REFERENCES

6.1 The Medicines and Healthcare products Regulatory Agency (MHRA) advises that in certain circumstances the electromagnetic interference from mobile phones can interfere with some devices, particularly if used within 2 meters of such devices. It has issued a number of reference documents relating to this:

- DB 1999(02) Emergency service radios and mobile data terminals: compatibility problems with medical devices. This document covers the impact of radio communications on the safe use of medical devices.
- DB 9702 Electromagnetic Compatibility of Medical Devices with Mobile Communications. This device bulletin includes the findings of a study conducted into the effects of mobile communications.
- Safety Notice 2001(06) - Update on Electromagnetic Compatibility of Medical Devices with Mobile Communications: TETRA (Terrestrial Trunked Radio Systems) and Outside media broadcasts from hospital premises.

6.2 Using Mobile Phones in NHS Hospitals (DOH January 2009).

Further references:

- NHS Protect, Patients recording NHS staff in health and social care settings (March 2016) Policy@nhsprotect.gsi.gov.uk.
- NHS Protect – Misuse of Social Media to Harass, Intimidate or Threaten NHS Staff May 2016 (Policy@nhsprotect.gsi.gov.uk).

7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Adverse Incident Serious Incidents Policy CP3 and CPG3
- Security Policy and Procedural Guidelines RM09 and RMPG09
- Purchase and Use of Mobile Phones and Pagers CP7 and CPG7
- Records Management Policy and Procedures CP9
- IT & T (Information Technology and Telecommunications) Security Policy and Procedural Guidelines CP37
- Patient/Client Property and Money Procedure FP09/02

END
USE OF MOBILE PHONES PROCEDURE

PROCEDURE REFERENCE NUMBER: CPG54
VERSION NUMBER: 6
REPLACES SEPT DOCUMENT CP54 Use of Mobile Phones Policy
REPLACES NEP DOCUMENT IT3 ICT Mobile Computing Device Policy
KEY CHANGES FROM PREVIOUS VERSION EPUT Format
AUTHOR: Practice Development Lead Nurse

CONSULTATION GROUPS:
- Trust wide
- Operational Services including Medical
- Estates & Facilities
- Purchasing Department
- Communications & Engagement
- Compliance
- IT & Telecoms
- Patient Experience Dept.
- Risk Management
- Safeguarding
- Training & Development
- Contact Centre
- Pharmacy & Medicines
- Quality & Practice

IMPLEMENTATION DATE: April 2017
LAST REVIEW DATE: March 2017
NEXT REVIEW DATE: March 2020
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE: Chairs Action following August 2017 meeting
RATIFICATION BY FINANCE AND PERFORMANCE COMMITTEE: 21st September 2017
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PROCEDURE SUMMARY
The purpose of this procedure is to identify working arrangements for the use of Mobile Phones within all areas of the Trust for Staff, Patients and Visitors. The widest possible use of mobile phones for Staff, Patients and Visitors will be considered within patient areas: where local risk assessments indicate that such use would not represent a threat to patients’ or others own safety and security. Risk Assessments must include use of the operation of electronically sensitive medical devices in critical care situations or where levels of privacy and dignity may be affected. ‘Patient’ will be the terminology used throughout this document and will refer to a patient, resident or service user.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
- Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

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The Director responsible for monitoring and reviewing this procedure is Executive Director of Nursing
1.0 INTRODUCTION

1.1 Whenever anyone is in hospital/Nursing Home or within a residential community, day or resource centre setting, communication with family and friends may become an essential element of support and comfort, the widespread use of mobile phones and their integrated functionality such as texting and e-mailing may provide a positive aspect of support.

1.2 Mobile phones may have extended functions which include camera, audio and video recording capability, music players, email and internet functions. There is a potential for patients and visitors to use this functionality to take inappropriate photographs, videos or recordings that present potential to interfere with patient dignity and privacy.

1.3 NHS Protect has produced the good practice advice in their “Patients Recording NHS staff in Health and Social Care Settings” May 2016 document for use in health and social care settings. The document provides clarification to NHS clinical and non-clinical staff working within health and social care settings on dealing with situations where patients might record their treatment and care. This advice covers both covert and overt recording of consultations. However, it predominantly concerns overt recording as the patient will generally ask NHS staff for permission for recording to take place.

1.4 There are no specific legal requirements that govern an individual making a personal recording of their medical consultation or treatment, either overtly or covertly, for their private use. The position may, however, change once a recording is no longer used as a record of the consultation, for example where the recording is disclosed or publicised in a modified way which is not connected to the consultation. This could include an instance where it is designed to cause detriment to or harass another individual captured in the recording. Any such disclosure or publication, depending on the nature and context, may attract a civil action for damages and may also be a criminal offence which could include an offence contrary to section 1 of the Protection From Harassment Act 1997, an offence contrary to section 4, 4A or 5 of the Public Order Act 1986, an offence contrary to section 1 of the Malicious Communications Act 1988 or an offence contrary to section 127 of the Communications Act 2003.

1.5 In addition, ring tones or music played via mobile phones could disturb others who are trying to recuperate and constant ‘chatter’ of other patients, visitors or staff on mobile phones may be equally disruptive to those patients wishing to rest. Mobile phones could also potentially interfere with medical equipment and affect their use.

1.6 The Trust has designated mobile phone use areas, these are the only areas in which the use of mobile phones is permitted without a risk assessment being completed.
2.0 SCOPE

2.1 This procedure applies to all Staff, Patients and Visitors in all areas of the Trust.

3.0 DESIGNATED MOBILE PHONE USE AREAS

3.1 Designated Areas

3.1.1 Non patient areas are defined as those areas where there is no patient access.

3.1.2 Non patient areas and Trust reception areas are designated as acceptable for mobile phone use, where issues of privacy and dignity and interference with medical equipment can be kept to a minimum.

3.1.3 Reception areas are defined as areas where patients and visitors have unlimited access and which are staffed at all times (this does not include ward reception areas).

3.1.4 For all other areas, risk assessments must be undertaken to assess whether the use of mobile phones is appropriate. In these areas a sign should be displayed at the area entrance which directs staff, patients and visitors to contact the unit/department/home manager to confirm whether or not mobile phone use is allowed.

3.1.5 The possession or use of mobile phones is strictly prohibited to all staff, patients, contractors and visitors entering clinical areas at Brockfield House, Robin Pinto Unit, Woodlea Clinic, Hadleigh Unit, Edward House, Christopher Unit, Larkwood Unit. When entering patient areas in these units mobile phones should either be left in staff vehicle, at home or placed in the lockers within the reception area. However where someone needs use of a mobile phone for work related tasks then permission must be requested via security or in their absence one of the integrated clinical leads/unit coordinator for their authority. For all other not working on any of the secure wards at Brockfield, Robin Pinto, Woodlea Clinic, Hadleigh Unit, Edward House, Christopher Unit and Larkwood Unit will now be able to bring their mobile phone into non patient areas only. Staff in Larkwood Unit and on Poplar Ward in Rochford must read this procedure in conjunction with the Unit’s protocols on the use of Mobile phones.

3.2 Risk Assessments

3.2.1 Some patient areas can also be designated as a mobile phone use area. Local Risk Assessments must be undertaken to determine if a patient area is to be designated as a mobile phone use area, using the Trust Risk Assessment Form (RM11 Appendix 2) which is on intranet.

3.2.2 Any local area designated as a mobile phone use area must be outlined in local Operational Policies.
3.2.3 Camera functions, audio or video record functions may not be used in any Trust area. The only exception to this is for staff and teams where a job role or function demands this use and they must seek permission from a senior manager.

3.2.4 Any staff member who witnesses the use of such functions must ask the offender to stop, inform a senior manager, complete a Datix incident form and if the offender is a patient, inform their care co-ordinator or named nurse (where appropriate).

3.2.5 The use of camera phones within patient areas or patient’s own home risks breaching patient confidentiality. The only exception to this is for staff where a job role or function demands this use for example in community health services staff take photographs of wounds to monitor healing.

3.2.6 Patients and Visitors will be made aware of the Trust procedures concerning the use of mobile phones within the patient areas through information leaflets and local posters.

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<th>4.0 STAFF USE OF MOBILE PHONES</th>
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### 4.1 General Use

4.1.1 Secure services have their own mobile phone operational protocols therefore staff, patients and visitors in these services must refer to Use of Mobile Telephone within Secure Services Protocols SSOP35 and SSOP40 which are on intranet.

4.1.2 For all other services staff on duty may use mobile phones for work related issues within mobile phone use designated areas. Staff may also use mobile phones within patient areas, where a local risk assessment has been undertaken, however consideration must be given to patients who are resting and only in emergency circumstances should a mobile phone be used within earshot of a patient. Staff can use mobile phones for personal use only when on designated breaks except for emergency use as detailed in section 4.1.4 below.

4.1.3 All Trust employees must adhere to the law in relation to the use of mobile telephones whilst driving. With effect from December 2003 the hand-held use by a driver of a mobile phone in a car is in direct breach of road traffic regulations. In no circumstances must a mobile phone be used when driving, unless using ‘hands-free’ equipment. In such circumstances, it is the driver’s responsibility to ensure it is safe to make or receive calls, given the driving conditions at the time. They must:
  - Keep calls as short as possible,
  - Avoid complex or emotionally sensitive calls,
  - Never hold the phone or send or read a text message.
In general, drivers must endeavour to stop in a safe place to make or receive calls, as per Trust policy CP7.

4.1.4 Staff may not use the camera function, any of the recording functions, or play music within patient areas, unless this falls within their job role to do so.

4.1.5 Staff are reminded that the use of mobile phones must be kept to a minimum and for emergency use only. Whilst it is appreciated that family and friends may need to contact you, or you them, under special circumstances (e.g. illness) the use of mobile phones must not in any way impact on the workplace (e.g. workload, distraction to team members, putting private calls before business calls).

4.1.6 Where special circumstances occur members of staff must liaise with their line management to apprise them of the situation.

4.1.7 If a staff member uses their phone inappropriately this will be addressed by their manager through the Conduct & Capability Policy and Procedure HRPG27a.

4.1.8 If a mobile phone is lost or stolen the phone user will complete a Datix incident reporting form and advise IT and Purchasing department so the phone can be barred. (Guidance on completing this form can be found in the Trust's Adverse Incident Procedural Guidelines CPG3).

4.2 Clinical Use

4.2.1 Secure services have their own mobile phone operational protocols therefore staff in these services must refer to secure services mobile phone protocols which are on intranet.

4.2.2 Where possible staff are encouraged not to give out individual telephone numbers.

4.2.3 If in any circumstances, it is felt necessary for staff to provide a patient or carer with their mobile phone number, they must undertake a risk assessment. The assessment must take into consideration how the staff member will ensure that this number is not used in place of an emergency number and how the staff member will ensure that it is answered even when not on duty.

4.2.4 Both the staff member and the patient or carer must agree the conditions for use of their mobile phone number using the contract for providing a staff mobile phone number to a patient / carers (Appendix 1).

4.2.5 If it is necessary to provide a contact number the contact centre number must be used or a locally agreed out of hours number. Hours of contact must be made clear to patients/carers and staff as well as any alternative arrangements and any specific agreements documented in their care plan. The contact centre number is 0300 123
0808. They provide a messaging service within agreed working hours and will hold all teams contact numbers that connect patients to staff.

4.3 **Text Messaging**

4.3.1 Any text message sent to or received from a patient, carer or colleague is classified as patient information and must be treated with the same rules around confidentiality as any other patient information / record.

4.3.2 All text messages sent to or received from patient or carers must be recorded in the patient notes.

4.3.3 The use of text messaging must be risk assessed before being undertaken.

### 5.0 **PATIENT USE IN INPATIENT / NURSING HOME, DAY AND RESOURCE CENTRE AREAS**

5.1 Secure services have their own mobile phone operational protocols therefore staff in these services must refer to secure services mobile phone protocols which are on intranet.

5.2 On admission to inpatient ward, Day Treatment services and Resource centers patients must be made aware of the Precautionary Measures in 6.0 on page 8 of this document.

5.3 Any mobile phone retained for use by the patient must be used in a designated Trust or locally risk assessed area under agreed conditions.

5.4 A copy of the Risk Assessment and the Contract for Patient Use of a Mobile Phone (appendix 2) must be completed and signed by the patient and a member of the Multi-Disciplinary Team (MDT)/Clinical team. Both must be kept within the patients notes.

5.5 Risk Assessments for patient use of a mobile phone must include an assessment of the following for individual patient use:

- Whether the mobile phone is a camera phone
- Whether the mobile phone has email or internet functionality
- If the mobile phone is capable of audio / video recording
- The management and use of charging leads/wires
- Whether use would represent a threat to patients’ own safety or that of others
- Whether the operation of electrically sensitive medical devices in critical care situations would be affected
- Whether levels of privacy and dignity would be potentially affected

5.6 Extended functions, on any mobile phone cannot be used on Trust premises. Please see below

5.7 If it is assessed that a person continually abuses a mobile phone the issue will be re-assessed by the MDT/Clinical team regarding individual use and
potentially removed. In any situation where the staff member in charge considers a breach of confidentiality or potential breach of confidentiality mobile phone use must be reassessed as soon as possible. Any breach of confidentiality must be reported using guidelines as set out in Adverse Incident and Serious Untoward Incidents Policy CP3

5.8 Any mobile phone brought in to the inpatient area which is assessed and not agreed for the patient to use will be retained by staff for safekeeping using Trust Policy regarding property (Patient/Client Property and Money Procedure FP09 02) or will be returned home with agreement from the Patient to a relative or friend.

6.0 Precautionary Measures

6.1 Overt patient recordings
Although we cannot place restrictions on a patient wishing to record notes of a consultation or conversation with a health professional, where it is felt absolutely necessary by the patient to do so, staff should ensure that:
- Any recording is done openly and honestly.
- The recording process itself does not interfere with the consultation process or the treatment or care being administered.
- The patient understands that a note will be made in their health record stating that they have recorded the consultation or care being provided.
- The patient is reminded of the private and confidential nature of the recording and that it is their responsibility to keep it safe and secure.
- Any recording is only made for personal use.

6.2 Covert patient recordings
Although we cannot place restrictions on a patient wishing to covertly record a consultation or conversation with a health professional, where staff are aware that covert recording has occurred they should ensure that:
- The issue is discussed with the patient as per 6.1 above.
- Relevant staff should consider providing patients with a written record summary, and or a verbatim record (if practical) of their consultation for their own personal use.
- Patients are advised that they are entitled to see their notes, if they so wish, by informally asking the healthcare professional in charge of the consultation, or to request a paper copy of their medical notes formally through a Subject Access Request (SAR) made under the Data Protection Act 2018.
- Patients are given information on how they can complain if they have an issue with their treatment and care, and their attention is drawn to the relevant guidance from the Care Quality Commission (see below) and Information Commissioner’s Office.
7.0 MOBILE PHONE CHARGERS

7.1 Mobile phones need to be charged via the mains power supply, consequently there may be a ligature / other health and safety risks involving wires. All patient areas must risk assess this activity before mobile phone chargers are used.

7.2 Only approved chargers compatible with the make and model of the phone may be used when charging mobile phones on Trust premises. Whether Trust or personal property, the charger must be up to date in relation to portable appliance testing (PAT) before permitted for use. Failure to observe this requirement will contravene Health and Safety Regulations and could place individuals at risk.

7.3 To avoid probability or likelihood of leaving devices unplugged medical devices are not to be unplugged to charge phone.

7.4 Recent information has also been identified regarding the potential danger of using an electrical device whilst still attached to the mains electricity supply, therefore mobile phones must not be used whilst still plugged in to the mains electrical supply.

8.0 REPORTING BREACHES

8.1 Any staff member who witnesses the use of video or audio recording which has not been agreed by all concerned must:
   - ask the individual to stop
   - inform a senior manager
   - inform information governance leads via completion of a Datix incident form

   If the individual is a patient complete Datix incident form and inform also their doctor, named nurse and care co-ordinator (where appropriate).

9.0 MONITORING AND REVIEW

9.1 This policy and procedural guideline will be reviewed and monitored for compliance 3 yearly or as required by legislation/best practice guidelines.

9.2 Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

9.3 Following an incident where a mobile phone interferes with medical equipment this must be reported on Datix. The Integrated Risk Team will then be responsible for reporting this to the MHRA and NPSA as required.
10.0 REFERENCES

- NHS Protect, Patients recording NHS staff in health and social care settings (March 2016) Policy@nhsprotect.gsi.gov.uk
- NHS Protect – Misuse of Social Media to Harass, Intimidate or Threaten NHS Staff May 2016 (Policy@nhsprotect.gsi.gov.uk)
INFORMATION SHARING & CONSENT PROCEDURE

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<tr>
<td>AUTHOR</td>
<td>Information Governance Manager</td>
</tr>
<tr>
<td>CONSULTATION GROUPS</td>
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</tr>
<tr>
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</tr>
<tr>
<td>AMENDMENT DATE(S)</td>
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</tr>
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</tr>
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<tr>
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<td>16 August 2017</td>
</tr>
<tr>
<td>RATIFICATION BY QUALITY COMMITTEE:</td>
<td>14 September 2017</td>
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This Procedure document aims to ensure that all information held by Essex Partnership University NHS Foundation Trust (the 'Trust) about patients / clients / staff is kept secure and is only used / shared for the purpose for which the information was collected, in accordance with legal requirements and best practice.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

This document should be read in conjunction with service specific information sharing agreements

<table>
<thead>
<tr>
<th>Services</th>
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The Director responsible for monitoring and reviewing this procedure is

The Executive Medical Director
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1.0 INTRODUCTION

1.1 Sharing Information can bring many benefits. It can support more efficient, easier access to services. It can help make sure that the vulnerable are given the protection they need, and organisations can co-operate in delivering the care that those with complex needs rely on.

1.2 Sharing information presents risks. Information systems are becoming more complex and widespread. There is a potential for more information about our private lives, often highly sensitive, to become known to more and more people.

1.3 This information sharing policy and procedure sets out the obligations and commitments that staff must follow to ensure that legislation is not breached and patients/clients/families/carers/staff/employees confidentiality is maintained.

1.4 The Freedom of Information Act 2000 gives everyone the right to ask for information held by a public authority, to be told whether the information is held, and, unless exempt, to have a copy of the information.

2.0 DECIDING TO SHARE PERSONAL INFORMATION

2.1 Any information sharing must be necessary and any information shared must be relevant and not excessive. Before sharing information you should decide:

- Why you need to share confidential information.
- Do you need to share information in a personally identifiable form or would anonymised, pseudonymised, or statistical information be enough?
- What legal provisions exist that require or permit you to share information?
- Whether any issues might arise as the result of sharing confidential information.
- Is consent from the individual required, and if so how would you obtain consent, what would you do if consent is withheld.
3.0 PROCESS FOR INFORMATION SHARING IN THE TRUST

3.1 In order for the Trust to meet its obligation under Criteria 207 of the Information Governance Toolkit, information sharing protocols or agreements must be in place with all non NHS organisations (and all NHS organisations outside the Trust’s remit). All staff who share confidential information must ensure that a protocol or agreement exists before sharing any information with non NHS Organisations. The Information Governance Steering Sub-Committee will be informed of / approve all information sharing protocols and agreements that cover the sharing of corporate information.

3.2 Any information to be shared electronically must first be encrypted or password protected. When submitting information sharing protocols or agreements for consideration, details of the method in which data will be shared must be given to ensure the information is secure in transit.

4.0 SECONDARY USES

4.1 Health professionals may receive requests for disclosure of patient information from those not directly involved in the patient’s care. Such secondary use of confidential information falls into three broad categories:

- Use within the NHS for administration, planning, audit, commissioning and payment by results.
- Use by agencies commissioned by the NHS to carry out such roles on its behalf.
- Use where confidential information goes beyond healthcare provision in the NHS to include research and education.

4.2 Patient/client/staff/employee data may be disclosed to an appropriate and secure authority and used for secondary purposes if:

- They are required by law.
- The patient/client/staff/employee has given explicit consent.
- The health professional is satisfied, in some limited circumstances that the patient/client/staff/employee is aware of the use and has not objected to it and so has effectively provided implied consent.
- Disclosure is authorised by the Ethics and Confidentiality Committee of the National Information Governance Board under S251 of the NHS Act 2006.
- The health professional is satisfied that the legal and professional criteria for disclosure without consent in the ‘public interest’ have been met and has sought advice from the Caldicott Guardian, Information Governance Manager, professional body or defence organisation in the case of any doubt.

4.3 In the absence of patient/client/staff/employee consent, anonymised data should be used for any secondary purpose where it is practicable to do so.
Some secondary uses of confidential data are for social purposes unconnected with the provision of health care, e.g. for insurance or employment purposes. Such disclosure requires explicit patient/client/staff/employee consent.

5.0 TRAINING

5.1 The Trust will maintain a high level of information governance / security awareness within the organisation by ensuring that all staff receive appropriate, job relevant, training. This may include:

- Team Briefings
- Publications via Trust Today, Viewpoint and others
- On-Line training via the Connecting for Health Information Governance website.
- Training via the Trusts’ e-learning programme (OLM)
- It will be a mandatory requirement for all staff involved in any type of information governance / security breach to complete training, irrespective of previous sessions.
- Training will be done in accordance with the Induction and Mandatory Training Policy.

6.0 MONITORING AND REVIEW

6.1 This procedural guideline will be reviewed in line with its associated policy document and / or whenever changes in legislation, guidance from Department of Health, the NHS Executive or the Information Commissioner’s Office require.

6.2 The Executive Medical Director is responsible as the Caldicott Guardian in association with the Executive Finance Officer / Senior Information Risk Owner (SIRO) for the implementation of these procedural guidelines and its associated policy document.

END
Extract from the General Data Protection Regulation

Art. 5 GDPR Principles relating to processing of personal data

1. Personal data shall be:
   1. processed lawfully, fairly and in a transparent manner in relation to the data subject ('lawfulness, fairness and transparency');
   2. collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall, in accordance with Article 89(1), not be considered to be incompatible with the initial purposes ('purpose limitation');
   3. adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed ('data minimisation');
   4. accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay ('accuracy');
   5. kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) subject to implementation of the appropriate technical and organisational measures required by this Regulation in order to safeguard the rights and freedoms of the data subject ('storage limitation');
   6. processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures ('integrity and confidentiality').

2. The controller shall be responsible for, and be able to demonstrate compliance with, paragraph 1 ('accountability').

Art. 6 GDPR Lawfulness of processing

1. Processing shall be lawful only if and to the extent that at least one of the following applies:
   1. the data subject has given consent to the processing of his or her personal data for one or more specific purposes;
   2. processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract;
   3. processing is necessary for compliance with a legal obligation to which the controller is subject;
   4. processing is necessary in order to protect the vital interests of the data subject or of another natural person;
5. processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller;

6. processing is necessary for the purposes of the legitimate interests pursued by the controller or by a third party, except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child.

Point (f) of the first subparagraph shall not apply to processing carried out by public authorities in the performance of their tasks.

2. Member States may maintain or introduce more specific provisions to adapt the application of the rules of this Regulation with regard to processing for compliance with points (c) and (e) of paragraph 1 by determining more precisely specific requirements for the processing and other measures to ensure lawful and fair processing including for other specific processing situations as provided for in Chapter IX.

3. The basis for the processing referred to in point (c) and (e) of paragraph 1 shall be laid down by:

1. Union law; or

2. Member State law to which the controller is subject.

The purpose of the processing shall be determined in that legal basis or, as regards the processing referred to in point (e) of paragraph 1, shall be necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. That legal basis may contain specific provisions to adapt the application of rules of this Regulation, inter alia: the general conditions governing the lawfulness of processing by the controller; the types of data which are subject to the processing; the data subjects concerned; the entities to, and the purposes for which, the personal data may be disclosed; the purpose limitation; storage periods; and processing operations and processing procedures, including measures to ensure lawful and fair processing such as those for other specific processing situations as provided for in Chapter IX. The Union or the Member State law shall meet an objective of public interest and be proportionate to the legitimate aim pursued.

4. Where the processing for a purpose other than that for which the personal data have been collected is not based on the data subject's consent or on a Union or Member State law which constitutes a necessary and proportionate measure in a democratic society to safeguard the objectives referred to in Article 23(1), the controller shall, in order to ascertain whether processing for another purpose is compatible with the purpose for which the personal data are initially collected, take into account, inter alia:

1. any link between the purposes for which the personal data have been collected and the purposes of the intended further processing;

2. the context in which the personal data have been collected, in particular regarding the relationship between data subjects and the controller;

3. the nature of the personal data, in particular whether special categories of personal data are processed, pursuant to Article 9, or whether personal data related to criminal convictions and offences are processed, pursuant to Article 10;

4. the possible consequences of the intended further processing for data subjects;

5. the existence of appropriate safeguards, which may include encryption or pseudonymisation.
Art. 7 GDPR Conditions for consent

1. Where processing is based on consent, the controller shall be able to demonstrate that the data subject has consented to processing of his or her personal data.

2. If the data subject's consent is given in the context of a written declaration which also concerns other matters, the request for consent shall be presented in a manner which is clearly distinguishable from the other matters, in an intelligible and easily accessible form, using clear and plain language. Any part of such a declaration which constitutes an infringement of this Regulation shall not be binding.

3. The data subject shall have the right to withdraw his or her consent at any time. The withdrawal of consent shall not affect the lawfulness of processing based on consent before its withdrawal. Prior to giving consent, the data subject shall be informed thereof. It shall be as easy to withdraw as to give consent.

4. When assessing whether consent is freely given, utmost account shall be taken of whether, inter alia, the performance of a contract, including the provision of a service, is conditional on consent to the processing of personal data that is not necessary for the performance of that contract.

Art. 9 GDPR Processing of special categories of personal data

1. Processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person’s sex life or sexual orientation shall be prohibited.

2. Paragraph 1 shall not apply if one of the following applies:

   1. the data subject has given explicit consent to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;

   2. processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject;

   3. processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent;

   4. processing is carried out in the course of its legitimate activities with appropriate safeguards by a foundation, association or any other not-for-profit body with a political, philosophical, religious or trade union aim and on condition that the processing relates solely to the members or to former members of the body or to persons who have regular contact with it in connection with its purposes and that the personal data are not disclosed outside that body without the consent of the data subjects;

   5. processing relates to personal data which are manifestly made public by the data subject;

   6. processing is necessary for the establishment, exercise or defence of legal claims or whenever courts are acting in their judicial capacity;
7. processing is necessary for reasons of substantial public interest, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;

8. processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3;

9. processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;

10. processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

3. Personal data referred to in paragraph 1 may be processed for the purposes referred to in point (h) of paragraph 2 when those data are processed by or under the responsibility of a professional subject to the obligation of professional secrecy under Union or Member State law or rules established by national competent bodies or by another person also subject to an obligation of secrecy under Union or Member State law or rules established by national competent bodies.

4. Member States may maintain or introduce further conditions, including limitations, with regard to the processing of genetic data, biometric data or data concerning health.

END
INFORMATION FOR PATIENTS / CARERS / RELATIVES ON SHARING INFORMATION

CORE INFORMATION FOR PATIENTS

- We ask you for information so that you can receive proper care and treatment.
- We keep this information, together with details of your care, because it may be needed if we see you again.
- We may use some of this information for other reasons: for example, to help us protect the health of the public generally and to see that the NHS runs efficiently, plans for the future, trains its staff, pays its bills and can account for its actions.
- Information may also be needed to help educate tomorrow’s clinical staff and to carry out medical and other health research for the benefit of everyone.
- Sometimes the law requires us to pass on information: for example, to notify a birth.
- The NHS Central Register for England & Wales contains basic personal details of all patients registered with a general practitioner. The Register does not contain clinical information.

You have a right of access to your health records

EVERYONE WORKING FOR THE NHS HAS A LEGAL DUTY TO KEEP INFORMATION ABOUT YOU CONFIDENTIAL.

You may be receiving care from other people as well as the NHS. So that we can all network together for your benefit we may need to share some information about you. We only ever use or pass on information about you if people have a genuine need for it in your and everyone’s interests. Whenever we can we shall remove details which identify you.

Anyone who receives information from us is also under a legal duty to keep it confidential.

If you agree, your relatives, friends and carers will be kept up to date with the progress of your treatment.

THE MAIN REASONS FOR WHICH YOUR INFORMATION MAY BE NEEDED ARE:

- Health care and treatment
- Looking after the health of the general public
Managing and planning the NHS, e.g.
- making sure that our services can meet patient needs in the future
- paying your doctor, nurse, dentist, or other staff, and the hospital which treats you for the care they provide
- auditing accounts
- preparing statistics on NHS performance and activity (where steps will be taken to ensure you cannot be identified)
- investigating complaints or legal claims

Helping staff to review the care they provide to make sure it is of the highest Standard

- Training and educating staff (but you can choose whether or not to be involved personally)
- Research approved by the Local Research Ethics Committee. (If anything to do with the research would involve you personally, you will be contacted to see if you are willing)

If at any time you would like to know more about how we use your information you can speak to the person in charge of your care or to the Information Governance Team or Data Protection Officer.
### INFORMATION SHARING PROTOCOL

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<th>Email</th>
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### Version Control

| Date Agreement comes into force       |                                      |
| Date of Agreement review              |                                      |
| Agreement owner (Organisation)        |                                      |
| Agreement drawn up by (Author(s))     |                                      |
| Status of document – DRAFT/FOR APPROVAL/APPROVED |                                      |
| Version                               |                                      |
Information Sharing Protocol

1. Purpose
The parties have entered into this Information Sharing Agreement to facilitate and enable the smooth transition of Information Sharing between them. The Information Sharing Agreement is a requirement of the DSPT and also meets the best practice guidance of the Information Commissioners Data Sharing Code of Practice. This could consist of data being transferred just once or on an ongoing regular basis, as agreed by the parties involved.

Benefits to the patient will include:

Benefits to the patient will include timelier sharing of information between EPUT and …………

2. Information to be shared

The types of information listed above is not exhaustive and additional information can be shared if certain criteria is met and this will be considered on a case by case basis, as appropriate.

3. Legal Basis for Sharing information

The purpose of this information sharing agreement is to provide a detailed process for information sharing between/for the …………… service/ organisations.

This information Sharing Agreement is entered into for the purpose of the parties sharing information as required or permitted under the data protection legislation and any other relevant legislation which shall include (but not limited to):

- Data Protection Act 2018
- General Data Protection Regulation
- Freedom Of Information Act 2000
- Human Rights Act 1998
- Mental Health Act 1983
- Health and Social Care Act 2012
- Mental capacity Act 2015
- HSCIC Guide To Confidentiality
- Information Governance/Caldicott 2 Review: to share or not to share
- Records Management NHS Code or practice
- NHS England Safe Haven Procedure
- NHS Constitution
- Information Security Management: Code Of Practice
The parties acknowledge and agree that they will share information whenever either or both parties are under a statutory duty to do so. In this case, the party requesting the information shall make clear in its Data Securing Request the legislation underpinning the request for information and the disclosure of information shall comply with the relevant legislation and be made in accordance with the terms of this Information Sharing Agreement, if applicable.

The parties acknowledge and agree that they will not be bound by the terms of this Information Sharing Agreement in the event either or both of them are prohibited to share information by any legislation.

If consent is deemed to be required for the sharing of personal data, this will be a transparent process.

Where it has been identified that the parties are permitted to share information without obtaining consent, this should be justified, if required, under their statutory or legal powers. Data subjects should be made aware of this decision and provided with the details of the data share, unless, by doing this will risk harm to others or hinder any investigation or legal proceeding.

The decision to share information without consent will be fully documented and held within the patients 'care record'.

It is good practice to seek freely given, specific, informed and valid consent of individuals to share their information. However disclosure may be lawful in certain circumstances without consent, for example the performance of public functions, legal obligations, prevention/detection of crime.

*(Explain the legal power(s) you have that allow you to share the information – include how the sharing is consistent with the General Data Protection Regulation 2016 (GDPR)).*

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<th>Special Categories of Data</th>
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<td><strong>Article 9(2)(h)</strong></td>
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<td><strong>Legitimate Interests</strong></td>
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Other legislation or statute as follows
Children’s Act 2004, Section 10 & 11- Cooperation to improve well-being.
Children’s Act 1989. Part III: Section 17 (1) (provision of service)

Fair Processing in accordance with General Data Protection Regulation 2016 article 12.

Fair processing requirements have been satisfied by:
Information of both parties’ Fair Processing Notices being either fully available on their respective publicly available websites or available on request (via electronic or hardcopy):

The information listed above will be available to the data subjects in the following methods:

- Your health records: what you need to know (EPUT leaflet)
- Your health records: what you need to know (EPUT Poster)
- …
- …

4. Access and individuals’ rights
(Explain what to do when an organisation receives a DPA or FOI request for access to shared data).

Subject Access is an individual’s right to have a copy of information relating to them which is processed by an organisation.

Once information is disclosed from one agency to another, the recipient organisation becomes the Data Controller for that information. With regards to subject access requests, the Data Controller has a statutory duty to comply with Article 15, unless an exemption applies. It is good practice for the recipient organisation to contact the originating organisation. This enables the originating organisation to advise the use of any statutory exemptions that may need to be applied prior to disclosure to the requesting individual.

If a party receives a request for information under the Freedom of Information (FOI) Act [2000] that relates to data that has been disclosed for the purposes of this Information Sharing Protocol, it is best practice to seek advice from the originating organisation prior to release. This allows the originating organisation to rely on any statutory exemption under the provisions of the FOI Act and to identify any perceived harms. However, the decision to release data under the FOI Act is the responsibility of the agency that received the request.

5. Keeping information secure
All information shared between the parties involved in this ISP will be held in a secure location with limited access and used only for the purposes listed in this agreement.
Each party shall ensure that access to information provided by the other party under this ISP will only be granted to those staff who ‘need to know’ the information.

The information shared between the parties must not be disclosed to any third party.

All information held on portable devices must be encrypted to industry standard FIPS 140-2/256-bit asymmetrical encryption.

All data will remain and be stored on servers physically located within the United Kingdom.

Security for the exchange of information will be achieved through a secure - fill in exchange type (e.g. secure site, secure nhs.mail to nhs.mail)

Partners receiving information will:

- Ensure their employees can only access the shared information appropriate to their role;
- Ensure that their employees of appropriately trained to understand their responsibilities to maintain confidentiality and privacy;
- Protect the physical security of the shared information.

6. Information format and frequency of sharing

The format the information shared is either in - insert format type here (e.g. Microsoft excel or csv file).

The frequency with which the information will be shared is a (……………….. ) transfer of information.

7. Data Retention

(Include detail here how long each organisation will retain the information for).

Information will be retained in accordance with each partners’ data retention policy and in any event no longer than is necessary.

For the purposes of this agreement, destruction means that data must be irretrievable following destruction or deletion, in accordance with ISO27001 international standard for information security.

The controller will retain information in accordance with the Department of Health’s retention of records schedules.

The processor must not make multiple copies of the data.

The processor shall ensure that the destruction of data will also take place for backup media and provide written confirmation to the controller when destruction has taken place.
8. Responsibility for exchanging these data and ensuring data are accurate

Each of the data providers will ensure the accuracy of the data being shared using their own internal quality assurance checks.

For the purposes of this Protocol the responsibilities are defined as: Caldicott Guardians and Senior Information Risk Owners (SIRO) who have signed the Information Sharing Agreement as having overall responsibility within their own organisation have the duty for ensuring the organisation has the necessary powers to share the information requested. Any information shared must only be used for the purpose as requested.

The parties in discharging their obligations under this information sharing agreement shall comply with the eight data protection principles.

The parties shall ensure that the information shared is relevant and proportionate to the purpose for which it is shared and will comply with the Data Protection Act, information will not be passed to any third party other than allowed by law, retention for the intelligence purposes shall be allowed but only in line with the Data Protection Act.

EPUT have/have not undertaken a privacy impact assessment as under this information sharing agreement information will be shared only where the parties are legally required or permitted to do so.

All parties involved have agreed that the service users (data subjects) need to be informed of the following:

- What information is going to be shared
- In what format is the data going to be exchanged
- Who the information is going to be shared with
- For what purposes it will be used

Unless by doing so would risk harm or self to others or hinder any investigation or legal proceedings.

Data Controllers for this Protocol are:

Joint Data Controllers for this Protocol are:

[“Joint” covers the situation where the determination is exercised by data controllers acting together, typically with written data controller agreements setting out the purposes for processing, the manner of processing and the means by which joint data controller responsibilities will be satisfied. The participation of the parties may take different forms and need not necessarily be equally shared across all aspects of the processing. Their contributions may be sequential or simultaneous and their liability if something goes wrong may differ.]
Data Controllers in Common for this Protocol are:

[“In common” is where data controllers share a pool of personal data, often disclosing data to each other but with each processing the data independently of the other(s). As with ‘joint’ arrangements, data controllers in common should have written agreements and processes for ensuring that all data controller responsibilities are satisfied. Each needs to exercise due diligence in ensuring that all parties involved are meeting the requirements of law.]

Data Processors are:

[A data processor can be anyone (other than an employee of the data controller) who processes the data on behalf of the data controller. The Act imposes specific obligations upon data controllers when the processing of personal data is carried out on their behalf by data processors.]

Where Data Processors are a part of this Protocol, the data controller retains full responsibility for the actions of the data processor – if there is a data protection breach then the data controller remains responsible. The key obligation is that the processing by a data processor must be carried out under a written contract which requires the data processor to act only on instructions from the data controller. In the absence of a written contract a Partner to this protocol will be a data controller in its own right and will need to meet all the requirements of the Data Protection Bill and the General Data Protection Regulations 2018.

9. Complaints

Partner agencies will use their standard organisational procedures to deal with complaints from the public arising from information sharing under this protocol.

10. Breach of Confidentiality

(Provided detail here of what the expectation in the event of a breach of the data sharing initiative. Including who should be contacted and reporting timescales).

Any reported potential or actual breach of security or inappropriate / unauthorised disclosure of data will be investigated. It is the responsibility of the Data Provider to report the incident following its own internal reporting processes for data breaches.
11. Agreement

We undertake to implement and adhere to this protocol.

Signed by Governance Lead

Print: .................................................................

Signed: .................................................................

On behalf of
(Organisation): .................................................................

Signed by Governance Lead

Print: .................................................................

Signed: .................................................................

On behalf of
(Organisation): .................................................................

Signed by Governance Lead

Print: .................................................................

Signed: .................................................................

On behalf of
(Organisation): .................................................................
<table>
<thead>
<tr>
<th>Definitions</th>
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<tr>
<td><strong>FoIA</strong></td>
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<td><strong>Personnel</strong></td>
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<td><strong>Sensitive personal data</strong></td>
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CONSENT TO SHARE INFORMATION FORM

Please discuss this form or any queries you may have with your care professional at your clinical assessment appointment.

Please think about whether you will give permission (your consent) to share your information where it is in your best interests.

If you have any further questions please phone the Patient Advice and Liaison Service (PALS) on 0800 085 7935.

I have received a copy of the "Your Information - What you need to know" leaflet and have considered the options below.

I, confirm that I give Essex Partnership University NHS Foundation Trust my permission to share any information about me, where it is in my best interests, as follows:

Please tick box:

- To any organisation Essex Partnership University NHS Foundation Trust consider it in my best interests to do so. Such as Social services, General Practitioner, Benefits Agency, Probation, Police, Court Officials, Housing Department, Education Department, Legal Representatives.

- To the following people – please tick all relevant boxes and please name

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<tr>
<th>Next of Kin</th>
<th>Nearest Relative</th>
<th>Substantive (Main) Carer</th>
<th>Carer</th>
<th>Family</th>
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<th>Others</th>
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<td>Are there any exceptions or do you have any specific wishes not covered above</td>
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<td>Has Patient got Capacity</td>
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SHARING INFORMATION (Guidance for Patients)

Respecting Your Confidentiality
Essex Partnership University NHS Foundation Trust pledges to respect your confidentiality at all times. This is your right under the law.

This leaflet talks about your health and social care records and the information we hold about you (names, address, date of birth, ethnicity and so on) called personal information.

Our Pledge
Our pledge to you means that
- If a health or social care professional needs to see your records for your treatment they will not pass on any information they read to any unauthorised person
- We will seek your permission if an outside organisation asks to see your records
- We will not pass on any personal information (like your address, phone number or other personal details) to anyone without your permission.
- You can make a complaint if you think confidentiality has been broken
- You can see a copy of your records to make sure they are accurate
- You can ask for all letters written about you to be copied to you.

Sometimes in your best interests it is helpful to share some information with other organisations. This leaflet explains why and how we will ask for your consent.

We have to provide statistics and data to the Department of Health (and similar bodies) about the services we provide but all personal details (or any identifiable information) are removed.

Sharing Health and Social Care Information
We provide many services in partnership with your General Practitioner, other NHS Trusts, Social Care agencies and local authority departments. This means that sometimes we will need to share your health and social care records with others involved in your care or treatment. We have procedures and protocols that govern how we share information which safeguard your right to confidentiality.

Access to Your Health / Social Care Records
The Data Protection Act 2018 gives people who have received NHS and Social Care services the right to access their own personal records. It is important that you trust staff with your personal information and our policy on the use of their information is your guarantee that your personal information will not be passed to others without proper safeguards.

If you would like to know more about how we use your information you can speak to the person in charge of your care or the Trust’s Caldicott Guardian.
If you want a leaflet about seeing your records, or how to ask for copies of all letters written about you, please call Patient Advice and Liaison (PALs) on Freephone 0800 085 7935 (Essex & Bedfordshire)

Your Right to Know
Please read this leaflet so that you can understand how we may use information about you. Please ask us if you need any more explanation. You can also help to keep your details up to date by telling us when anything changes in any way, for example if you move home.

What is Personal Information?
This is information about you - your name, address, date of birth. We also take information about your health (you maybe disabled), your family situation (and next of kin), your ethnic origin and religion.

What are Health / Social Care Records?
These are the notes and letters that health and social care professionals write about all aspects of your care and treatment.

Why Does the Trust Keep Records?
The law says we have to, but it also benefits you. Records allow us:
- to understand your needs so we can plan your care
- to make sure we provide high quality care
- to give you a record of what has happened to you
- to train new staff
- to carry out research about developing good quality services.

There are many groups who may provide care for you, each keeping their own information about you. You may be asked to give the same information several times and so sharing your information with these groups, with your permission, will reduce these requests and save your time.

To make sure that your information is safe, groups must sign an agreement with us to treat your information as private and that they will only use it for the purpose of the help they are giving you.

These groups have rules about how they use your information and if they want to they must ask your permission.

At the end of this leaflet there is a consent form where you can tell us what you give us permission to share.

How Does Sharing Information Help Me?
Sharing information means that you won’t be asked for the same details so often. Care professionals will not need to keep asking you basic information.
Can I Say No?
Yes you can and you can withdraw your permission at any time. However, please talk to a member of staff about this and any worries you have.

Are There Exceptions or Special Circumstances?
There are limited times when we have to provide information without asking you, for example a Court may order us to do so, or where someone could be in danger or if there has been a serious crime.

What About The Freedom of Information Act?
Personal information is exempt from requests under the Freedom of Information Act.

Can I Limit What Sort Of Information Is Shared?
Yes. In most cases we will tell you what type of information is likely to be shared with others. If there is something or someone you do not want us to pass information onto, we will not do so.

How is My Information Kept Safe?
- We will only share information with other professional organisations that pledge to keep it confidential
- We will only share what is absolutely necessary to make sure your services are delivered safely and effectively
- We use secure computer networks – the general public do not have access to them
- We will keep a record of everyone outside this Trust who has asked to see your information and when and why they did
- It will only be shared where it is in your best interests, not the Trust’s or someone else’s

What If I Think My Information Is Being Misused?
If you think your personal information is being misused please tell us quickly so that we can take steps to correct the situation.

The Trust has a complaints procedure that can deal with your concerns (see information at the end of this leaflet)
The Caldicott Guardian
Under the law every Trust has to have a senior manager who makes sure that confidentiality is respected throughout the organisation. This is called the Caldicott Guardian (named after the lawyer who chaired an important inquiry into confidentiality). You can write to the Caldicott Guardian about any concerns you may have:

The Caldicott Guardian
Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford, Essex
SS11 7XX

Telephone: 0300 123 0808
E-mail: [removed]

More Information
If you want a leaflet / more information about:

- making a complaints
- having a copy of your records
- having letters written about you, copied to you
- the Freedom of Information Act
- the Data Protection Act
- anything else

Please call the Patient Advice and Liaison Service on Freephone 0800 085 7935 or 0800 013 1223.

You can make a complaint during office hours by phoning 0300 123 0808.
CONSENT GUIDANCE FOR INFORMATION SHARING

1. Introduction
The aim of this document is to give guidance to enable personal information concerning service users to be shared between organisations without compromising confidentiality unless there is a legal requirement, or an overriding public interest to do so.

Confidentiality is an essential requirement for the preservation of trust between service users and health professionals and is subject to legal and ethical safeguards. Service users should be able to expect that information about their health which they give in confidence will be kept confidential unless there is a compelling reason why it should not. There is also a strong public interest in maintaining confidentiality so that individuals will be encouraged to seek appropriate treatment and share information relevant to it.

As a general principle all personal information must only be collected, held and shared on a strict ‘need to know’ basis and all decisions to share information that are not directly associated with the direct continuing healthcare of the patient should be recorded.

2. Purpose
The purpose of this document is to provide specific guidance for all staff on consent and information sharing issues. This document forms an appendix to the Trust’s Information Sharing Policy and Procedure.

3. Consent
Consent is required in all cases of sharing service user identifiable information unless disclosure is required by law, or there is an overriding public interest in disclosure.

3.1 Definition of Consent
Consent to disclosure may be explicit or implied. It may also be consent to disclosure of specific information to a particular person or body for a particular purpose or it may be consent to general future disclosure for particular purposes. In either case consent should be informed and freely given.

Consent is defined in “Confidentiality: NHS Code of Practice (2003) as follows:

(a) Informed Consent
All consent should be fully informed. Every patient should be informed about what happens to the information they give to the NHS (it is the minimum requirement under the Data Protection Act 1998). For each episode of care you should ensure that your service user is aware of who will see their information and
INFORMATION SHARING & CONSENT PROCEDURE

what you will be doing with it and give them the opportunity of saying ‘no’ to information sharing, unless legislation dictates otherwise.

All service users should receive the following information:

- Who the Data Controller is
- Why the information is needed
- The purposes for which the information will be processed
- Who will see the information
- Any disclosures that may need to be made to other organisations (e.g. Acute Hospitals, Social care, Clinical audit, GP, Mental Health Teams, Drug Teams etc)
- The circumstances in which information may be disclosed without consent, where there is an overriding public interest (e.g. child protection, or serious crime.)
- Information restricted by legislation (e.g. serious communicable diseases.)
- Information that must be passed on because of legislation (e.g. births, deaths, cancer registries, abortion.)

If service users have any reservations about information sharing then explain that the direct continuing care could be affected by restrictions placed on sharing. If service users still refuse to share any information then you have not gained consent for that particular information and the service user’s wishes must be respected (unless there is a legal requirement, or an overriding public interest in disclosure.)

(b) Implied Consent
Service user agreement that has been signalled by behaviour (this consent also needs to be fully informed).

Implied consent is not a lesser form of consent but in order for it to be valid it is important that service users are made aware that information about them will be shared, with whom it will be shared, and of their right to refuse. Health professionals bear responsibility for the disclosures they make, so when consent is taken to be implied, they must be able to demonstrate that the assumption of consent was made in good faith and based on good information. If not, it is no consent at all and some other justification will be needed for its disclosure. In addition to information provided face to face in the course of a consultation, leaflets, posters and information included with an appointment letter can play a part in conveying to service users the reality and necessity of information sharing. Implied consent is usually sufficient for direct service user care (see paragraph 4.1 below).
(c) **Express/Explicit Consent**
Articulated service user agreement. Clear and voluntary indication of preference or choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear. Explicit consent is the ideal as there is no doubt as to what has been agreed.

3.2 **Recording Consent**
Record in the service user’s record if the service user has been provided with and understands the notice/leaflet regarding information sharing and has not said ‘no’ to sharing any part of their information.

Where a service user has refused to share information this should be recorded in the service user’s record, dated and time stamped. That information must not be shared (unless there is a legal requirement or an overriding public interest in disclosure.)

3.3 **Keeping Consent Up To Date**
It is essential that children, once they gain capacity, are asked to confirm their own choice, as a previous recorded choice regarding consent will have been made by another party, on their behalf, which may not reflect their own choice.

It may also be essential to revisit the consent at other times e.g. when changes which impact on how information is used are introduced. Consent should also be reviewed whenever there are changes to information sharing/disclosure during an episode of care.

4. **What You Need To Know Before Sharing Information**

4.1 **Sharing Information With Other Health Professionals**
In the absence of evidence to the contrary, service users are normally considered to have given implied consent for the use of their information by health professionals for the purpose of the care they receive. Information sharing in this context is acceptable to the extent that health professionals share what is necessary and relevant for service user care on a ‘need to know’ basis. Healthcare and social care although often closely related, do not always fall into the same category, and disclosures of information to social care usually require explicit consent from competent service users. Sometimes two competing interests come into conflict, such as the service user’s informed refusal to allow disclosure, and the need to provide effective treatment to that person. A service user’s refusal to allow information sharing with another health professional may compromise service user safety, but if this is an informed decision by a competent person it should be respected.

4.2 **Multi – Agency Working**
Health professionals during the course of their treatment of service users will have contact with partner organisations from time to time. These include social care, housing and benefits agencies. Health professionals should from the outset discuss with service users the desirability of sharing information with other agencies as appropriate. Other agencies may wish to be involved in discussions about service users at various points in their treatment, or to attend case conferences, or multi-disciplinary meetings. Health professionals may also be invited to attend external case conferences organised by partner organisations to discuss the health and welfare of service users. In all these circumstances information sharing should take place with explicit consent or in the absence of explicit consent where disclosure is required by law, or there is an overriding public interest in disclosure.

4.3 **Assessment Of Capacity**

All people aged 16 and over are presumed, in law, to have the capacity to give or withhold their consent to disclosure of confidential information unless there is evidence to the contrary. A service user who is suffering from a mental disorder or impairment does not necessarily lack the capacity to give or withhold their consent. Equally, service users who would otherwise be competent may be temporarily incapable of giving valid consent due to factors such as extreme fatigue, drunkenness, shock, fear, severe pain or sedation. The fact that an individual has made a decision that appears to others to be irrational or unjustified should not be taken on its own as conclusive evidence that the individual lacks the mental capacity to make that decision. If, however, the decision is clearly contrary to previously expressed wishes, or is based on a misperception of reality, this may be indicative of a lack of capacity and further investigation will be required.

There is no presumption of capacity for people under 16 in England, and Wales, and those under this age must demonstrate their competence by meeting certain standards set by the courts. The central test is whether the young person has sufficient understanding and intelligence to understand fully what is proposed.

To demonstrate capacity individuals should be able to:

- Understand in simple language (with the use of communication aids, if appropriate) what is to be disclosed and why it is being disclosed
- Understand the main benefits of disclosure
- Understand, in broad terms, the consequences of disclosure
- Retain the information long enough to use it and weigh it in the balance in order to arrive at a decision
- Communicate the decision (by any means)
- Make a free decision (i.e. free from undue pressure)
4.4 Adults Who Lack Capacity

4.4.1 Temporary Or Permanent Mental Incapacity
Service users with mental disorders or learning disabilities should not automatically be regarded as lacking the capacity to give or withhold their consent to disclosure of confidential information. Unless unconscious, most people suffering from a mental impairment can make valid decisions about some matters that affect them. An individual’s mental capacity must be judged in relation to that particular decision being made. If therefore a service user has the requisite capacity, disclosure of information to relatives or third parties requires service user consent. One of the most difficult dilemmas for health professionals occurs where the extent of such service user’s mental capacity is in doubt. In such cases health professionals must assess the information which is available from the service user’s health record and from third parties. They should attempt to discuss with service users their needs and preferences as well as assess their ability to understand their condition and prognosis. If there is still doubt about a service user’s competence to give or withhold consent, health professionals should seek a second opinion.

4.4.2 Relatives, Carers And Friends
If a service user lacks capacity, health professionals may need to share information with relatives, friends or carers to enable them to assess the service user's best interests. Where a service user is seriously ill and lacks capacity, it would be unreasonable always to refuse to provide any information to those close to the service user on the basis that the service user has not given explicit consent. This does not, however, mean that all information should be routinely shared, and where the information is sensitive, a judgement will be needed about how much information the service user is likely to want to be shared, and with whom. Where there is evidence that the service user did not want information shared, this must be respected.

4.4.3 Next Of Kin
Although widely used, the phrase ‘next of kin’ has no legal definition or status. If a person is nominated by a service user as next of kin and given authority to discuss the service user’s condition, such a person may provide valuable information about the service user’s wishes to staff caring for the service user. However, the nominated person cannot give or withhold consent to the sharing of information about the service user and has no rights of access to the service user’s medical records. The service user may nominate anyone as next of kin. In the absence of such a nomination, no-one can claim to be next of kin.
4.4.4 Proxy Decision-Makers

In England and Wales, the Mental Capacity Act 2005 allows people over 18 years of age who have capacity to appoint a welfare attorney to make health and personal welfare decisions once capacity is lost. The Court of Protection may also appoint a deputy to make these decisions. Where a service user lacks capacity and has no relatives or friends to be consulted, the Mental Capacity Act requires and Independent Mental Capacity Advocate to be appointed and consulted about all decisions about ‘serious medical treatment’, or place of residence. An attorney or deputy can also be appointed to make decisions relating to the management of property and financial affairs. In the case of health information, health professionals may only disclose information on the basis of the service user’s best interests.

4.4.5 Abuse And Neglect

Where health professionals have concerns about a service user lacking capacity that may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body, in order to prevent further harm. Where there is any doubt as to whether disclosure is considered to be in the service user’s best interests, it is recommended that the health professional discusses the matter on an anonymised basis with a senior colleague, the Caldicott Guardian, Information Governance Manager or Trust Solicitor. Health professionals must ensure that their concerns and the actions they have taken or intend to take, including any discussion with the service user, colleagues or professionals in other agencies, are clearly recorded in the service user’s medical records.

4.5 Children And Young People

4.5.1 Competent Children

There is no presumption of capacity for people under 16 in England, Wales and Northern Ireland and those under that age must demonstrate they have sufficient understanding of what is proposed. However, children who are aged 12 or over are generally expected to have capacity to give or withhold their consent to the release of information. Younger children may also have sufficient capacity. When assessing a child’s capacity it is important to explain the issues in a way that is suitable for their age. If the child is competent to understand what is involved in the proposed treatment, the health professional should, unless there are convincing reasons to the contrary, for instance abuse is suspected; respect the child’s wishes if they do not want parents or guardians to know. However, every reasonable effort must be made to persuade the child to involve
parents or guardians particularly for important or life-changing decisions.

4.5.2 Children Who Lack Capacity
The duty of confidentiality owed to a child who lacks capacity is the same as that owed to any other person. Occasionally, young people seek medical treatment, for example, contraception, but are judged to lack the capacity to give consent. An explicit request by a child that information should not be disclosed to parents or guardians, or indeed to any third party, must be respected except in the most exceptional circumstances, for example, where it puts the child at risk of significant harm, in which case disclosure may take place in the 'public interest' without consent. Therefore, even where the health professional considers a child to be too immature to consent to the treatment requested, confidentiality should still be respected concerning the consultation, unless there are very convincing reasons to the contrary. Where a health professional decides to disclose information to a third party against a child’s wishes, the child should generally be told before the information is disclosed. The discussion with the child and the reasons for disclosure should also be documented in the child’s record.

4.5.3 Parental Responsibility
Anyone with parental responsibility can give or withhold consent to the release of information where the child lacks capacity. Not all parents have parental responsibility.

- In relation to children born after 1 December 2003, both of a child’s biological parents have parental responsibility if they are registered on a child’s birth certificate.
- In relation to children born before these dates, a child’s biological father will only automatically acquire parental responsibility if the parents were married at the time of the child’s birth or some time thereafter. If the parents have never been married, only the mother automatically has parental responsibility, but the father may acquire that status by order or agreement. Neither parent loses parental responsibility on divorce.
- Where the child has been formally adopted, the adoptive parents are the child’s legal parents and automatically acquire parental responsibility.
- Where the child has been born as a result of assisted reproduction, there are rules under the Human fertilisation and Embryology Act 2008 that determine the child’s legal parentage.
- In some circumstances people other than parents acquire parental responsibility, for example by the appointment of a guardian or on the order of a court.
• A local authority acquires parental responsibility (shared with the parents) while the child is the subject of a care or supervision order.
• In some circumstances parental responsibility can be delegated to other carers such as grandparents and child-minders.

If there is doubt about whether the person giving or withholding consent has parental responsibility, legal advice should be sought.

Where an individual who has parental responsibility refuses to share relevant information with other health professionals or agencies and the health professional considers that it is not in the best interest of the child (for example, it puts the child at risk of significant harm), disclosure may take place in the public interest without consent.

4.5.4 Safeguarding Children
Where health professionals have concerns about a child who may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body, in order to prevent further harm. The best interests of the child or children involved must guide decision-making at all times. Knowing what to do when service users do not want confidential information disclosed, despite this being the best way to ensure that they do not suffer harm or abuse, is very difficult for health professionals. Health professionals should not make promises to the child about confidentiality that they may not be able to keep but, as in the case of any service user, trust is best maintained if disclosure is not made without prior discussion between the health professional and the child, unless to do so would expose the child or others to an increased risk of serious harm.

Where there is any doubt as to whether disclosure is in the child’s best interests, it is recommended that the health professional discusses the matter anonymously with an experienced colleague, Safeguarding Children and Families Team, the Caldicott Guardian, Information Governance Manager, Trust Solicitor, their professional body or defence body.

Health professionals must ensure that their concerns, and the actions they have taken, or intend to take, including any discussion with the child, colleagues or professionals in other agencies, are clearly recorded in the child’s medical record. Health professionals may be involved in case reviews for which the child’s records may need to be disclosed, but care should be
taken not to disclose the notes of other family members without consent unless it can be justified in the public interest.

4.6 **Best Interests**

All decisions taken on behalf of someone who lacks capacity must be taken in their best interest. A best interest judgement is not an attempt to determine what the service user would have wanted. It is as objective a test as possible of what would be in the service user’s actual best interests, taking into account all relevant factors. A number of factors should be addressed including:

- The service user’s own wishes (where these can be ascertained)
- Where there is more than one option, which option is least restrictive of the service user’s future choices
- The view of the parents, if the service user is a child
- The views of people close to the service user, especially close relatives, partners, carers, welfare attorneys, court-appointed deputies or guardians, about what the service user is likely to see as beneficial

4.7 **Public Interest**

4.7.1 **General Principles**

In the absence of service user consent (a legal obligation or anonymisation) any decision as to whether identifiable information is to be shared with third parties must be made on a case by case basis and must be justifiable in the ‘public interest’. Public interest is the general welfare and rights of the public that are to be recognised, protected and advanced. Disclosures in the public interest based on the common law are made where disclosure is essential to prevent a serious and imminent threat to public health, national security, the life of the individual or a third party or to prevent or detect serious crime. Ultimately, the public interest can only be determined by the courts. However, when considering disclosing information to protect the public interest, health professionals must:

- Consider how the benefits of making the disclosure balance against the harms associated with breaching the service user’s confidentiality both to the individual clinical relationship and to maintaining public trust in a confidential service.
- Assess the urgency of the need for disclosure.
- Persuade the service user to disclose voluntarily.
- Inform the service user before making the disclosure and seek his or her consent, unless to do so would increase the risk of harm or inhibit effective investigation.
- Disclose the information promptly to the appropriate body.
INFORMATION SHARING & CONSENT PROCEDURE

- Reveal only the minimum information necessary to achieve the objective.
- Seek assurance that the information will be used only for the purpose for which it is disclosed.
- Document the steps taken to seek or obtain consent, and the reasons for disclosing the information without consent.
- Be able to justify the decision.
- Document both the extent of and grounds for the disclosure.

Health professionals should be aware that they risk criticism, and even legal liability, if they fail to take action to avoid serious harm. There is no specific legislation which tells health professionals whether or not to disclose information in a particular case, but general guidance about the categories of cases in which decisions to disclose may be justifiable are below. Guidance should be sought from the Caldicott Guardian, Information Governance Manager, Trust Solicitor, professional body or defence body where there is any doubt as to whether disclosure should take place in the public interest.

4.7.2 Serious Crime And National Security
There is no legal definition as to what constitutes a 'serious crime'. In the Police and Criminal Evidence Act 1984 a 'serious arrestable offence' is an offence that has caused or may cause:

- Serious harm to the security of the state or to public order.
- Serious interference with the administration of justice or with the investigation of an offence.
- Death.
- Serious injury.
- Substantial financial gain or serious loss.

This includes crimes such as murder, manslaughter, rape, treason, kidnapping and abuse of children or other vulnerable people. Serious harm to the security of the state or to public order and serious fraud will also fall into this category. In contrast, theft, minor fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence.

4.7.3 Public Safety
A common example of what can be categorised as public safety occurs in connection with the assessment of service users with, for example, diabetes, epilepsy, defective eyesight, hypoglycaemia or serious cardiac conditions who have been advised by health professionals to discontinue driving, but who nevertheless continue. The DVLA should be informed if anybody is thought to be at risk.
Issues of public safety may similarly arise in circumstances where an individual who legitimately possesses firearms is thought by health professionals to be a risk because of drug or alcohol addiction or a medical condition such as depression. The police should be informed if anybody is thought to be at risk.

5. **Information Sharing That Requires Express Consent**

National guidance has identified certain areas of information sharing that must only be carried out on an express/explicit consent basis. Consent is required for information sharing that does not directly contribute to direct continuing healthcare, unless there is a robust public interest in releasing information without the service user’s consent or you have the express/explicit consent in writing, from the service user or recorded in the service users health record.

For most information sharing issues that are not for the direct continuing care of a service user you should consult the Caldicott Guardian or Information Governance Manager.

The following table gives further details:

<table>
<thead>
<tr>
<th>Carers and Relatives</th>
<th>Generally where a service user has the capacity to consent express/explicit consent is required before sharing health information. Confidentiality can be a highly controversial issue. Carers want and need information about the person they are caring for, whereas professionals feel bound by codes of conduct on confidentiality.</th>
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<tbody>
<tr>
<td>NHS Complaints Committees</td>
<td>Complaint Committees will invariably need service user information. However, express consent of the complainant, and any other service users whose record may need to be reviewed, is required prior to disclosure.</td>
</tr>
<tr>
<td>Management Purposes</td>
<td>Commissioners, prescribing advisors, financial audit, resource allocation etc., - no restrictions are imposed if the data is anonymised or pseudonymised.</td>
</tr>
<tr>
<td>Occupational Health Professionals</td>
<td>Information on staff referred to occupational health departments. However, if clinicians are the service users, the powers of professional regulatory bodies for disclosure may apply.</td>
</tr>
<tr>
<td>Researchers</td>
<td>The use of service user information for research goes beyond health care provision in the NHS and explicit service user consent is therefore required. For example, whilst most people would be happy to be included in research there may be some that might object on the grounds of, for example, ‘religion’. However, if the research project is to use anonymised or pseudonymised data, (which is preferable) no restrictions are imposed. (refer to anonymisation and pseudonymisation below. Alternatively, an application can</td>
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be made to the Ethics and Confidentiality Committee of the National Information Governance Board under section 251 of the NHS Act 2006.

Before any research project can be undertaken an application must be made to the Local Research Ethics Committee for approval and before making any application to the Ethics and Confidentiality Committee Of the National Information Governance Board under Section 251 of the NHS Act 2006.
Teaching  
According to the Confidentiality: NHS Code of Practice teaching is not to be regarded as direct healthcare purposes and will require explicit consent.

Sure Start Teams  
Disclosures to Sure Start teams for anything other than the direct continuing healthcare of young children needs explicit consent from parents.

Example: extracting lists of children’s names who are below the age of 5 from information held by an organisation to enable Sure Start to target certain groups of families to give them toothpaste samples would require explicit consent.

The Media  
You need explicit consent to release information to the media about care and treatment (including a service user’s presence in a hospital) unless there is an exceptional robust public interest in releasing information.

Police  
Information required by the Police either needs explicit consent of the service user, a Court Order or, where criminal activities are concerned refer to section 6.1 below on Enabling Information Sharing in the Public Interest.

Solicitors  
Solicitors requesting information must produce an up to date written signed consent from the service user before you release any information. If you have any doubts as to the authenticity of the consent or the fact that the whole of the service user’s record has been requested contact the service user direct – you must obtain consent from any third parties before releasing third party information.

6. Legislation Enabling/Requiring/Restricting Information Sharing

6.1 Enabling Information Sharing in the Public Interest

The following legislation permits information to be shared without seeking consent e.g. if you believe someone has committed serious harm, or a serious crime. However the legislation does not require you to do so. Decisions to share should be made on a case by case basis, and in the public interest.

1. Child Protection (Children’s Act 1989 and the Protection of Children Act 1999). Allows information to be shared if a child is considered at risk of significant harm.
2. Prevention and Detection of Crime (Section 115 of the Crime and Disorder Act 1998) – e.g. request from the Police where someone is suspected of committing a serious crime.
3. Disclosures to a health professional within a Sure Start team under the NHS Act 1997 where disclosures directly and only support healthcare of young children. (If health records are to be held within partner organisations, parents must be properly informed).
4. Data Protection Act 1998, Section 29 (3) provides that the non-disclosure rules will not apply if information sharing is required for:

- The prevention or detection of crime
- The apprehension or prosecution of offenders
- The collection or assessment of any tax or duty

The police may request information under section 29 (3) of the Data Protection Act 1998. Section 35 of the Act provides that disclosures required by law or made in connection with legal proceedings are also exempted from non-disclosure. However, the decision to disclose must be weighed against the individual’s right of data protection.

6.2 Requiring Information Sharing

Information can be shared without consent if requested to do so by the following public bodies/officials but service users should be informed that disclosure has been required:

1. Courts, including a coroner’s court, tribunals and enquiries – Only give the information requested in the order and no more. Many different Acts give courts the powers to issue court orders.
2. General Medical Council (GMC) – Entitled to access confidential patient health records as part of an investigation under the Medical Act 1983. The GMC have indicated that they would always try to obtain consent first.
4. Health Service Ombudsman – Has the same powers as the courts to disclose person identifiable information. Any request made should be complied with, without obtaining a court order.
7. Immunisations and vaccinations – Under the Education Act 1944 information must be passed to NHS Trusts from schools.
9. Abortion Regulations 1991 – a doctor carrying out a termination of pregnancy must notify the Chief Medical Officer, giving a reference number and the date of birth and postcode of the woman concerned.
10. Section 251 of the NHS Act 2006 – gives the Secretary of State for Health power to make regulations permitting the disclosure of identifiable information without consent in certain circumstances.
Health professionals can apply to the Ethics and Confidentiality Committee of the National Information Governance Board, an independent public body which advises the Secretary of State for Health in England and Wales about the lawful disclosure of service user identifiable information.

11. Members of Parliament – Non-statutory investigations (e.g. Members of Parliament). If a MP states, in writing that he/she has a service user’s consent for disclosure this may be accepted without further contact with the service user but – carefully consider the request and contact the service user if in any doubt.

6.3 Restricting Information Sharing
Health professionals are required by law to restrict the disclosure of some specific types of information, for example:

1. Human Fertilisation and Embryology Act 2008
2. NHS (Venereal Diseases Regulations) 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 1992
3. The Gender Recognition Act 2004
4. The Adoption Act 1976

7. Anonymisation and Pseudonymisation

7.1 Anonymisation
Information can be used without service user consent and requires the removal of:

- Name
- Address
- Full postal code
- NHS number
- Date of Birth
- Local Identifiers
- Anything else that could identify a service user e.g. photograph, x-ray, dental records etc.

Information that has been anonymised can never be reverted back to its original form.

Information may be used more freely if the subject of the information is not identifiable in any way. When anonymised data will serve the purpose, health professionals must anonymise data to this extent and, if necessary, take technical advice about anonymisation before releasing data. Whilst it is not ethically necessary to seek consent for the use of anonymised data, general information about when their data will be anonymised should be available to service users.

7.2 Pseudonymisation
Pseudonymisation is sometimes referred to as reversible anonymisation. Patient identifiers, such as name, address or NHS
number, are substituted with a pseudonym, code or other unique reference so that the data will only be identifiable to those who have the code or reference. Where those who are using data have no means to reverse the process, and so no way to identify an individual from the data they have, the data may be treated as anonymised and there is no common law requirement to seek consent for their use. For those who have access to both pseudonymised data and the means to reconstitute them, they should be treated as identifiable. The use of pseudonymised data is common in research. As with anonymised data, service users should generally be informed when it is intended that their information will be pseudonymised.

8. **Deceased persons**

Although the Data Protection Act 1998 does not apply to records of deceased persons the ethical obligation to respect a service user’s confidentiality extends beyond death. The Information Tribunal in England and Wales has also held that a duty of confidence attaches to the records of the deceased under section 41 of the Freedom of Information Act 2000. If a patient has requested that their information is not disclosed after their death this must be respected. The Access to Health Records Act 1990 gives limited statutory rights of access to those who ‘may have a claim’ arising out of the death of a deceased patient. Care must always be taken when sharing records of the deceased and advice should be sought in cases of doubt.
Legal Duties and Powers to Share Information in relation to Children and Young People

**Statutory Provisions to Information Sharing – Child Protection**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any agency or public body</td>
<td>There is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm</td>
<td>Social Care</td>
<td>Section 47 Children’s Act 1989</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>To undertake enquiries in order to decide if action should be taken to safeguard or promote the child’s welfare</td>
<td>Any agency who may have information</td>
<td>Section 47 (1) Children’s Act 1989</td>
</tr>
<tr>
<td>Local Housing Authority, Special Health Authority, Primary Care Trust, NHS Trust</td>
<td>Children’s Services request for information in order to decide if action should be taken to safeguard or promote the child’s welfare</td>
<td>Children’s Services</td>
<td>Section 47 (9) Children’s Act 1989</td>
</tr>
</tbody>
</table>

**Child Protection – People Unsuitable to Work with Children/Vulnerable Adults**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any organisation employing a person in child care position</td>
<td>An individual has been found guilty of misconduct (whether or not in the course of his/her employment)</td>
<td>Department of Education and Skills, Department of Health</td>
<td>Protection of Children Act 1999 Section 2A</td>
</tr>
<tr>
<td>Any organisation dealing with child care</td>
<td>The organisation wishes to offer a job to a person in a child care position</td>
<td>Department of Education and Skills, Department of Health</td>
<td>Protection of Children Act 1999 Section 3</td>
</tr>
</tbody>
</table>
### INFORMATION SHARING & CONSENT PROCEDURE

<table>
<thead>
<tr>
<th>child care capacity</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Any organisation employing a person in a care of vulnerable people position</td>
<td>A person is found to be unsuitable to work with vulnerable people</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>

**Children with a Disability**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Services/Local Authority</td>
<td>To compile and maintain a register of disabled children</td>
<td>Health</td>
<td>Children’s Act 1989 Section 17 (2)</td>
</tr>
<tr>
<td>Any Local Authority Service</td>
<td>There is a need for health or housing provision and Health or Housing can assist with the assessment</td>
<td>Primary Care Trust, Health Authority or Local Housing Authority</td>
<td>Section 47 National Health Service Act and Community Care Act</td>
</tr>
<tr>
<td>Children’s Services/Local Authority</td>
<td>To compile and maintain a register of blind; partially sighted; deaf with speech; deaf without speech; hard of hearing; and general classes (those whose primary handicap is neither visual nor auditory)</td>
<td>Health Services</td>
<td>National Assistance Act 1948 Section 29</td>
</tr>
</tbody>
</table>

**Children with Special Educational Needs**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education/Health</td>
<td>To assess a child’s SEN</td>
<td>Health, Education, Children’s Services. Also they should seek advice from child’s</td>
<td>Section 322 Education Act 1996</td>
</tr>
<tr>
<td>LEA</td>
<td>Considering making an assessment of SEN. LEA under obligation to send copies of the notice stating they are considering an assessment of SEN</td>
<td>Children’s Services, Health Authority, Head Teacher of School pupil registered with (if any). If the child receives education from an early education provider, to the head of SEN in relation to that provider</td>
<td>Education (Special Education Needs) (England) (Consolidation) Regulation 2001 (SI 3455/2001), Regulation 7(1)</td>
</tr>
</tbody>
</table>

**Children and Young People involved or likely to be involved in Crime and Disorder**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police, Housing, National Park Authority, Health, Probation; Youth Offending Team</td>
<td>Have reasonable belief that a child or young person is likely to commit a crime and therefore to prevent crime occurring</td>
<td>Any appropriate agency that can assist the child or young person to prevent them from committing a crime. E.g. Health, Youth Offending, Voluntary Agency if appropriate</td>
<td>Crime &amp; Disorder Act 1998 Section 115; Section 17 (1); Section 37 and Section 38. (Information disclosed must be on a need to know basis and minimum amount provided)</td>
</tr>
</tbody>
</table>
A Child or Young Person who is in the Care of the Local Authority

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Services</td>
<td>Because a Looked-After Child is being accommodated at an establishment at which education is provided</td>
<td>The Local Education Authority of the area in which the establishment is located</td>
<td>Children Act 1989 Section 28</td>
</tr>
<tr>
<td></td>
<td>Because parents/carers of a LAC have moved to another area and have another child</td>
<td>LEA, Health Authority, relevant agencies</td>
<td>For documents before a Court in any proceedings under the Children Act or Adoption Act leave must always be obtained prior to disclosing (sharing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Health Authority or Local Education Authority</td>
<td>Because a child is being accommodated by them and they are obliged to inform Social care of this fact</td>
<td>Children’s Services in area where the child is being accommodated</td>
<td>Children Act 1989 section 85</td>
</tr>
</tbody>
</table>
A Child or Young Person who is Leaving or Has Left Care

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Services</td>
<td>Because a young person is entitled to leaving care services and social care has a duty to keep in contact with such a young person and to provide advice and assistance. A young person is eligible if he/she has been in care for a period of 13 weeks or more since he/she was 14 and has left care after 16 but is still under 21. It does not include children who have received respite care or if the young person has returned home.</td>
<td>Any agency that may have any information about the young person which enables the LA to undertake its statutory duty. Most likely to be Health Services but could by any agency (GP registration)</td>
<td>Children Act 1989 Section 23 and Section 24, as amended by Children (Leaving Care) Act 2000 sections 24, 24A to 24D</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>Because Children’s Services has lost contact with an eligible care leave and has to take reasonable steps to locate them</td>
<td>Any agency who has this information, most likely Health</td>
<td>Children Act 1989 Section 23 and Section 24, as amended by Children (Leaving Care) Act 2000 sections 24, 24A to 24D</td>
</tr>
</tbody>
</table>
General Functions, Powers and Duties (Implied Statutory Powers)

To use implied statutory powers, stronger justification is required to demonstrate that it is necessary to share sensitive data without explicit consent

<table>
<thead>
<tr>
<th>Agency</th>
<th>Why do you want to share/request information?</th>
<th>From whom do you wish to share/request information?</th>
<th>Legal basis to share/request information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Local Authority Department</td>
<td>Because the department has a statutory duty to carry out a particular function, e.g. filling in the Pupil Level Annual School Census by the LEA</td>
<td>Other agencies (including voluntary agencies) that hold relevant information to enable the LA department to carry out its statutory duty. Without the information they would not be able to carry out the particular function</td>
<td>Section 111 of the Local Government Act 1972, give LA’s the power 2to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of any of their functions”</td>
</tr>
<tr>
<td>Any Local authority Department</td>
<td>Because the local authority considers that with the information it can: (a) promote or improve the economic well-being in their area (b) promote or improve the social well-being of their area (c) promote or improve the environmental well-being of their area</td>
<td>Any other agency who holds relevant information</td>
<td>Section 2 of the Local Government Act 2000, which gives the LA “a power to do anything they consider is likely to achieve any one or more of the objectives” as set out in column 2. So long as there are no restrictions or prohibitions or limitations in other enactments, i.e. must be compatible with the</td>
</tr>
<tr>
<td>Requirement</td>
<td>Description</td>
<td>Other Parties</td>
<td>Legal Basis</td>
</tr>
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</tr>
<tr>
<td>Any Health Service within NHS</td>
<td>To provide a comprehensive health service in England and Wales to improve the physical and mental health of the population and to prevent and diagnose and treat illness</td>
<td>Other NHS practitioners working within the Health Service and practitioners from other agencies e.g. social care, who are carrying out health service functions that would otherwise be carried out by the NHS</td>
<td>National Health Service Act 1977, Section 2</td>
</tr>
<tr>
<td>Any Health Service within NHS and Local Authority</td>
<td>In order for Health to exercise their Health Service functions and for the LA to exercise its functions in order to secure and advance the health and welfare of the people of England and Wales</td>
<td>Other NHS practitioners working within the Health Service and practitioners from other agencies e.g. social care, who are carrying out health service functions that would otherwise be carried out by the NHS</td>
<td>National Health Service Act 1977, Section 22</td>
</tr>
<tr>
<td>Any Local Authority; any Local Education Authority; any Local Housing Authority; Any Health Authority</td>
<td>Because it is felt that a child or young person or family is in need of services to safeguard and promote the welfare of a child or young person. Section 17 of Children’s Act states a child is in need if: (a) He/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable</td>
<td>Other agencies within this partnership who are involved with the child, young person or family and with any other agency that may provide the appropriate services (including voluntary agencies)</td>
<td>Children’s Act 1989. Part III: • Section 17 (1) (provision of service) This places a general duty on every LA “to safeguard and promote the welfare of children within their area who are in need and so far as is consistent with that duty, to promote the upbringing of such</td>
</tr>
<tr>
<td>Health Service</td>
<td>A child or young person has physical or mental health problems which require extra services</td>
<td>Any agency that can provide appropriate health services (that could be voluntary agency providing a health service)</td>
<td>National Health Service Act 1977, Section 1</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>Because it is felt that another organisation could assist them to provide support for children in need and or their families. Any authority to whom such a request is made has duty to cooperate provided that the request is not incompatible with the performance of its own</td>
<td>Other local authorities, any local education authority, any local housing authority, any health authority</td>
<td>Children Act 1989, Section 27</td>
</tr>
</tbody>
</table>

**INFORMATION SHARING & CONSENT PROCEDURE**

standard of health or development without the provision for him/her of services by a local authority under this part

(b) His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services

(c) He/she is disabled. “Family” includes any person who has parental responsibility for the child and any other person with whom he/she has been living

children by their families, by providing a range and level of services appropriate to those children's needs”

- Section 27 (1)(2) and (3) (other agencies acting on behalf of the LA)
- Section 17(5) (voluntary agencies) Section 17(10) and (11) (definition of a child in need) Section 2 Local Government Act 2000
| Children’s Services | Record involvement of agency with child or young person, investigate suitable service provision to improve the wellbeing of children so far as relating to: (a) physical and mental health and emotional wellbeing; (b) protection from harm and neglect; (c) education, training and recreation; (d) the contribution made by them to society; (e) social and economic wellbeing | Districts, Police, Probation, Youth Offending Team, any health authority, local education authority, schools, probation board, Youth Offending Team providers under section 114 Learning and Skills Act 2000; the governor of a prison or secure training centre in England (or, in the case of a contracted out prison or secure training centre, its director); the British Transport Police Authority; a person registered in England for child minding or the provision of day care; a registered social landlord; a voluntary organisation | Children’s Act 2004, Section 10 & 11 |
| A Database: (a) name, address, gender, DoB (b) a number identifying him/her (c) the name and contact details of any person with parental responsibility who has care of him/her at any time | Districts, Police, Probation, YOT, any health authority, local education authority, probation board, YOT providers under section 114 Learning and Skills Act 2000 | Children’s Act 2004 Section 12 (1,2,3,4) |
(d) details of any education being received by him/her
(e) the name and contact details of any person providing primary medical services in relation to him/her under Part 1 of the NHS Act 1977 (c.49)
(f) the name and contact details of any person providing to him/her services of which description as the SoS regulations specify
(g) information as to the existence of any cause for concern in relation to him/her Information of such description, not including medical records or other personal records, as the SoS regulations specify

### HEALTH SERVICE

**General functions/powers/duties**

<table>
<thead>
<tr>
<th>Section/Regulation</th>
<th>Description</th>
</tr>
</thead>
</table>
| Section 1 National Health Service Act 1977 | “1(1) It is the Secretary of State’s duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement:

  a) In the physical and mental health of the people of those countries, and
  b) In the prevention, diagnosis and treatment of illness,” |
<table>
<thead>
<tr>
<th>Section 31 Health Act 1999</th>
<th>And for that purpose to provide the effective provision of services in accordance with this Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (S.I. 2000/617)</td>
<td>This section allows the Secretary of State to make regulations in connection with enabling the NHS bodies and local authorities to enter into prescribed arrangements in relation to prescribed functions on the NHS bodies and prescribed health-related functions of local authorities</td>
</tr>
<tr>
<td>Adoption Agencies Regulations 1983 (S.I. 1983/1964)</td>
<td>These regulations are made under s31 Health Act 1999 and allow NHS bodies and local authorities to enter into partnership arrangements in relation to the exercise of any NHS functions if the partnership arrangements are likely to lead to an improvement in the way in which those functions are exercised.</td>
</tr>
<tr>
<td>NHS (General Ophthalmic Services) Regulations 1986 (S.I. 1986/975)</td>
<td>Regulation 6(5) obliges the adoption agency to consult its medical adviser in relation to arrangements for access to and disclosures of health information which is required or permitted by virtue of regulation 15</td>
</tr>
<tr>
<td>Section 47 Children Act 1989</td>
<td>This requires opticians to keep records and imposes an obligation to disclose to the PCT or the Secretary of State on request</td>
</tr>
<tr>
<td>Section 47 National Health Service and Community Care Act 1990</td>
<td>S47(9) provides, “Where a local authority are conducting enquiries under this section, it shall be the duty of any person mentioned in subsection (11) to assist them with those enquiries (in particular by providing relevant information and advice) if called upon by the authority to do so”</td>
</tr>
<tr>
<td>Section 85 Children Act 1989</td>
<td></td>
</tr>
<tr>
<td>NHS (General Dental Services) regulations 1992 (S.I. 1992/661) Schedule 1 Para 25</td>
<td>These regulations place an obligation on dentists to keep records and to disclose to a PCT, the Secretary of State, the Dental Practice Board or a dental officer on request</td>
</tr>
<tr>
<td>Section 31 Health Action 1999</td>
<td>S31(3)(g) provides that regulations may make provisions as to the sharing of information between NHS bodies and local authorities</td>
</tr>
<tr>
<td>Section 60 Health and Social Care Act 2001</td>
<td>This allows for the SoS to make regulations in respect of the processing of prescribed patient information for medical purposes if he considers it necessary or expedient:</td>
</tr>
<tr>
<td><strong>INFORMATION SHARING &amp; CONSENT PROCEDURE</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **a)** In the interests of improving patient care, or  
**b)** In the public interest |
| **Heath Service (Control of Patient Information) Regulations 2002 (S.I. 2002/1438)**  
These regulations are made under 260 of the Health and Social Care Act 2001 and provide circumstances when confidential patient information may be processed for medical purposes |
Appendix 5

Consent to Information Sharing in TPP SystmOne

SystmOne supports patient choice not only in terms of whether information is ‘shared out’ between organisations (i.e. between the Trust and GP Practices) which is known as NHS CRS level, but also whether it is ‘shared in’ between units in an organisation, this is known as the patients ‘unit level sharing preference’

It should be noted that allowing ‘sharing out’ only allows those units at which a patient is registered to have access to the patient record, this means that if a patient consents to sharing at NHS CRS Level at their GP Practice, only those units within the Trust that have the patient registered will be able to see the patient’s record, not all units within the Trust, therefore the majority of patient records will not be seen outside of the GP Practice.

1. Unit Level Sharing Preference

Any clinician when referring a patient into another service within the Trust should explain to the patient the ability within SystmOne to share their health records with the service to which they are being referred. If the patient consents/dissents to sharing this should be indicated on the referral.

Within the Trust, patients are usually registered within a unit by an administrator. If the patient has been referred to the unit by another Trust unit then that referral should state whether or not the patient has been informed and consented/dissented to sharing their record. If this is the case the administrator can mark the record as shareable/private as per the Quick Reference Guide to setting sharing preferences.

If the patient has dissented to share at NHS CRS level then the sharing preferences will be set to ‘implicit dissent’ and the record will remain private until the patient is asked for their consent/dissent to share.

When a clinician has their first consultation with that patient they must then explain the sharing ability of SystmOne and update the sharing preferences within the record accordingly.

An example of how sharing preferences can be set is given below.

2. NHS CRS Level Sharing Preference

Every person registered on the PDS (Patient Demographics Service) has a global flag which indicates, in broadest terms, whether or not they wish to participate in the NHS Care Records Service (NHS CRS). The flag known as the patient’s NHS CRS information sharing preference, can be viewed and changed in SystmOne but is ultimately held on PDS and will be accessed in time by all clinical systems delivered by NHS Connecting for Health as part of the National Programme for IT.
The NHS CRS flag is set initially to ‘Implied Consent’ on PDS. When a patient specifies an NHS CRS information sharing preference, the flag should be changed to either explicit consent or dissent accordingly.

When a patient explicitly consents or dissents to NHS CRS information sharing, their choice will affect how their information is shared not only within SystmOne, but across the NHS Care Record Service as a whole. It determines two things: 1) whether information in the patient’s electronic record will be shared outside of the legal organisation by which it was created; 2) whether the patient’s Summary Care Record, if they wish to have one, will be shared.

If a patient’s NHS CRS information sharing preference is set to dissent, this will not prevent the clinician they are seeing from creating a Choose and Book referral, as clinical communications of this nature are not impacted by sharing preferences.

3. Sharing preferences for individual events

SystmOne allows users to set the sharing preference for individual events in the patient record, based on the patient’s wishes. This means that, where the record sharing preference as a whole has been set to ‘shareable’, it is still possible to mark individual events that the patient wishes to keep within the confines of the unit as private.

An ‘event’ refers to any information entered into the patient record with the same date and time stamp.

4. Obtaining consent to share children’s records

Consent for sharing of children records should be sought using the guidance in appendix 4 section 4.5. If consent is not given by either the person with parental responsibility or the child, the following guidance should be followed: (see page 45 below)
Sharing Diagram on TPP (SystmOne)

Parent/patient asked for consent to share record with other health professionals involved in their care

Consent Given

No

Yes

Re-iterate benefits of sharing

Consent Given

No

Yes

Use professional judgement as to whether decision will put child at risk

Child at risk

No

Yes

Parent/Patient to be advised that may need to seek further advice on decision

Consult team leader as to whether or not have sufficient concern/evidence to override decision around dissent

Is there sufficient concern/evidence

No

Yes

Concern raised with safeguarding children and families team to make them aware

Note made on template that have overridden parent/patient dissent to prevent child being put at risk of harm

Dissent to share recorded on TPP

Consent to share recorded on TPP
Sharing Example

The patient is receiving care from three organisations; GP, District Nursing and Smoking Cessation. The patient wants their GP and District Nurse to share information with each other and the patient wants both the GP and District Nurse to be able to access the information being recorded by the Smoking Cessation service; however the patient does not want the Smoking Cessation service to see any other medical information. The sharing settings would be as follows:-

![Diagram of sharing example]

- GP Record
- Smoking Cessation Record
- Shared Patient Record
- District Nurse Record
PROCEDURE ON COMMUNICATING PATIENT SAFETY EVENTS: BEING OPEN AND THE DUTY OF CANDOUR

PROCEDURE REFERENCE NUMBER: CPG36
VERSION NUMBER: 6
REPLACES SEPT DOCUMENT CPG36/V5
REPLACES NCP DOCUMENT N/A
KEY CHANGES FROM PREVIOUS VERSION EPUT format
AUTHOR: [Redacted], Assistant Director Quality and Practice
CONSULTATION GROUPS: Learning Lessons Oversight and Scrutiny Committee, Identified Leads, Community and Mental Health staff
IMPLEMENTATION DATE: 1 July 2017
AMENDMENT DATE(S): N/A
LAST REVIEW DATE: N/A
NEXT REVIEW DATE: May 2020
APPROVAL BY CLINICAL GOVERNANCE & QUALITY COMMITTEE: 26 May 2017
RATIFICATION BY QUALITY COMMITTEE: 15 June 2017
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PROCEDURE SUMMARY
This policy and associated guidance aims to ensure that the Trust has an open, honest and consistent approach to communication with patients, relatives, staff or relevant others in the event of any patient safety incident, complaint or claim. The guidance describes the process for acknowledging, apologising and explaining when things go wrong and also outlines the professional, contractual and statutory Duty of Candour to which staff must comply to ensure that when cases of severe or moderate harm occur patients and relatives are fully informed and involved in the investigation process.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
Monitoring of implementation and compliance with this policy and associated procedural guideline will be undertaken by the Trust Safeguarding Group and the Mental Health and Safeguarding Committee.

<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Essex MH&amp;LD</td>
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<tr>
<td>CHS</td>
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</tbody>
</table>

The Director responsible for monitoring and reviewing this procedure is Executive Director of Mental Health & Deputy CEO
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE ON COMMUNICATING PATIENT SAFETY EVENTS ‘BEING OPEN’

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1.0 INTRODUCTION

1.1. This procedure outlines clear processes regarding the principles of “Being Open”, which involves;
   - Acknowledging, apologising and explaining when things go wrong;
   - Conducting a thorough investigation into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident recurring;
   - Providing the support for those involved to cope with the physical and psychological consequences of what happened.

1.2. For the purpose of this guidance the term incident will refer to any type of incident including a complaint, claim or a patient safety event.

1.3. Following a patient safety event staff must ensure the procedures described within CP3 Serious Incident Policy including Adverse Events are followed. When a complaint from a service user, relative and or carer is received staff must follow procedures described within CP2 and CPG2 Complaints Policy and Guidelines. Trust guidelines regarding claims are found within CP10 Negligence and Insurance Claims Policy.

2.0 FOUNDATIONS AND GENERAL CONSIDERATIONS OF THE “BEING OPEN” PROCESS

2.1. The Trust promotes a culture of openness and considers it vital to improving service user safety and the quality of healthcare systems. This procedure for encouraging open communication is reflected and supported by the ‘Ten Principles of Being Open’ as identified in the National Patient Safety Agency’s document ‘Being Open: communicating patient safety incidents with patients and their relatives/carers’ (NPSA 2009). These are included within Appendix 1.

2.2. “Being Open” when things go wrong is key to the partnership between service users and those who provide their care. See Appendix 2 for the benefits to service users their families and carer’s healthcare staff and healthcare organisations.

2.3. Staff may be unclear about who should talk to service users when things go wrong and what they should say; there is a fear that they might upset the service user, say the wrong things or make the situation worse and admit liability. These procedural guidelines set out the processes of communication with service users and raising awareness about this provides staff with the confidence to communicate effectively following an incident.
3.0. BEING OPEN AND DUTY OF CANDOUR PROCESS

3.1 The table below outlines the minimum response required for patient safety incidents by level of severity.

<table>
<thead>
<tr>
<th>Patient Safety Incident Severity Level</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>No harm/near miss/no injury</td>
<td>Patients are not usually involved in investigations and these types of incidents are outside the scope of the Being Open and Duty of Candour policy. However, it is within the scope of the healthcare professional’s accountability and responsibility to hold a discussion with the patient and/or relative, should this prove appropriate.</td>
</tr>
<tr>
<td>Minor/Low harm</td>
<td>Unless there are specific indications or the patient requests it, the communication, investigation, analysis and the implementation of changes will happen at service delivery level with the participation of those directly involved in the incident. Again it is within the scope of healthcare professional’s accountability and responsibility to hold a discussion with the patient and/or relative, in the spirit of being open and transparent, including them in all aspects of care delivery and governance.</td>
</tr>
<tr>
<td>Moderate harm, Severe harm or death</td>
<td>A higher response is required in these circumstances; Duty of Candour process as outlined in this document should be applied. Notification should be in accordance with the Trust’s incident reporting procedure. A member of the Serious Incidents Team will be available to provide support and advice during the Duty of Candour process. The patient (if possible) and their family/relatives/carers must be kept informed of investigative procedures, outcomes and action planning.</td>
</tr>
</tbody>
</table>

3.2 A flowchart that illustrates the stages of the Duty of Candour process is contained within Appendix 3.

3.3. Stage 1: Incident detection or recognition.

3.3.1 The “Being Open/Duty of Candour” process begins with recognition that a service user has suffered harm or has died as a result of a patient safety event. As soon as a patient safety event is identified the top priority is prompt and appropriate clinical care and prevention of further harm. Following a patient safety event staff must ensure the procedures described within CP3 Serious Incident Policy including Adverse Events are followed. If the patient safety event is determined as being the result of a criminal act the risk manager and the chief executive must be informed.

3.4. Stage 2: Preliminary Team discussions.

3.4.1 The Multidisciplinary team MDT, including the most senior health professional involved in the patient safety event should meet as soon as possible after the event to:

- Establish the basic clinical and other facts;
• Check recorded consent and next of kin details;
• Assess the incident to determine the level of immediate response;
• Identify who will be responsible for discussion with the service user, their family and carers. The allocation of a family liaison officer could be considered here (see Serious Incident Policy and Procedure CP3). Where ever possible a substitute or appropriate deputy should be identified to act in the nominated contact person’s absence.
• Consider the appropriate support for the service user (if any). This includes the use of a facilitator, advocate or healthcare professional.
• Identify immediate support needs for staff involved (see Workforce Wellbeing policy and procedure HRPG36);
• Ensure there is a consistent approach by all team members around the discussions with the service user, family and carers.

3.5 Stage 3: The initial “Being Open/Duty of Candour” discussion.

3.5.1. The initial discussion with the service user their family and carers should occur as soon as possible after recognition of the patient safety event. Factors to be considered include:
• Clinical condition of the service user;
• Service user preference for where the meeting takes place and which healthcare professional leads the discussion;
• Service user privacy and comfort;
• Availability of the service users family and or carers;
• Availability of key staff involved in the incident and in the “Being Open” process;
• Availability of support staff, for example a translator or independent advocate, if required;
• Arranging the meeting in a sensitive location.

3.5.2. Those identified to conduct the initial meeting should be mindful that service users, their families and carers may be anxious, angry and frustrated even when the discussion is conducted appropriately.

3.5.3. The content of the initial discussion should cover the following;
• An apology and acknowledgment of what happened.
• The facts as they are known and agreed by the MDT.
• Service Users/family/carers are to be informed that an incident investigation is being carried out and more information will become available as it progresses.
• The service user/family/carers understanding of what happened is taken into consideration, as well as any questions or concerns they may have.
• If a service user’s first language is not English then arrangements need to be made for appropriate translators to be present at the meeting. Avoidance or an explanation of clinical jargon is required at this meeting.
• An explanation of what will happen next in terms of the short through to the long term treatment plan and incident analysis findings.
• Information on likely short and long term effects of the incident (if known). Long term effect may be communicated at later meetings when more is known.
An offer of practical and emotional support for the patient, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance.

3.5.4. It is essential that the following does not occur during the discussion:
- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different individuals;
- Lack of clarity whether a patient safety incident, or the degree of harm, has occurred, is not a reason to avoid disclosure.

3.5.5. This verbal discussion, or any attempt, must be documented using the Contact Record Template in Appendix 4.

3.6. **Stage 4: Written Communication**

3.6.1. For cases of moderate, severe harm or death, written notification must follow the initial discussion outlined above. The member of staff identified to take this forward should contact the Serious Incidents Department who are responsible for supporting this stage of the process.

3.6.2. The written correspondence must be provided within 10 working days of the incident and include:
- Re-iterate the apology and acknowledgement of the incident as applicable;
- Outline the process of investigation and potential timescales;
- Provide relevant contact details;
- Invite further involvement and contact which includes an offer to share the findings of the investigation once completed and a meeting with a Senior Manager or the Family Liaison Officer to further discuss how learning will be taken forward.

3.7. **Stage 5: Follow up discussions/meetings.**

3.7.1. Follow up discussions with the service user their family and carers are an important step in the “Being Open” process. Depending on the seriousness of the incident and the timeline for the investigation there may be more than one follow-up discussion.

3.7.2. The following guidelines will assist in making the communication effective.
- The discussion occurs at the earliest practical opportunity.
- Consideration is given to the timing and location of the meeting, based on both the service user’s health and personal circumstances.
- Feedback is given on progress to date and information provided on the investigation process.
- No speculation or attribution of blame.
- A written record of the discussion is kept and shared with the Service user their family and carers if requested.
- All queries are responded to appropriately.
• If completing the process at this point the service user, their family and carers should be asked if they are satisfied with the investigation and a record of this is made in the patient’s records.
• The service user is provided contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals or an agreed substitute.

3.8. **Stage 6: Process completion.**
3.8.1. After completion of the incident investigation, feedback should take the form most acceptable to the service user/family/next of kin. Whatever method is used, the communication should include:
  • The chronology of clinical and other relevant facts;
  • Details of the service user their family and carers concerns and complaints;
  • A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the patient safety event;
  • A summary of the factors that contributed to the incident;
  • Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.

3.8.2. It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may have to be withheld or restricted; in these cases the service user must be informed of the reasons for restriction.

3.8.3. Continuity of care: When a service user has been harmed during the course of treatment and requires further therapeutic management or rehabilitation, they should be informed of the ongoing management plan. Reassurance will need to be given that they will continue to be treated according to their clinical needs, even in circumstances where there is dispute between them and the healthcare team. They should also be informed that they have the right to be treated elsewhere if they prefer.

3.8.4. Wherever possible it is advisable to send a brief communication to the patient’s GP or appropriate community care service before discharge, describing a summary of the patient safety event, the current condition of the patient and key investigations that have been carried out. It may be valuable to include the GP in one of the follow up discussions either at discharge or at a later stage.

3.8.5. Monitoring: The Risk manager or equivalent should develop a plan for monitoring investigation recommendations for system improvements and practice changes and the implementation and effectiveness of those recommendations.

3.8.6. Effective communication with staff is a vital step in ensuring that the recommended changes are fully implemented and monitored. It will also facilitate the move towards increased awareness of patient safety issues and the value of “Being Open”.

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4.0 REQUIREMENTS FOR DOCUMENTING ALL COMMUNICATION

4.1. Throughout the “Being Open” process it is important to record discussions with the patient, their family and carers as well as the incident investigation using the template in Appendix 4.

4.2 Copies of all correspondence and record forms must be saved in the patient’s file and on Datix.

4.3. In addition to the details provided in the Contact Record Template (Appendix 4), other written documentation that should be kept on record are:
   - Copies of letters sent to the service user, their family and carers; and GP;
   - Copies of any statements taken in relation to the patient safety event;
   - A copy of the incident report.
   - A copy of the original complaint (where appropriate)
   - A copy of the original claim (where appropriate)

5.0 PATIENT ISSUES TO BE CONSIDERED

5.1. Patients death.
When a patient safety event involves a service user’s death, it is even more crucial that communication is sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. A Family Liaison Officer must be appointed and contact offered. Establishing open channels of communication may also allow the family/carers to indicate if they need bereavement counselling or assistance at any stage. In any event an apology should be issued as soon as possible after the service user’s death, together with an explanation that the coroners’ process has been initiated and a realistic timeframe of when the family and carers will be provided with more information.

5.2 Patients with cognitive impairment.
Where a service user has a condition(s) that limit their ability to understand what is happening to them and they have an authorised person to act on their behalf by an enduring power of attorney, then the being open discussion should be held with them. The Mental Capacity Act (2005) Code of Practice (2007) clearly states that all those working with people who may lack capacity are legally required to “have regard to” relevant guidance in the Code of Practice. This means that all those working for Trust must be aware of the Code of Practice when acting or making decisions for someone who lacks capacity to make a decision for themselves. Clinicians will need to adhere to the Trust Policy MCP01 Mental Capacity Act 2005 Policy, to determine the most appropriate person to discuss the incident with and hold “Being Open” discussions. Where ever possible the person with cognitive difficulties should be involved.

5.3. Patients with Learning Difficulties.
Where a service user has difficulties expressing their opinions verbally and they are not cognitively impaired, they should be supported by alternative communication methods, (writing questions down etc.) and an advocate should be appointed. Appropriate advocates may include carer’s family or friends of the service user, who should focus on ensuring that the views of the service user are considered and discussed.
5.4. **Service users with different language or cultural considerations.**
The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss patient safety event information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. The service user’s family or friends should not be used to translate and the employment of professional translators is required.

5.5. **Service users with different communication needs.**
A number of service users will have particular communication difficulties, such as hearing impairment. Plans for the “Being Open” meetings should fully consider these needs.

5.6. **Children.**
The legal age of maturity for giving consent to treatment is 16 years old. At this age the young person has the right to make decisions about their treatment and their right to confidentiality is vested in them rather than their parents or guardians. It is however considered good practice to encourage children to involve their families in decision making.

The courts have stated that children who fully understand what is involved in a proposed procedure can also give consent (Gillick competence or the Fraser guidelines). Where a child is judged to have cognitive ability and the emotional maturity to understand the information provided they should be involved directly in the “Being Open” process after a patient safety incident.

The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is proved to the parents alone or in the presence of the child. In these instances the parents’ views on the issue should be sought.

5.6. **Patients who do not agree with the information provided.**
Sometimes, despite the best efforts of healthcare staff or others, the relationship between the service user, their family or carers and the nominated healthcare professional breaks down. The may not accept the information provided or may not wish to participate in the “Being Open” process. In this case, the following strategies may assist.

- Deal with the issue as soon as it emerges;
- Where appropriate and consent is in place, involve family and carers from the initial discussion stage;
- Maintain comprehensive records, using the template in Appendix 4
- Write a comprehensive list of the points that the service user; their family and carers disagree with and reassure them you will follow up these issues;
- Ensure the Line managers and the MDT are made aware of the difficulties at all times so that appropriate decision making can be made.
- Offer the service user; their family and carers another contact person with whom they may feel more comfortable with.
- Ensure the service user; their family and carers are fully aware of the formal complaints procedures;
- Use and appropriate mutually acceptable mediator to help identify the issues between the healthcare organisation and the service user and to look for mutually agreeable solution.

### 6.0 ASSOCIATED DOCUMENTS

6.1. The Trusts documents of Policy and Procedural Guidance associated with this policy are:
- CP2 and CPG2 Complaints Policy and Guidelines.
- CP10 NHS Litigation Authority Claims Policy
- CP3 Adverse Incident Reporting including Serious incident Policy
- CG28 Clinical Risk Assessment and Management Clinical Guideline
- CP53/ CPG53 Raising Concerns Policy (Whistleblowing Policy)
- HR32/ HRPG32 Disciplinary for Hospital & Community Medical and Dental Staff Policy
- MCP1/ MCPG1 Mental Capacity Act 2005 Policy
- HR36/ HRPG36 Workforce Wellbeing Service Policy

6.2. This Trust Policy and Associated Procedural Guidelines is consistent with the following professional and government bodies’ guidance:
- National Patient Safety Agency (NPSA), Being open; communicating patient safety events with patients their families and carers. 2009.
- General Medical Council, Good Medical Practice. 2001
- The Mental Capacity Act 2005.

END
Being Open Procedure CPG36: Appendix 1
Principles of Being Open

1. **Principle of acknowledgement**
   All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the patient and/or their carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all healthcare staff.

2. **Principle of truthfulness, timeliness and clarity of communication**
   Information about a patient safety incident must be given to patients, family and/or carers in a truthful and open manner by an appropriately nominated person. Patients should be provided with a step-by-step explanation of what happened, that considers their individual needs and is delivered openly. Communication should also be timely; Patients, family and/or carers should be provided with information about what happened as soon as practicable.

   It is also essential that any information given is based solely on the facts known at the time. Healthcare staff should explain that new information may emerge as an incident investigation is undertaken, and patients, family and/or carers will be kept up-to-date with the progress of an investigation.

   Patients, family and/or carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff. Medical jargon, which they may not understand, should be avoided.

3. **Principle of apology**
   Patients, family and/or carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded apology, as early as possible.
   Both verbal and written apologies should be given. The decision on which staff member should give the apology should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred.

   Verbal apologies are essential because they allow face-to-face contact between the patient and/or their carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

   It is important not to delay for any reason, including; setting up a more formal multidisciplinary *Being open* discussion with the patient and/or their carers; fear and apprehension; or lack of staff availability. Delays are likely to increase the patient’s, family’s and/or their carer’s sense of anxiety, anger or frustration. Patient and public focus groups reported that patients were more likely to seek medico-legal advice if verbal and written apologies were not delivered promptly.
4. **Principle of recognising patient and carer expectations**

Patients, family and/or carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences, in a face-to-face meeting. They should be treated sympathetically, with respect and consideration. Patients, family and/or carers should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator. When appropriate, information on accessing the Patient Advisory and Liaison Service (PALS) and other relevant support groups like Cruse Bereavement Care and Action against Medical Accidents (AvMA) should be given to the patient as soon as it is possible.

5. **Principle of professional support**

Organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Staff should feel supported throughout the incident investigation process as they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration.

To ensure a robust and consistent approach to incident investigation, healthcare organisations are advised to use the National Reporting and Learning Service (NRLS) Incident Decision Tree.

Where there is reason for the organisation to believe a member of staff has committed a punitive or criminal act, the organisation should take steps to preserve its position, and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and or representation.

6. **Principle of risk management and systems improvement**

Root cause analysis (RCA) should be used to uncover the underlying causes of a patient safety incident. Investigations should focus on improving systems of care, which will then be reviewed and audited for their effectiveness.

Every organisation’s *Being open* policy should be integrated into local incident reporting and risk management policies and processes. *Being open* is one part of an integrated approach to improving patient safety following a patient safety incident. It should be embedded in an overarching approach to risk management that includes local and national incident reporting, analysis of incidents using Root cause Analysis or Significant Event Audit, decision-making about staff accountability using the Incident Decision Tree and an organisational approach that follows the NPSA’s “Seven steps to patient safety” (2009).

7. **Principle of multidisciplinary responsibility**

Any policy on openness applies to all staff that have key roles in the patient’s care. Most healthcare provision involves multidisciplinary teams and communication with patients and/or their carers following an incident that led to harm, should reflect this. This will ensure that the *Being open* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.
To ensure multidisciplinary involvement in the *Being open* process, it is important to identify clinical, nursing and managerial leaders that will support it. Both senior managers and senior clinicians who are opinion leaders must participate in incident investigation and clinical risk management.

8. **Principle of clinical governance**

*Being open* has the support of patient safety and quality improvement processes through the clinical governance framework, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the Chief Executive to the Board to ensure these changes are implemented and their effectiveness reviewed. These findings should be disseminated to staff so that they can learn from patient safety incidents.

These actions are monitored to ensure that the implementation and effects of changes in practice following a patient safety incident. Continuous learning programmes and audits should be developed that allow healthcare organisations to learn from the patients’ experience and that monitor the implementation and effects of changes in practice following a patient safety incident.

9. **Principle of confidentiality**

Full consideration of, and respect for, should be given to the patient’s and/or their carer’s and staff's privacy and confidentiality. Details of a patient safety incident should at all times be considered confidential.

The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information.

Communications with parties outside of the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the patient and/or their carers about who will be involved in the investigation before it takes place and give them the opportunity to raise any objections.

10. **Principle of continuity of care**

Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.
## Benefits of Being Open/Duty of Candour

<table>
<thead>
<tr>
<th>Healthcare Organisations and Teams</th>
<th>Healthcare Professionals</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>A reputation of respect and trust for the organisation and/or team;</td>
<td>Confident in how to communicate effectively when things go wrong;</td>
<td>Receive a meaningful apology and explanation when things go wrong;</td>
</tr>
<tr>
<td>Reinforces a culture of openness;</td>
<td>Feel supported in apologising and explaining to patients, their families and carers;</td>
<td>Feel their concerns and distress have been acknowledged;</td>
</tr>
<tr>
<td>Potentially reduces the costs of litigation;</td>
<td>Feel satisfied that communication has been handled in the most appropriate way;</td>
<td>Reassured that the organisation will learn lessons to prevent harm happening to someone else;</td>
</tr>
<tr>
<td>Improves the patient experience and satisfaction with the organisation;</td>
<td>Improved understanding of incidents from the perspective of the patient, their family and carers;</td>
<td>Reduce the trauma felt when things go wrong;</td>
</tr>
<tr>
<td>A reputation for supporting staff when things go wrong;</td>
<td>Know that lessons learned from incidents will help prevent them happening again;</td>
<td>Have greater respect and trust for the organisation.</td>
</tr>
<tr>
<td>Embodies the NHS Constitution for England pledge to patients around <em>Being open</em>;</td>
<td>Gain a good reputation for handling a difficult situation well.</td>
<td>Reassured that they will continue to be treated according to their clinical needs.</td>
</tr>
<tr>
<td>Greater opportunity to learn when things go wrong.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Key Message** | **Detail**
---|---
**Review Incident – Verbal Duty of Candour** | You are made aware/involved in an incident has occurred involving a patient. Do you suspect there is a possibility that the patient has suffered from harm?  
**YES**  
Follow the Trust’s incident reporting procedure. Provide an apology to patient (or relatives) and explain and that initial investigation will be undertaken to find out what has occurred and that can be shared with the patient/relative.  
**NO**  
Follow the Trust’s incident reporting procedure. Provide an apology to patient (or relatives) for any aspect of poor patient experience, and provide contact details for PALS team if required  
Refer to Section 3 of the Trust’s Being Open Procedure (CPG36) for guidance on holding this discussion

**Document** | Complete the Being Open/Duty of Candour Contact Record Template available on the Trust Intranet Appendix 4: Being Open Procedure CPG36 or from the Serious Incidents Team. Include:  
- Reference incident number for tracking purposes  
- Identify who was present  
- Detail of discussion  
- Any questions/concerns raised and answers provided  
- Planned follow up

**Confirmation of Incident** | Incident will be reviewed by Executive SI Review Group

**Written Duty of Candour** | Within 10 working days of SI being declared/moderate harm recorded - written apology and details of investigation to be sent to patient/relative, with offer of sharing the investigation once it has been completed and approved by the Clinical Commissioning Group. (Letter template provided by Serious Incidents Department)  
Refer to the Trust’s Being Open Procedure (CPG36) for further guidance

**Incident investigation** | Process of investigation follows. Contact maintained as appropriate/agreed.

**Duty of Candour – sharing the report** | Follow up, offering the opportunity to review /discuss the report and provide any additional assistance required.

**Meeting** | Facilitate meeting with family to review the report, where this has been accepted, to ensure a clear understanding of the output and offer the opportunity to come back to evidence practice changes.

**Document** | Ensure output from all contact is documented/uploaded onto Datix and patient record using the Contact Record Template.

**Evidence of Compliance** | The Senior Management Team must ensure that all aspects of Duty of Candour have been evidenced and uploaded on the Datix system to meet contractual and legal responsibilities.
Being Open Procedure CPG36: Appendix 4
Contact Record Template

**Being Open / Duty of Candour Contact Record**

**Description of contact:**

- Telephone [ ]
- Face-to-Face [ ]

Incident/Datix Number: ________________________________

Name of person(s) contacted/present: ________________________________

Relationship of person(s) to the patient: ________________________________

Date of contact: ____________  Time of contact: ____________

**Brief overview of conversation:**


**Please highlight any concerns that were discussed by the family:**


**Planned Follow up contact:**


FLO/Staff Name: ________________________________  Date: ____________

Please save a record of this in the patient's file and upload to the Datix record for the case/ email to serious.incident@eput.nhs.uk
CONFIDENTIALITY PROCEDURE

POLICY REFERENCE NUMBER: CPG59b
VERSION NUMBER: 5
KEY CHANGES FROM PREVIOUS VERSION: Made compliant with GDPR
AUTHOR: [Redacted]
CONSULTATION GROUPS: IGSSC
IMPLEMENTATION DATE: MAY 2018
AMENDMENT DATE(S): March 2018; August 18
LAST REVIEW DATE: N/A
NEXT REVIEW DATE: March 2020
APPROVAL BY IGSSC COMMITTEE: IGSSC July 2018

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POLICY SUMMARY

The purpose of this Procedure is to ensure that staff understand their responsibilities regarding the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (“DPA”), thereby ensuring that lawful and correct processing of personal information is a key part of building and maintaining trust and confidence in Essex Partnership University NHS Foundation Trust (the “Trust”).

The Trust monitors the implementation of and compliance with this policy in the following ways:

The Information Governance Steering Sub Committee and Quality Committee will have overall responsibility for overseeing the implementation of this policy and its associated procedural guidelines, taking forward any action relating to information governance/security within the Trust. The Information Service Management Team and Information Governance Steering Sub-Committee will be responsible for overseeing the operational implementation of this policy and its associated procedures, as appropriate.

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The Director responsible for monitoring and reviewing this policy is
Chief Finance Officer
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CONFIDENTIALITY PROCEDURE

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CONFIDENTIALITY PROCEDURE

Assurance Statement
The purpose of this Procedure is to ensure that all staff understand their responsibilities regarding confidentiality of data, thereby ensuring that lawful and correct processing of personal information is a key part of building and maintaining trust and confidence in Essex Partnership University NHS Foundation Trust (the “Trust”).

1.0 INTRODUCTION

1.1 All legislation relevant to an individual’s right to confidentiality and the ways in which that can be achieved and maintained are paramount to the Trust. This relates to roles that are reliant upon computer systems such as: service user administration, payment, purchasing, invoicing and treatment planning. Legislation also regulates the use of manual records relating to service users, staff and others whose information may be held within the Trust.

1.2 Patients expect that information about them will be treated as confidential and are given that assurance in the Patient Charter (1997), ‘everyone working for the NHS is under a legal duty to keep your records confidential.’ Patients who feel that confidence has been breached may issue a complaint under the NHS complaints procedure or they could take legal action.

2.0 CONFIDENTIALITY GUIDANCE SECTION

2.1 Access to Confidential Information

2.1.1 It is the Trust’s responsibility to protect the rights of patients, staff and individuals, who expect confidentiality of personal information held and processed by the Trust.

2.1.2 The Trust expects that all employees ensure that all confidential information attained in the course of their work is treated in strict confidence, and is in addition to responsibilities associated with individual professional codes of practice.

2.1.3 It will be the individual responsibility of all service managers to keep all confidential information safe and secure and identify measures within their own area of responsibility, which limit access to information to authorised personnel only.

2.1.4 All information obtained by Trust employees in the course of their work may only be disclosed to third parties with the express consent of the individual and as authorised by the Trust, or where required by order of a court or where
it can be justified in the wider public interest under the General Data Protection Regulation.

2.1.5 Any decision to disclose confidential information about a patient's treatment or care should always, in the first instance, be brought to the attention of the patient's Responsible Medical Officer. It will be their responsibility to assess whether disclosure of information is in the interests of the patient and liaison with the person in charge, decide whether the patient is able to give informed consent. Any decision relating to the disclosure of personal data about a patient to a third party, whether that disclosure is verbal or written, should be recorded in the patient's health records.

2.1.6 If any doubt exists concerning the nature of information being classified as confidential, Trust employees are advised to treat the information as confidential and seek clarification from their service manager or the Trust’s Data Protection Officer, before disclosing information.

2.1.7 Any disclosure of confidential information, not in accordance with the terms of these guidelines or its associated policy, will be viewed as a serious breach of discipline and will be dealt with under the Trust’s disciplinary rules and procedures.

2.2 Requests for Confidential Information

2.2.1 All requests for confidential information concerning a patient, staff or other individual, including requests from third parties, must be passed to the appropriate service manager, who will be responsible dealing with the matter, adhering to the guidelines set out within this policy. Further clarification and advice may be sought from the Trust’s Information Governance Team or Data Protection Officer.

3.0 CALDICOTT PRINCIPLES

3.1 The Caldicott Principles were developed in 1997 following a review of how patient information was handled across the NHS. The Review Panel was chaired by Dame Fiona Caldicott and it set out six Principles that organisations should follow to ensure that information that can identify a patient is protected and only used when it is appropriate to do so. Since then, when deciding whether they needed to use information that would identify an individual, an organisation should use the Principles as a test. The Principles were extended to adult social care records in 2000.
The Caldicott Principles (revised 2013) are:

**Principle 1 - Justify the purpose(s) for using confidential information**

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

**Principle 2 - Don’t use personal confidential data unless it is absolutely necessary**

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

**Principle 3 - Use the minimum necessary personal confidential data**

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

**Principle 4 - Access to personal confidential data should be on a strict need-to-know basis**

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

**Principle 5 - Everyone with access to personal confidential data should be aware of their responsibilities**

Action should be taken to ensure that those handling personal confidential data - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

**Principle 6 - Comply with the law**

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

**Principle 7 - The duty to share information can be as important as the duty to protect patient confidentiality (added in 2013)**

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.
4.0 THIRD PARTY REQUESTS FOR CONFIDENTIAL INFORMATION

4.1 In cases where requests for confidential information about a patient are made from a third party, the patient will be informed unless it can be demonstrated by the patient’s Responsible Medical Officer and / or the Trust’s nominated representatives that it is not in the interests of the patient to do so.

4.2 It will be the normal practice of designated Trust employees to record requests for confidential information from third parties and this should be recorded in the patient’s health records along with the actions taken as a result of the request.

5.0 REPORTING BREACHES OF CONFIDENTIALITY

5.1 Any potential or actual breaches of confidentiality must be reported to the line manager immediately.

5.2 The Information Governance Team should be notified and a DATIX incident report completed. The Information Governance Team will be able to give advice on how to rectify / reduce the impact of the breach.

(Note: refer to Information Security Incident Reporting Procedure (CPG50d)

6.0 TRAINING AND SUPPORT

6.1 The Trust will maintain a high level of information governance / security awareness within the organisation by ensuring that all staff receive appropriate, job relevant, training. This may include:

- Team Briefings
- Publications via Trust Today, Viewpoint and others
- On-Line training via the NHS Digital website.
- Training via the Trust’s e-learning programme (OLM)
- It will be a mandatory requirement for all staff involved in any type of information governance / security breach to complete training, irrespective of previous sessions.
- Training will be done in accordance with the Induction and Mandatory Training Policy (HR21).

7.0 MONITORING AND REVIEW

7.1 This procedural guideline will be reviewed in line with its associated policy document and / or whenever changes in legislation, guidance from Department of Health, the NHS Executive or the Information Commissioner’s Office require.
7.2 The Chief Finance Officer is responsible (as the Trust SIRO) with the Caldicott Guardian for the implementation of these procedural guidelines and its associated policy document.
INDUCTION/ MANDATORY TRAINING POLICY

POLICY REFERENCE NUMBER: HR21
VERSION NUMBER: 1
REPLACES SEPT DOCUMENT HR21 v5
REPLACES NEP DOCUMENT Not applicable
AUTHOR: Workforce Development Lead
CONSULTATION GROUPS: Workforce Planning and Organisational Development Group/Workforce Development Strategy Group Clinical Governance and Quality SMT/Committee Joint Consultative Committee Clinical Board Health Safety and Security Committee/Risk Management Committee Mandatory Training Leads Medical Director ESR Leads HR Workstream

IMPLEMENTATION DATE: April 2017
AMENDMENT DATE(S): January 2018
LAST REVIEW DATE: January 2018
NEXT REVIEW DATE: April 2020
APPROVAL BY TRUST BOARD January 2018

POLICY SUMMARY
The policy sets out the responsibilities for the delivery, completion and monitoring of corporate induction, local induction and mandatory training. It covers timescales, notifications and the appendices cover the required components. It applies to all staff, including Bank and Agency workers.

The Trust monitors the implementation of and compliance with this policy in the following ways:
Through monthly monitoring of compliance figures and regular internal audits

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INDUCTION/MANDATORY TRAINING POLICY

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

INDUCTION/MANDATORY TRAINING POLICY

Assurance Statement
The purpose of this policy is to ensure that the Trust's workforce receive the required mandatory training components as set out and agreed by the organisation. This policy also covers corporate induction training for new starters and local workplace induction. This policy will provide a systematic approach to the structure and monitoring of induction and mandatory training. The curriculum is based on relevant statutory guidelines and regulations.

The purpose of this policy is to reinforce the Values of the Trust in order to deliver our Core Principles in line with the Clinical / Corporate Governance agenda. The management and staff of EPUT agree to follow this policy and the associated procedural guidelines for staff induction and mandatory training requirements.

1.0 INTRODUCTION

1.1 The Trust recognises the importance of Corporate Induction, and Mandatory Training to assist staff in maintaining a safe working environment and ensuring that our service users receive a quality service.

1.2 Induction and Mandatory Training is a dual responsibility shared by the staff member and their line manager. The individual’s responsibility is to ensure that they attend mandatory training; the manager’s responsibility is to enable this to happen. The role of the Workforce Development and Training Department is to assist in this process by providing tools such as checklists, organising courses, and monitoring and reporting on compliance.

1.3 The Trust is committed to releasing staff from duties to attend their Induction/Mandatory Training requirements.

1.4 All Trust staff and managers will have access to data to enable them to check their individual and their team’s compliance.

1.5 Mandatory Training updates for existing staff must be attended according to the timings specified in the Training Needs Analysis chart (Appendix 1) of the procedural guidelines. Some updates will be delivered through e-learning packages. Compliance targets have been set for all Mandatory Training: 90% Safeguarding, 90% TASI Training, 90% Inpatient Fire safety, 85% all other Mandatory Training.
2.0 DUTIES

2.1 The Mandatory Training Administrators will pre-book all Mandatory Training for all new starters, and will also send out reminders for Mandatory Training updates. Medical staff can contact the Medical Education Manager for assistance.

2.2 Staff and managers are responsible for ensuring compliance timescales are adhered to, when training is requested.

2.3 It is the responsibility of the Mandatory Training Administrators to inform of any capacity issues that arise when booking staff on courses.

2.4 Human Resources will be responsible for notifying the Mandatory Training Administrators of all new starters. Human Resources and the Mandatory Training Administrators will work together to send pre-booked training dates to all new starters and their managers. All mandatory training must be completed within the first 12 weeks of employment; extenuating circumstances can be taken into consideration.

2.5 The Mandatory Training Administrators will be responsible for providing the statistics relating to Mandatory Practice Training by the 5th working day of each month.

2.5.1 Staff who do not complete a Mandatory course will receive notification from the Mandatory Training Administrators, informing them and their managers of their non-compliance with mandatory training. It is the Line Manager’s responsibility to ensure training is re-booked.

2.5.2 Action will be taken by Workforce Development and Training to notify relevant corporate departments about repeated DNAs.

2.6 Line Managers will ensure that staff attend the appropriate Mandatory Training & update courses relevant to their area of work, as set out within this guidance and the training needs analysis (Appendix 1).

2.7 Line Managers will monitor the Mandatory requirements of the staff working within their areas through supervision/appraisal and the compliance lists.

2.8 The individual is responsible for the completion of their identified Mandatory Training requirements and the subsequent updating of their skills in accordance with this guidance.

2.9 The individual is responsible for ensuring they sign any attendance register at face to face Mandatory Training sessions.

2.10 All Staff will also complete the local workplace induction in accordance with procedural guidelines.
2.11 The process of delivering and monitoring Corporate Induction, Mandatory Training will be coordinated by the Workforce Development and Training Department.

2.12 The Workforce Development and Training Department is responsible for the annual review of mandatory training and the updating of the appendices. When amendments are made all staff will be notified.

2.13 All staff should complete a course evaluation form.

2.14 The Workforce Development and Training Department is responsible for ensuring that all Mandatory training is provided by suitably qualified staff. This will include the validation of credentials of all trainers prior to engaging them to deliver mandatory training.

2.15 All external providers of Mandatory training must be registered on the database held by Workforce Development and Training.

2.16 Managers are responsible for creating an appropriate risk assessment for any staff who are unable to complete any mandatory training requirements. For on-going issues, the risk assessment should be repeated after 6 months and a decision taken as to whether this course should be removed from their curriculum.

3.0 DEFINITIONS

3.1 Mandatory

Mandatory Training can be defined as a statutory or legal obligation. It is required in order for the Trust to meet Health and Safety legislation and other relevant guidance. Additional training needs are determined by the outcome of risk assessments for the relevant staff groups (Appendix 1).

3.2 Corporate Induction

This is a three part process which consists of a face to face induction to the Trust; this is followed by an e-learning induction programme and local workplace induction. Staff must complete all parts of this process within the first six weeks of employment within the Trust.

3.3 Local workplace induction

Permanent staff – The local workplace induction (Appendix 2) is a checklist designed to introduce the new member of staff to their workplace. Completion of the checklist can take up to a week and incorporates health and safety guidance, communication systems and local policies and procedures. Medical staff need to complete their checklist.

Locum, bank and agency staff – The local workplace induction checklist (Appendix 3) is intended to take between 15 and 30 minutes to complete and must be completed at the beginning of the shift. It includes orientation to the workplace and general responsibilities and duties, including those under
health and safety guidance. It should be completed if 3 months or more has elapsed since the individual worked at that base.

3.4 Junior Doctors assessment of competency

Assessment of competency checklists must be completed for all junior doctors within the first week of each new placement and before completing their first on-call. (Appendix 4). This checklist will record the acquired skills and competence of the doctor to date. Learning needs must be identified by the supervisor and junior doctor.

4.0 PRINCIPLES

4.1 Mandatory training requirements will be linked to service needs.

4.2 All training within the Trust is provided in line with the Policy on Equality and Diversity. Where an individual member of staff has been assessed by Occupational Health as having a disability which impacts on their ability to complete Mandatory Training, reasonable adjustments will be made in line with the Trust policy on Disability in Employment. If any member of staff has additional learning needs to enable them to complete training they should contact the Workforce Development and Training Department for help and advice.

4.3 Exemption from a Mandatory training component on any grounds, whether this is temporary or long term, will need to be discussed with the line manager and agreed with the Service Director. Exemption will not be detrimental to present or future employment (in line with the Sickness Absence Policy and the Equality & Diversity Policy).

4.4 If staff members do not attend the required Induction / Mandatory training requirements (other than where an agreement has been made with the Line Manager and Service Director) as set out within this policy, this may be addressed under the Trust’s Conduct and Capability Policy.

4.5 Applications for study leave or extended study leave should not be submitted or authorised by line managers unless all Mandatory Training is up-to-date.

4.5.1 Where a member of staff is unable to attend an element of Mandatory Training, due to staffing or work related issues within the clinical area, this will always be counted as a DNA if it falls within two weeks of the course commencement. Only the Director of the service can give exemption to a member of staff, if the staff member's health status, (e.g. pregnancy) precludes them from completing an element of Mandatory Training.

4.5.2 A manager will not prevent a member of staff from attending Mandatory Training courses unless in exceptional circumstances. If this does occur the manager is required to submit written rational for this action to their Director. The individual has the right to seek advice from the Human Resources Directorate or their union / professional body.
Applications by that individual for study / extended study leave will be considered as per normal providing written explanation is submitted.

4.6 This policy should be read in conjunction with the Training and Study Leave Policy.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 The effectiveness of the Policy and these Procedural Guidelines will be monitored by Workforce, Development and Training. Monitoring will include the production of monthly training reports including statistical information on compliance, DNAs, cancellations etc. to circulate to the appropriate committees within the Trust. Regular audits will also be undertaken.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

- Health and Safety at Work Act (1974)
- The Management of Health and Safety at Work Regulations 1999
- Resuscitation Council Guidelines
- Equality Act 2010
- Manual Handling Operations 1992
- Food Hygiene
- Fire Safety
- Information Governance and Data Protection Act
- Freedom of Information Act
- NICE Guidance
- NMC Code of Practice
- DH Guidance on Restrictive Practice
- GMC Code of Practice
- HCPC Code of Practice
- Mental Capacity Act
- Display Screen Regulations 1992
- Corporate Manslaughter Act 2007
- Best practice in managing risk
- Intercollegiate Guidance in Safeguarding Adults 2016
- Children’s Act 1989 and 2004
- Domestic Abuse and Victim of Crime Act 2003
- Sex Offenders Act 2003
- Care Act 2014
- Human Rights Act 1998
- Deprivation of Liberty Safeguards 2007
- Time Back Guidance

This is not an exhaustive list and other regulations and guidance have informed the policy.
7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

This policy should be read in conjunction with:

- Health & Safety Policy
- Equality & Diversity Policy
- Training and Study Leave Policy
- Supervision and Appraisal Policy
- KSF Guidelines
- Conduct and Capability Policy
- Manual Handling Policy
- Rapid tranquilisation policy
- Restrictive Practices Policy
- Clinical Risk Assessment and Management Policy
- Cardio-Pulmonary Resuscitation (CPR)
- Infection Control
- Food hygiene
- Fire policy
- Supervision of Junior Doctors
- Medicine Management Policy
- Safeguarding Adults and Vulnerable Children
- Disability in Employment

END
## MANDATORY TRAINING NEEDS ANALYSIS

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<tr>
<th>STATUTORY / MANDATORY TRAINING</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
<th>DURATION</th>
<th>UPDATE INTERVAL</th>
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<td><strong>Clinical</strong></td>
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<tr>
<td>Care Program Approach (Mental</td>
<td>Clinical: Care</td>
<td>All new starters to the</td>
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<td>Non-clinical: Complaints handling</td>
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<td>Clinical &amp; Non Clinical</td>
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<td>E-learning (to be completed within 6 weeks of start date)</td>
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<td>Depending on course</td>
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### MANDATORY TRAINING NEEDS ANALYSIS

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<th>UPDATE INTERVAL</th>
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<tbody>
<tr>
<td><strong>Basic Life Support</strong> (CSTF Adult Resuscitation Levels 1 and 2)</td>
<td>All inpatient nursing staff</td>
<td>Direct</td>
<td>3.5 hours</td>
<td>Annual</td>
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<td><strong>Basic Life Support</strong> (Mental Health &amp; Community staff) CSTF Adult Resuscitation Level 1 &amp; 2</td>
<td>Mental Health - All clinical staff, psychology, allied health professionals, social care staff, medical staff and pharmacy staff. All OT staff with the exemption of head OT’s Front line administration staff with daily service user contact based on risk assessment.</td>
<td>Direct</td>
<td>3.5 hours</td>
<td>Annual</td>
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<tr>
<td><strong>Enhanced Emergency Skills</strong> (Mental Health) CSTF (Adult Resuscitation Level 3) (Junior doctors on rotation of less than 6 months undertake basic life support incorporating AED and Anaphylaxis)</td>
<td>All Mental Health qualified in-patient nursing and medical staff</td>
<td>Direct</td>
<td>Initial 2 days Update 1 day</td>
<td>Annual</td>
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<tr>
<td><strong>Anaphylaxis and AED</strong> CSTF Adult Resuscitation Level 2</td>
<td>Identified Community Health Care Service staff plus medical staff on rotation of 6 months or less</td>
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<td>½ hour</td>
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## Mandatory Training Needs Analysis

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<th>Staff Category</th>
<th>Delivery Method</th>
<th>Duration</th>
<th>Update Interval</th>
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<tr>
<td><strong>Restrictive Practice</strong></td>
<td>All inpatient nursing staff (Acute admission staff, Acute / Challenging behaviour staff, Learning disability staff, Intensive Care unit staff, Secure / Forensic services) Occupational therapists identified through risk assessment. Any other staff where it is identified from a risk assessment or contractual requirement.</td>
<td>Direct</td>
<td>5 days initial and 3 day update (with Search to be added to day 3 or to be undertaken on the wards – local variances apply)</td>
<td>Annual</td>
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<td><strong>Physical Interventions (TASI) – Initial and Update</strong></td>
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<tr>
<td>Includes breakaways, restraint BLS update, SMS – PSTS, emergency responses</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Conflict Resolution</strong> (Community Health Care Services)</td>
<td>All front line staff in community health care services (all staff whose work involves entering areas where service users have unrestricted access)</td>
<td>Direct</td>
<td>Initial as part of Induction 3.5hrs update</td>
<td>Three yearly</td>
</tr>
<tr>
<td>anticipation, de-escalation and coping with disturbed / violent behaviour</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>CSTF NHS Conflict Resolution</td>
<td></td>
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</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Restrictive Practices contd</td>
<td>Mental Health Community based nursing staff, psychology, allied health professionals, social care staff, medical staff and pharmacy staff. All OT staff with the exemption of head OT's. Front line administration staff with daily service user contact based on risk assessment.</td>
<td>Direct</td>
<td>1 day</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Personal Safety Level 1</strong> (Mental Health)</td>
<td>anticipation, de-escalation and coping with disturbed / violent behaviour, practical skills &amp; CPR update</td>
<td>Direct</td>
<td>1 day</td>
<td></td>
</tr>
<tr>
<td><strong>Personal Safety – Level 2</strong> (Mental Health)</td>
<td>anticipation, de-escalation and coping with disturbed / violent behaviour, practical skills</td>
<td>Direct</td>
<td>1 day</td>
<td>Every 18 months</td>
</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
</tr>
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<td>------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>FIT FOR WORK E-Learning (CSTF Health Safety &amp; Welfare)</strong></td>
<td>All Trust staff</td>
<td>E-learning</td>
<td></td>
<td>Annual</td>
</tr>
<tr>
<td>CSTF (Manual Handling Level 1)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Ergonomics at work</td>
<td></td>
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<tr>
<td>• Display screen equipment</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Manual handling (non-patient handling)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Work related stress</td>
<td></td>
<td></td>
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<tr>
<td>• Hazardous substances</td>
<td></td>
<td></td>
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<tr>
<td>• Reporting Procedure</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Slips Trips and Falls (low risk areas)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Food Hygiene</strong></td>
<td>Catering staff</td>
<td>Direct</td>
<td>Half day</td>
<td>Three Yearly</td>
</tr>
<tr>
<td>Housekeepers In patient nursing staff All occupational therapists and identified administration &amp; domestic staff who handle food</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fire Safety Training (General)</strong></td>
<td>All non-inpatient staff NOT based at inpatient units</td>
<td>E-learning / face to face (Direct with cascade trainer)</td>
<td>E-Learning, Direct 1 hour</td>
<td>Annual alternate years</td>
</tr>
<tr>
<td>CSTF Fire Safety</td>
<td></td>
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</tr>
<tr>
<td><strong>Fire Safety Training (Inpatient Services)</strong></td>
<td>All in-patient nursing staff</td>
<td>Direct face to face</td>
<td>Direct 2 hours</td>
<td>Annual</td>
</tr>
<tr>
<td>CSTF Fire Safety</td>
<td></td>
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</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
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</tr>
<tr>
<td><strong>Infection Prevention, Control &amp; Hand Hygiene</strong></td>
<td><em>Relevant staff, contractors and other persons, whose normal duties are directly or indirectly concerned with providing care i.e.: Nursing staff, medical staff, occupational therapy staff, social care staff, and psychologists on in-patient services, physiotherapists, and pharmacy staff. Catering staff, domestics and housekeeping staff (including external contractors) and front line administration staff (Staff who have direct service user contact e.g.. reception staff based on risk assessment).</em></td>
<td>E-learning</td>
<td>E-learning</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Infection Prevention and Control (Mental Health)</strong></td>
<td></td>
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<tr>
<td>To include:</td>
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<tr>
<td>- Inoculation (Sharps) training</td>
<td></td>
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<tr>
<td>- Hand hygiene</td>
<td></td>
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</tr>
<tr>
<td><strong>CSTF Infection Prevention and Control Level 2</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Infection Prevention and Control</strong> (Community Health Care services)</td>
<td>All clinical staff, support, and domestic/cleaning staff, including front line administration staff that has direct service user contact. ( e.g. reception staff based on risk assessment.)</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>CSTF Infection Prevention and Control Level 2</strong></td>
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</tbody>
</table>
## Mandatory Training Needs Analysis

### Manual Handling Training Guide

The below is a guide and managers will need to assess if staff require a greater level of training based upon risk assessment than the level set in the analysis. Following risk assessment managers can alternate staff training levels in liaison with the training team. E.G. alternating years staff can undertake level one 2 and 3.

<table>
<thead>
<tr>
<th>Manual handling</th>
<th>Staff Category</th>
<th>Delivery Method</th>
<th>Duration</th>
<th>Update Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction CSTF Manual Handling Level 2</td>
<td>All new starters to the Trust in a clinical role.</td>
<td>Face to face</td>
<td>1 day</td>
<td>Annual</td>
</tr>
</tbody>
</table>

### Manual Handling

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Community services where no manual handling is part of the role of the practitioners.</th>
<th>Community staff</th>
<th>OLM (E-learning &amp; podcasts.)</th>
<th>E-learning</th>
<th>Annual</th>
</tr>
</thead>
</table>

| CSTF Manual Handling Level 1 | . | Forensics, Adult acute mental health and CAMHS services. | OLM (E-learning & podcasts) | E-learning and practical competency assessment | Annual |

<p>| Level 2 | This level covers staff areas where Link workers are in place to cover practical competencies and staff are required to update theory by E-learning to complete their Training. | Forensics, Adult acute mental health and CAMHS services. | OLM (E-learning &amp; podcasts) | E-learning and practical competency assessment | Annual |</p>
<table>
<thead>
<tr>
<th>STATUTORY / MANDATORY TRAINING</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
<th>DURATION</th>
<th>UPDATE INTERVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling</td>
<td></td>
<td>Face to Face Back care and hoisting theory and practical combined NO LINK WORKERS IN AREA OR TEAM</td>
<td>0.5 day</td>
<td>Annual</td>
</tr>
<tr>
<td>Level 3</td>
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<tr>
<td>This level covers all areas where manual handling is a component of the staff’s member’s role and there are no link workers in the team or practice areas. CSTF Manual Handling Level 2</td>
<td>Older adult services Learning Disability services Inpatient community services</td>
<td>Face to face</td>
<td>4 days</td>
<td>Once</td>
</tr>
<tr>
<td>Manual Handling - Link worker induction program</td>
<td>For any clinical staff member who wishes to become a link worker (sponsored by their manager) with a willingness to cascade knowledge and training to colleagues. CSTF Manual Handling Level 2</td>
<td>Face to face</td>
<td>2 days</td>
<td>Annual</td>
</tr>
<tr>
<td>4 day course, covering theory, practical and assessment skills. CSTF Manual Handling Level 2</td>
<td>Trained link workers</td>
<td>Face to face</td>
<td>1 day</td>
<td>Annual</td>
</tr>
<tr>
<td>Manual Handling - Link worker update</td>
<td>OT / PHYSIO / PAEDIATRIC TEAMS</td>
<td>Face to face in-house or through CPD courses</td>
<td>1 day</td>
<td>Annual</td>
</tr>
<tr>
<td>CSTF Manual Handling Level 2</td>
<td>Non clinical staff who do not provide direct care to service users High risk areas will increase the numbers of key workers to ensure safe systems of work are in place. CSTF Manual Handling Level 1</td>
<td>E-learning (Part of fit for work)</td>
<td>E-Learning</td>
<td>Annual</td>
</tr>
<tr>
<td>MANDATORY TRAINING NEEDS ANALYSIS</td>
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<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
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<tr>
<td>OLM – 000 Preventing Falls in Hospital</td>
<td>All older peoples inpatient nursing and therapy staff</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Slips, Trips and Falls</td>
<td>All adult inpatient nursing staff</td>
<td>E-learning</td>
<td></td>
<td>Three yearly</td>
</tr>
<tr>
<td></td>
<td>All inpatient support workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Fall reducing inpatient falls risk and post falls management.</td>
<td>All Junior doctors and staff grade doctors</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Incident, complaint and claim investigation training</td>
<td>All staff</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Once No update requirement.</td>
</tr>
<tr>
<td>Risk awareness training for Senior Managers</td>
<td>Executive team, Executive Team direct reports and Trust board</td>
<td>E-learning or Direct</td>
<td>E-learning or direct</td>
<td>Annually</td>
</tr>
<tr>
<td>Clinical Risk (Qualified Mental Health staff and initial course for support staff)</td>
<td>Nursing staff, medical staff, social care staff, all qualified occupational therapy staff and qualified allied health professionals</td>
<td>Direct / E learning</td>
<td>1 day</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Clinical Risk (Unqualified Mental Health staff)</td>
<td>Nursing staff, social care support staff, all occupational therapy support staff and unqualified allied health professionals These staff will complete the qualified course initially then update via this course.</td>
<td>Direct / E-Learning</td>
<td>3.5 hours</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Care Program Approach (Mental Health Services)</td>
<td>All staff who undertake the role of Care Co-ordinator.</td>
<td>Direct/E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
</tbody>
</table>
### MANDATORY TRAINING NEEDS ANALYSIS

<table>
<thead>
<tr>
<th>STATUTORY / MANDATORY TRAINING</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
<th>DURATION</th>
<th>UPDATE INTERVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Certificate</td>
<td>All Health or Social Care Support workers new to the Trust who can achieve the competencies as part of their role.</td>
<td>Work based learning</td>
<td>Probationary Period</td>
<td>N/A</td>
</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
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<td>----------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Safeguarding Adults and Children</strong></td>
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</tr>
<tr>
<td><strong>Safeguarding Adult and Children Level 1</strong></td>
<td></td>
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</tr>
<tr>
<td>CSTF Safeguarding Adult Level 1</td>
<td>Level 1 Non-clinical staff</td>
<td>E-learning</td>
<td>1 hour</td>
<td>3 yearly</td>
</tr>
<tr>
<td>CSTF Safeguarding Children Level 1</td>
<td></td>
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</tr>
<tr>
<td><strong>Safeguarding Adults and Children Level 2</strong></td>
<td></td>
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</tr>
<tr>
<td>CSTF Safeguarding Adults Level2</td>
<td>Group 2</td>
<td>E-learning</td>
<td>Level 2</td>
<td>3 yearly</td>
</tr>
<tr>
<td>CSTF Safeguarding Children level 2</td>
<td>All clinical staff</td>
<td></td>
<td>(includes level 1)</td>
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<td></td>
<td></td>
<td></td>
<td>(2 hrs)</td>
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</tbody>
</table>
## MANDATORY TRAINING NEEDS ANALYSIS

<table>
<thead>
<tr>
<th>STATUTORY / MANDATORY TRAINING</th>
<th>STAFF CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children level 3</td>
<td>Health Visitors, School Nurses, Community staff nurses 0-19 team service, Locality Leads for Children (Bedford), Locality Managers for Children, Heads of service for Children’s Community Services, Team leaders in Children’s Community Services, Modern Matrons for Children’s Community Services, Family Nurse Practitioners, Paediatric Nurses and Doctors, Registered Paediatrics allied health professionals, CAMHS Registered staff and doctors, Psychiatrists working with adults (NOT older people), Learning Disability, Community Drug &amp; Alcohol (STARS) registered staff, Psychiatric Nurses Band 5-8, Working with Adults (NOT older people) Community Social Workers (working with Adults), Managers and team leaders in IAPT, Safeguarding Practitioners, Sexual Health staff, e.g. senior nurses for CASH, Clinical Nurse Specialists for CASH, modern matrons for CASH, Chlamydia screening coordinator and Nurse practitioner for Chlamydia. Lead Immunisation nurses, Lead nursery nurses</td>
</tr>
<tr>
<td>CSTF Safeguarding Children Level 3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DELIVERY METHOD</th>
<th>DURATION</th>
<th>UPDATE INTERVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face. Interagency-agency Local Safeguarding Children Board training programmes. Conferences. Workshops.</td>
<td>6 hours One day</td>
<td>3 yearly</td>
</tr>
</tbody>
</table>
## MANDATORY TRAINING NEEDS ANALYSIS

<table>
<thead>
<tr>
<th>STATUTORY / MANDATORY TRAINING</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
<th>DURATION</th>
<th>UPDATE INTERVAL</th>
</tr>
</thead>
</table>
| **Safeguarding Adults Level 3** | **HALF DAY (Awareness)**  
Community Health Services  
All clinical nurses CMS Doctors  
Nurses (including community / inpatient/ outpatient / specialist nurses / community matrons / case managers).  
Occupational Therapists  
Podiatrists  
Physiotherapists  
Dietitian  
Psychologist  
Speech and language Therapists  
CAMHS staff band 6-8  
Safeguarding children’s teams  
Team leaders / managers IAPT | In-house training.  
Local Safeguarding Adult Boards (LSAB)  
Training programmes.  
Conferences.  
Workshops | Half Day  
3 Hours | Three yearly |
| **FULL DAY Investigations** | **FULL DAY (investigations)**  
Mental Health  
All Psychiatrists. All Nurses Band 5-8c working in community and inpatients areas for adults and older peoples services for mental health. Learning Disability Inpatient areas and Drug & Alcohol services (STARS).  
Head of OT, Social Workers, Manager and Team Leader of IAPT  
Managers of AHP, MCA DoLS, Lead | | One day  
6 Hours |
## MANDATORY TRAINING NEEDS ANALYSIS

<table>
<thead>
<tr>
<th>STATUTORY / MANDATORY TRAINING</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
<th>DURATION</th>
<th>UPDATE INTERVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 4,5,6</td>
<td>Group 4/5/6/ Named &amp; Designated Nurses, Doctors and Safeguarding Specialists and Practitioners</td>
<td>Interagency-agency LSCB programmes Conferences Workshops</td>
<td>24 hours over three years</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Learning Disabilities and Autism</td>
<td>All clinical and front line staff</td>
<td>E-learning</td>
<td>45 minutes</td>
<td>Three yearly</td>
</tr>
</tbody>
</table>
## Mandatory Training Needs Analysis

<table>
<thead>
<tr>
<th>Statutory / Mandatory Training</th>
<th>Staff Category</th>
<th>Delivery Method</th>
<th>Duration</th>
<th>Update Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENT (WRAP)</td>
<td>Health Visitors, School Nurses, Community staff nurses 0-19 team service, Locality Leads for Children (Bedford), Locality Managers for Children, Heads of service for Children's Community Services, Team leaders in Children's Community Services, Modern Matrons for Children's Community Services, Family Nurse Practitioners, Paediatric Nurses and Doctors, Registered Paediatrics allied health professionals, CAMHS Registered staff and doctors, Psychiatrists working with adults (NOT older people), Learning Disability, Community Drug &amp; Alcohol (STARS) registered staff, Psychiatric Nurses Band 5-8, Working with Adults (NOT older people) Community Social Workers (working with Adults), Managers and team leaders in IAPT, Safeguarding Practitioners, Sexual Health staff (e.g. senior nurses for CASH, Clinical Nurse Specialists for CASH, modern matrons for CASH, Chlamydia screening coordinator and Nurse practitioner for Chlamydia, Lead Immunisation nurses, Lead nursery nurses)</td>
<td>Face to face</td>
<td>1-1.5 hours</td>
<td>Once only</td>
</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
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</tr>
<tr>
<td>Mental Health Act Training (NOT FOR THE SAFEGUARDING TEAM)</td>
<td>All clinical staff within Mental Health services including the Medical Directorate Non clinical staff working as part of the Mental Health Act Office team</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>All clinical staff band 5 - 7 working with adults or older people in Community Health Services Community Mental Health, LD and STARS. AHP band 5-7, Social Workers</td>
<td>E-learning</td>
<td>1 hour</td>
<td>Once no update requirement</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>Inpatient Areas Only All inpatient nurses, working with adults and older people Band 5 -8 in Community Health Services, Mental Health and LD (Inpatient only areas) All doctors working in Mental Health, Community Health and Learning Disability Services</td>
<td>Face to face</td>
<td>3 hours</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Dual Diagnosis (Mental Health)</td>
<td>All Qualified Mental Health Nursing and Medical Staff</td>
<td>(A) E-learning</td>
<td>E-learning</td>
<td>Once No update requirement.</td>
</tr>
<tr>
<td>Medicines Management (Mental Health staff) with Rapid Tranquillisation</td>
<td>Qualified practicing Nursing staff and Associate Practitioners Mental Health, Learning disabilities and CAHMS *PGD training delivered as required</td>
<td>Direct (Rapid Tranquillisation also available as e-learning)</td>
<td>1 day</td>
<td>Three yearly</td>
</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
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</tr>
<tr>
<td>Medicines Management (Community Health Care services)</td>
<td>Qualified practicing Nursing and Associate Practitioners Acute Community Health care staff</td>
<td>Direct</td>
<td>1 day</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Medicines Competency Framework (including calculations) (Mental Health staff)</td>
<td>Qualified practicing Nursing staff and Associate Practitioners Mental Health, Learning disabilities and CAHMS (inpatient and community)</td>
<td>Work based learning</td>
<td>3 months to complete</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Prescribing (Medical Staff and Non-medical prescribers)</td>
<td>All prescribers (medical staff (GMC requirement), and non-medical prescribers) in both CHS and Mental Health</td>
<td>E-learning</td>
<td>1 hour</td>
<td>Annual</td>
</tr>
<tr>
<td>Venous Thromboembolism (Community Health Care services)</td>
<td>Community services Inpatient qualified nursing staff Mental health Older Adult inpatient qualified nursing staff.</td>
<td>E-Learning</td>
<td>e-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Transfusion Process Training (Community Health Care services)</td>
<td>Staff who are involved in transfusion processes.</td>
<td>Direct</td>
<td>E-learning</td>
<td>Annual</td>
</tr>
<tr>
<td>Diabetes training (Community Health care services &amp; Mental Health)</td>
<td>All inpatient mental health nursing staff, qualified and unqualified inpatient mental health medical staff, pharmacists and pharmacy technicians, community health services nursing staff qualified and unqualified</td>
<td>E-learning or direct WEST ESSEX PROTOCOL REQUIRES ALTERNATE DIRECT AND E-LEARNING</td>
<td>E-learning or direct</td>
<td>Two yearly</td>
</tr>
<tr>
<td>Pressure Ulcer Prevention</td>
<td>All RGNs, Associate Practitioners and HCA support workers in Adult Community Healthcare Services. All nursing staff, registered and pre-professional, in older people’s MH in-patient services.</td>
<td>E-learning</td>
<td>½ hour</td>
<td>3 yearly</td>
</tr>
<tr>
<td>STATUTORY / MANDATORY TRAINING</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
<td>DURATION</td>
<td>UPDATE INTERVAL</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>Tier 1 In-patient Older people staff Mental Health, All clinical staff in community health care services (CSTF level1) Tier 2 Community Matrons, District Nurses, Rapid Intervention Teams(CSTF level 2)</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Once. No update requirement.</td>
</tr>
<tr>
<td>Observation of Service user training (Mental Health)</td>
<td>All inpatient nursing staff and medical staff</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Consent training (Acute community Health Care services)</td>
<td>Clinical Community Health care service staff offering and providing patient care and treatment.</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Information Governance CSTF Information Governance Incorporating Record Keeping</td>
<td>All staff to complete at relevant level for their role</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Annually</td>
</tr>
<tr>
<td>Customer Service</td>
<td>All staff</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Initially part of Corporate Induction. Update Three yearly</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>All staff</td>
<td>E-learning</td>
<td>½ hour</td>
<td>Once</td>
</tr>
<tr>
<td>Equality and Diversity CSTF Equality and Diversity &amp; Human Rights</td>
<td>All staff</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Three yearly</td>
</tr>
<tr>
<td>Harassment and Bullying</td>
<td>All staff</td>
<td>E-learning</td>
<td>E-learning</td>
<td>Once only</td>
</tr>
</tbody>
</table>
This checklist should be returned to the Human Resources Recruitment Team once completed. It will then be filed on the Inductee’s central personal file. The attached evaluation form needs to be returned to the Workforce Development & Training Department. The new Inductee and their Inductor have joint responsibility to ensure that this document is completed. It is recommended that the inductor and inductee keep a copy.

INDUCTEE NAME: ________________________________

START DATE: ________________ : JOB: ________________________________

SERVICE: ________________________________

INDUCTOR NAME: ________________________________

NAME OF SUPERVISOR/LINE MANAGER ________________________________

JOB TITLE: ________________________________

The duties and responsibilities of this staff member are? (Please give an overview)

Will the staff member be required to use their own vehicle for work-related business at any time? Yes / No

Vehicle Documents Checked?
**PRE START CHECKLIST**

This list is designed to remind Inductors of things they may need to do when preparing for a new member of staff. It is not exclusive, and space has been left to add items. Not all items will apply to everyone. Suggestions for new items should be included.

<table>
<thead>
<tr>
<th>Applicable</th>
<th>Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Book on Trust Induction course and Mandatory Training</td>
<td></td>
</tr>
<tr>
<td>Care Certificate workbook issued and supervisor assigned</td>
<td></td>
</tr>
<tr>
<td>Order name badge</td>
<td></td>
</tr>
<tr>
<td>Order name stamp</td>
<td></td>
</tr>
<tr>
<td>Add to departmental structure chart/mailing list/directory/timetable etc.</td>
<td></td>
</tr>
<tr>
<td>Order car park pass</td>
<td></td>
</tr>
<tr>
<td>Order lease car</td>
<td></td>
</tr>
<tr>
<td>Present documents as required if utilising their own vehicle on occasions for work related business.</td>
<td></td>
</tr>
<tr>
<td>Prepare departmental induction pack</td>
<td></td>
</tr>
<tr>
<td>Prepare timetable</td>
<td></td>
</tr>
<tr>
<td>Provide diary</td>
<td></td>
</tr>
<tr>
<td>Provide map</td>
<td></td>
</tr>
<tr>
<td>Prepare Annual Leave Application Form</td>
<td></td>
</tr>
<tr>
<td>Inform HQ of new info for internal directory (see attached form)</td>
<td></td>
</tr>
<tr>
<td>Set up e-mail account</td>
<td></td>
</tr>
<tr>
<td>Book with Recruitment to sign on</td>
<td></td>
</tr>
<tr>
<td>Order uniform</td>
<td></td>
</tr>
<tr>
<td>Order mobile phone</td>
<td></td>
</tr>
<tr>
<td>Order desk, chair, computer etc</td>
<td></td>
</tr>
<tr>
<td>Anything else for this role</td>
<td></td>
</tr>
</tbody>
</table>
The following list of items for discussion is intended as a generic guide. Inductors should use their own judgement regarding what needs to be discussed with each new member of staff, and should add any additional items which they feel appropriate. The checklist should be used in conjunction with the services local Induction checklist.

<table>
<thead>
<tr>
<th>DAY ONE IN WORKPLACE</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>General welcome and introduction to the work area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tour of department/site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cloakroom and toilet facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lockers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entrances &amp; exits to be used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entry systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Register on Intranet and give contact details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car parking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction and identification of Service Users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department function, mission and position in organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inc emergency numbers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evacuation procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assembly point(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First aid box</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local first aider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health &amp; Safety at Work Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protective clothing &amp; laundering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal alarm systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burglar alarm systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Policies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 3 of 10
## DAY ONE IN WORKPLACE

<table>
<thead>
<tr>
<th>Clinical Management</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management issues – including clinical emergency, psychiatric emergency and resuscitation procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree on relevant induction activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree on initial timetable/caseload</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Job aids

<table>
<thead>
<tr>
<th>Job aids</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal &amp; departmental standards/objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line management structure chart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions of employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch and tea breaks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking policy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Communication systems

<table>
<thead>
<tr>
<th>Communication systems</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication book</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Administrative systems

<table>
<thead>
<tr>
<th>Administrative systems</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Diary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheets/Statistical Systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic Patient Record Systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next of kin and sample signature</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Identify a supervisor/mentor for new member of staff:

Name: ____________________________ : Contact details/phone number: ____________________________

Other issues (carry over to next page for monitoring if appropriate):

Inductor’s signature: __________________ Inductee’s signature: __________________

Date: __________________
<table>
<thead>
<tr>
<th>BY END OF FIRST WEEK</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inductor</td>
<td>Inductee</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COSHH policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Health &amp; Safety policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local safety hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local incident/accident reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant risk assessments explained and completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Safety Representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection control procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Job aids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity badge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Conditions of employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual leave - allocation &amp; how to request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift/flexible working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requesting off duties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness absence policy/reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foundation Trust Membership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probation Processes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local Policies &amp; Procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessing Policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaints Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record Keeping Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct &amp; Capability Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grievance procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BY END OF FIRST WEEK</td>
<td>Initial when completed (or mark N/A)</td>
<td>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Inductor</strong></td>
<td><strong>Inductee</strong></td>
<td></td>
</tr>
<tr>
<td>Communication systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local meetings/newsletters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local team briefing group/dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision - dates set for future meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raising Concerns Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date set for objective-setting meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date set for interim Appraisal review(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vehicles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car park pass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of local Trust vehicles, e.g. house car, mini-bus, etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mileage claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lease cars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View documentation for own vehicle if used for work related business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust directory/ mailing list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In house forms e.g. self certificate, study leave, course application, change of circumstances etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Departmental induction:</strong> <em>(Suggested items - not exclusive)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision and Values</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current departmental objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental timetable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental telephone/address/mailing list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone answering standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate templates for reports/correspondence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BY END OF FIRST WEEK</td>
<td>Initial when completed (or mark N/A)</td>
<td>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Inductor</td>
<td>Inductee</td>
</tr>
<tr>
<td>etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction/visits to colleagues on other sites arranged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current initiatives (e.g. Action Plans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Induction issues identified on day one (carried over from page 2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other issues (carry over to next page for monitoring if appropriate):

Inductor’s signature: __________________ Inductee’s signature: __________________
Date: __________________
<table>
<thead>
<tr>
<th>BY END OF FIRST MONTH</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inductor</td>
<td>Inductee</td>
</tr>
<tr>
<td>Comment on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familiarity with Policies &amp; Procedures – Intranet checklist completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to carry out job function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Received?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Induction issues identified during first week (carried over from page 4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other issues:

Inductor’s signature: ____________________  
Inductee’s signature: ____________________  
Date: ____________________
<table>
<thead>
<tr>
<th>BY END OF THIRD MONTH</th>
<th>Initial when completed (or mark N/A)</th>
<th>COMMENTS / RECOMMENDATIONS FOR FURTHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment on:</td>
<td>Inductor</td>
<td>Inductee</td>
</tr>
<tr>
<td>Familiarity with Policies &amp; Procedures – Intranet Checklist completed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at agreed training courses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to carry out job function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Induction issues identified during first month (carried over from page 5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other issues:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I agree that all the initialled and listed issues in the checklist have been discussed.

Inductor’s signature: ________________

Inductee’s signature: ________________

Date: ________________

Senior Manager’s Signature: ____________________________

Senior Manager’s Name: ____________________________

Job Title: ____________________________

Please return a copy of the completed and signed workplace induction checklist to: The Human Resources Recruitment Team
EVALUATION

Inductee
Please comment on the usefulness of this checklist during your induction into your workplace:

- Not useful
- Fairly useful
- Useful
- Very useful

__________________________________________

Is there anything you would like to see added?

__________________________________________

Is there anything you would like to see omitted?

__________________________________________

Inductor
Please comment on the usefulness of this checklist during this workplace induction:

- Not useful
- Fairly useful
- Useful
- Very useful

__________________________________________

Is there anything you would like to see added?

__________________________________________

Is there anything you would like to see omitted?

__________________________________________

Thank you for completing this evaluation. Please return to Human Resources Department.
Local Workplace Induction for Locum / Bank / Agency Staff

This local workplace induction for locum/bank/agency staff is intended to take between 15 and 30 minutes. This arrangement demonstrates that there are appropriate arrangements in place to safeguard staff and service users.

All temporary staff should have a personal handover by the regular post holder or a more senior person who will explain the basic requirements of the post.

Each service should have a pack giving basic details of the work of the service, the staff structure and the location of key departments, communication systems and resuscitation arrangements, shown in conjunction with this form.

Name of staff member

Date

Name of workplace

Supervisor for this member of staff is

The staff member has been employed to do the following job?

The duties and responsibilities of this staff member are? (Please give an overview)

Tour of workplace including toilets, staff room, office etc

Introduction and Identification to staff and service users if applicable

Emergency procedures

Fire

(Equipment, exits and procedure)

Medical emergency

Psychiatric emergency

(Including bleep, communication and pharmacy arrangements)

Health and safety issues, responsibilities and information

(Including incident/accident reporting/risk assessments)

Care Certificate status checked -

Inductee sign

Inductor sign

This form must be returned to the Staff Bank Manager. A note of this induction must be made in the local workplace induction book and be signed and dated by inductor and inductee.
**Assessment of Competencies for Junior Doctors**

*To be completed within the first week of each new placement of trainees*

Please send a copy to the appropriate clinical tutor

<table>
<thead>
<tr>
<th>Post:</th>
<th>Location:</th>
<th>Supervisor:</th>
<th>Trainee’s Name:</th>
<th>Start date of placement:</th>
<th>End date:</th>
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<tr>
<th><strong>Skills and knowledge</strong></th>
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<th><strong>Learning need identified</strong></th>
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<td>Physical examination In line with the Trust Physical healthcare Policy</td>
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<td>Interpretation of blood results</td>
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<tr>
<td><strong>Safe management</strong> of commonly occurring physical conditions (urgent/non-urgent) including side effects of medication</td>
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<td>Psychiatric history taking</td>
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<td>Skills and knowledge</td>
<td>Sufficiently competent</td>
<td>Learning needs identified</td>
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<td>Safe Record keeping and defensible documentation – this will include clear entries</td>
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<td>in notes in line with CPA policy and health and social care record policy and the</td>
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<td>formulation of timely, accurate and clear discharge summaries</td>
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<td>Basic knowledge of key sections, holding powers and the processes for giving</td>
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<td>treatment under the Mental Health Act and Common Law</td>
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<td>Basic knowledge of the Mental Capacity Act and Consent to Treatment</td>
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<td>Risk assessment</td>
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<td>Multi disciplinary working</td>
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The trainee has assured the Supervisor that he/she has the competencies required for this post as outlined above. He/she understands that these will be subject to an ongoing monitoring process and learning needs will be addressed as indicated.

Trainee

Supervisor

Date
<table>
<thead>
<tr>
<th>Company</th>
<th>Main Contact Name</th>
<th>Address</th>
<th>Contact Number/s</th>
<th>Email</th>
<th>Training Topics that can be offered for delivery</th>
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<td>DOCUMENTS TO BE RECEIVED</td>
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<td>Reference 2 (Organisation &amp; date sent)</td>
<td>Ref 1 received and checked</td>
<td>Ref 2 received and checked</td>
<td>Equality statement from Training provider (signed)</td>
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**APPENDIX 5 TO BE COMPLETED BY TRAINING DEPARTMENT**
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<th>CHARGING STRUCTURE</th>
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<th>Cancellation Policy &amp; procedure Training Provider</th>
<th>Cancellation Policy &amp; procedure SEPT</th>
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## INDUCTION/MANDATORY TRAINING PROCEDURE

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<tr>
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<tr>
<td>AUTHOR:</td>
<td>Workforce Development Lead</td>
</tr>
<tr>
<td>CONSULTATION GROUPS:</td>
<td>Workforce Planning and Organisational Development Group/Workforce Development Strategy Group Clinical Governance and Quality SMT/Committee Joint Consultative Committee Clinical Board Health Safety and Security Committee/Risk Management Mandatory Training Leads Medical Director ESR Leads HR Work stream</td>
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<td>April 2017</td>
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<td>January 2018</td>
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<td>LAST REVIEW DATE:</td>
<td>January 2018</td>
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<tr>
<td>NEXT REVIEW DATE:</td>
<td>April 2020</td>
</tr>
<tr>
<td>APPROVAL BY TRUST BOARD</td>
<td>January 2018</td>
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### PROCEDURE SUMMARY

The procedure sets out the responsibilities for the delivery, completion and monitoring of corporate induction, local induction and mandatory training. It covers timescales, notifications. It also identifies the actions and implications for non-attendance and non-compliance. The appendices cover the required components. This policy, procedure and associated appendices apply to all staff, including Bank and Agency workers.

The Trust monitors the implementation of and compliance with this procedure in the following ways;

- Through monthly monitoring of compliance figures and regular internal audits.

<table>
<thead>
<tr>
<th>Services</th>
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<th>Comments</th>
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<td>Essex MH&amp;LD</td>
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<td>CHS</td>
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The Director responsible for monitoring and reviewing this procedure is Executive Director Mental Health and Deputy CEO
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURAL GUIDELINE TITLE

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2.0 RESPONSIBILITIES
3.0 LOCAL WORKPLACE INDUCTION
4.0 TIMESCALES FOR INDUCTION/MANDATORY TRAINING REQUIREMENTS
5.0 CORPORATE INDUCTION
6.0 MANDATORY TRAINING TO BE COMPLETED WITHIN 6 (6) WEEKS OF EMPLOYMENT
7.0 TRAINING TO BE COMPLETED WITHIN 3 MONTHS OF COMMENCEMENT
8.0 MANDATORY TRAINING UPDATES
9.0 MONITORING MANDATORY TRAINING
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APPENDICES
APPENDIX 1 – MANDATORY TRAINING NEEDS ANALYSIS
APPENDIX 2 – LOCAL INDUCTION FOR PERMANENT STAFF
APPENDIX 3 – LOCAL INDUCTION FOR TEMPORARY STAFF
APPENDIX 4 – ASSESSMENT OF COMPETENCIES FOR JUNIOR DOCTORS
APPENDIX 5 – EXTERNAL TRAINERS
The purpose of these Procedural Guidelines is to ensure the Trust’s workforce receive the required mandatory training components as set out and agreed by the Trust. They reinforce the values of the Trust in order to deliver our Core Principles in line with the Corporate / Clinical Governance agenda. These Procedural Guidelines cover corporate induction for new starters and local workplace induction. They provide a systematic approach to the structure and monitoring of Induction, and Mandatory Training.

1.0 INTRODUCTION

1.1 The Trust’s workforce has varying roles and responsibilities which comprise the service. As such training needs are many and varied.

1.2 The Workforce Development and Training Department have undertaken a training needs analysis on behalf of the Trust to ensure that the Mandatory Training provided by the Trust is appropriate for the different roles and responsibilities of staff. The Mandatory Training Matrix (Please see Appendix 1.) is set by staff role, however, individual risk assessments can be used to determine the necessary training requirements for a specific staff member, but these must be agreed by the service director.

1.3 The training needs analysis takes into account appropriate national guidelines and legislation. The analysis will be reviewed annually and appendix 1 updated accordingly. Action plans will be developed should the analysis find that training is required that is not currently provided by the Trust.

1.4 It is essential that staff undertake all the appropriate Mandatory Training (this includes all components of the Induction Processes), as identified in the training needs analysis, to ensure that the Trust’s workforce are appropriately trained.

1.5 Once the annual training needs analysis review has been undertaken, the Workforce Development and Training Department will produce an annual training prospectus which outlines all training being provided for the year as well as course details, dates and venues.
2.0 RESPONSIBILITIES

2.1 The Mandatory Training Administrators will pre-book all Mandatory Training for all new starters, and will also send out reminders for Mandatory Training updates. Substantively appointed medical staff will be treated the same as all other staff groups and are required to attend Corporate Induction within 6 weeks of commencing their employment. All doctors in training, doctors holding honorary contracts (including Foundation Doctors and GPVTS doctors) and NHS Locum appointments do not need to attend Corporate Induction but will attend a Medical Induction which is coordinated by Medical Education. Bank staff will attend a separate Corporate Induction.

2.2 Staff and managers are responsible for ensuring compliance timescales are adhered to, when training is requested.

2.3 It is the responsibility of the Mandatory Training Administrators to inform of any capacity issues that arise when booking staff on courses.

2.4 Human Resources will be responsible for notifying the Mandatory Training Administrators of all new starters. Human Resources and the Mandatory Training Administrators will work together to send pre-booked training dates to all new starters and a copy to their managers. All mandatory training must be completed within the first 12 weeks of employment.

2.5 Corporate Induction will be completed within 6 weeks of the individual commencing employment.

2.6 The Mandatory Training Administrators will be responsible for providing the statistics relating to Mandatory Training by the 5th working day of each month.

2.6.1 Staff who do not complete a Mandatory course will receive notification from the Mandatory Training Administrators, informing them of their non-compliance with mandatory training. Non-compliance will be recorded in the compliance statistics published on the Intranet. It is the Line Manager’s responsibility to ensure training is re-booked. If an individual fails to attend on the second occasion, the Service Director will be notified and the team fined. Non-attendance, after the second occasion, at a training event where the staff member can provide no adequate explanation may be investigated under the Conduct and Capability Policy.

2.6.2 Action will be taken by Workforce Development and Training to inform relevant corporate departments about repeated DNAs.

2.6.3 Bank staff who are non-compliant with their mandatory training will receive a written warning and notification of when training must be completed. Failure to meet this could lead to individuals being removed from the bank database.
2.6.4 Staff are responsible for notifying their manager and WDT of any specific learning needs that might affect their ability to complete any aspect of mandatory training.

2.7 Line Managers will ensure that staff attend the appropriate Mandatory Training & update courses relevant to their area of work, as set out within this guidance and the training needs analysis (Appendix 1).

2.8 Line Managers will monitor the Mandatory requirements of the staff working within their areas through supervision/ appraisal and the compliance lists.

2.9 The individual is responsible for the completion of their identified Mandatory Training requirements and the subsequent updating of their skills in accordance with this guidance.

2.10 The individual is responsible for ensuring they sign any attendance register at face to face Mandatory Training sessions.

2.11 All Staff will also complete the local workplace induction in accordance with procedural guidelines.

2.12 The process of delivering and monitoring Corporate Induction and Mandatory Training will be coordinated by the Workforce Development and Training Department.

2.13 The Workforce Development and Training Department is responsible for the annual review of mandatory training and the updating of the appendices. When amendments are made all staff will be notified.

2.14 All staff should complete a course evaluation form. This is to aid the evaluation of courses carried out by the Workforce Development & Training Department.

2.15 The Workforce Development and Training Department is responsible for ensuring that all Mandatory training is provided by suitably qualified staff. This will include the validation of credentials of all trainers prior to engaging them to deliver mandatory training.

2.16 All external providers of Mandatory training must be registered on the database held by Workforce Development and Training. The information required includes references and evidence of professional/technical credentials. No external trainer should be engaged before all information required is supplied and verified. Verification should include a check carried out by the Trust’s Local Counter Fraud Specialist. The information required is shown in Appendix 5.

2.17 The effectiveness of the Policy and these Procedural Guidelines will be monitored by Workforce, Development and Training. Monitoring will include the production of a monthly training report including statistical information to circulate to the appropriate committees within the Trust. Regular audits will also be undertaken.
2.18 Workforce Development and Training will notify the manager when a staff member fails to achieve course competencies. Managers are responsible for creating an appropriate risk assessment for staff who are unable to complete any mandatory training requirements. Workforce Development and Training will support in the identification of ways to achieve competence, where appropriate. Outcomes will be notified to the manager who will then take appropriate actions.

2.19 Workforce Development and Training will make reasonable adjustments to the training where special needs have been identified and where this is possible.

3.0 LOCAL WORKPLACE INDUCTION

3.1 Local workplace induction is mandatory for all new members of staff, it is also required if a member of staff changes work base or is absent from the workplace for more than 6 months. In addition the local workplace induction should be completed if three or more months have elapsed since returning to the work base in the case of locum, bank and agency staff. The local work base induction must be completed regardless of the number of days the staff member will be employed within that post.

3.2 The local workplace induction checklist (Appendices 3 and 4) are tools for the manager and new starter to ensure that all relevant issues are covered. It should be used from or on the first day of work, to plan and manage workplace induction activities.

3.3 The appropriate checklist must be completed by the line manager or nominated deputy. Appendix 2 should be completed for permanent members of staff. Appendix 3 should be completed for bank, locum and agency staff. Medical staff complete their checklist.

3.4 On completion of a checklist it will be the responsibility of the line manager to return the checklist to the appropriate department, (as stated on the form. This record should be signed by both inductee and inductor.

3.4.1 Local Induction for permanent staff (Appendix 2) must be returned to the recruitment team and/or HR within three months of commencement of employment. The recruitment team are responsible for checking that local induction is completed and will keep a log of all checklists received.

3.4.2 The Recruitment team and/or HR will monitor completion of local induction for permanent staff (Appendix 2). If a local induction checklist (Appendix 2) is not returned within four months of commencement of employment, a follow up letter will be sent to the individual and their line manager.
3.4.3 Local Induction for temporary staff (Appendix 3) where applicable must be returned to the Bank office/HR with the individual’s weekly timesheet (within one week of a shift taking place). The Bank Office (or HR where applicable) is responsible for checking that local induction is completed and will keep a log of all checklists received.

3.4.4 The Bank Office/HR will monitor the completion of local induction for temporary staff (Appendix 3). Should a local induction checklist (Appendix 3) not be returned within one month of commencement of employment a follow up letter will be sent to the individual and their line manager.

3.4.5 The Bank Office/HR will monitor the completion of local work base inductions (Appendix 3) for agency staff. These must be returned to the Bank Office (or HR if applicable) within one week of the individual’s shift commencement. The Bank Office/HR are responsible for checking that local induction has been completed and maintaining a log of all check lists.

3.4.6 Local Induction for temporary medical staff (Appendix 3) is required to be completed within one week of their first shift and returned to medical staffing/HR. Medical staffing/HR have the responsibility for checking that local induction is completed and will keep a log of all checklists received.

4.0 TIMESCALES FOR INDUCTION/MANDATORY TRAINING REQUIREMENTS

4.1 All new staff will attend the Trust Corporate Induction within 6 weeks of commencing employment with the organisation.

4.2 All components of Corporate Induction and mandatory e-learning, must be completed within six weeks, as specified in the Induction/Mandatory Training Policy. All other appropriate Mandatory requirements for new staff must be completed within the first twelve weeks of employment. (see Appendix 1).

4.3 Timescales for the completion of induction and mandatory training are set out in the relevant policy and procedure (HR21). Where new starters, subject to the probation period, fail to meet the required standard within the set time scale they may be deemed to have failed their probation period. Failure to successfully complete the probation period can result in termination of their contract. For advice on how to apply the probation policy please contact your assigned HR Advisor.

4.4 Assessment of competency checklists must be completed for all junior doctors within the first week of each new placement and returned to post graduate administrator within the medical directorate within one month of commencement and before they complete their first on-call (see section 4.5 of policy).
4.5 Failure to complete any aspect of Corporate Induction/Mandatory training within the specified timeframe will be followed up by notification to the individual and their manager. In the rare event failure to attend or failure to achieve competency levels of a course may not be due to an employee’s capability but their unwillingness to undertake the requirement of their role. Action may be taken under the conduct and capability policy where they:

Fail to attend without reasonable grounds

- Fail to attend without informing the line manager
- Fail to attend on 2 or more occasions. In such cases an investigation will be undertaken in accordance with the Conduct & Capability Policy and Procedure and disciplinary action may be taken against individuals with individuals at fault including managers.

4.6 In some circumstances the employee may not be able to pass the course. In these cases support may be offered, including:

- Extending the length of time to reach the desired pass mark.
- Providing additional support through mentoring or coaching
- Providing additional IT skills training

4.7 Non-attendance after the second occasion at a training event, where the staff member can provide no adequate explanation, may be investigated under the Conduct and Capability Policy. The outcome of such an investigation may result in a disciplinary sanction which could lead to dismissal. New staff who are subject to a probationary period of 6 months, and who fail to complete any aspect of the Corporate Induction, will be managed under the conditions of the Probationary Periods Policy and Procedure. The outcome of the assessment throughout the probationary period may be dismissal.

5.0 Corporate Induction

5.1 Corporate Induction Training sessions will be provided each month.

5.3 All new starters will be informed of the E-learning Induction requirements they need to undertake by a member of the Workforce Development & Training team within the Corporate Induction Session or by the Medical Workforce & Education.

5.4 Induction / Mandatory Training can be achieved through a number of diverse teaching styles utilising appropriate up to date methods such as face-to-face group teaching and e-learning.

5.5 All aspects of the induction process and e-learning will be completed within six weeks and the remaining mandatory training within 12 weeks of commencement of employment. It will be the responsibility of the line manager to ensure that all new staff members attend and complete all applicable components and continue their staff on the appropriate
6.0 MANDATORY TRAINING UPDATES

6.1 Mandatory Training update requirements for staff groups are set out in Appendix 1.

6.2 Applications for study leave other than Mandatory requirements will not be considered unless all Mandatory Training is up-to-date. In exceptional circumstances, consideration may be given.

6.3 When E-learning cannot be updated during working hours, it may be completed at home, and time taken in lieu, but with the manager’s agreement, and in accordance with the Time Back Guidance.

7.0 MONITORING MANDATORY TRAINING

7.1 It is the responsibility of the trainer to return all signed attendance sheets and evaluation forms, on completion of a course to Mandatory Training Administrators within 48 hours.

7.1.1 Records of training and Corporate Induction will be kept by the Mandatory Training Administrators. This will be in accordance with the Trust’s Record Management Policy. Records of Doctors’ assessment of competencies checklists will be maintained by the post graduate administrator within the Medical Directorate.

7.1.2 Mandatory training compliance figures will be included within the monthly Performance Report and will be presented to the Executive Team, and other relevant forums.

7.2 Workforce Development and Training will monitor capacity and compliance of all Mandatory training monthly. Action plans will be developed for the delivery of identified training where capacity/compliance is not being met.

7.3 Compliance statistics will be published on the intranet the Mandatory Training Administrators identifying which staff are up-to-date, when they are approaching update deadlines and those staff that are out of date.

7.4 A service manager will be able to check which training has been undertaken by a member of staff through:
   - Reviewing the published compliance statistics on the Intranet.
   - Reviewing through ESR
   - Requesting the individual downloads their training transcript through ESR.
7.5 All courses will be evaluated for content annually to ensure that effective learning strategies are being implemented. This review will be implemented by the Workforce Development & Training Department and include representation from, Service Users and Carers.

7.6 The Workforce Development & Training Department will audit mandatory training components to ensure that service specific issues are addressed.

7.7 For all Mandatory programs with a practical component, staff will be recorded as attended or completing the course. A status of completing indicates that a member of staff has demonstrated all the techniques involved. If a record of attendance only is recorded, a letter will be sent to the staff member’s manager informing them of this, and the member of staff will be marked as non-compliant.

7.8 Within any 12 month period, services can be charged for second and subsequent DNA by any member of staff, the charge will be £100 for each occurrence and will be deducted from the service budget by the Finance Department.

8.0 MONITORING IMPLEMENTATION AND EFFECTIVENESS

8.1 Monitoring of implementation and effectiveness of this Policy will be undertaken by the Workforce, Development and Training Department.

8.2 Monthly training statistical reports will be produced for presentation to the appropriate committees. Compliance levels are set for mandatory courses as follows:
90% Safeguarding
90% TASI
90% Inpatient Fire Safety
85% All other Mandatory Training.

Teams who are below 85% for a three month period will be highlighted within the performance report for Directors to take appropriate action.

8.3 An audit of compliance with training and Corporate Induction Processes will be undertaken three yearly. The audit results will be presented to the appropriate committees. The audit will cover as a minimum:

- Responsibilities
- Process for ensuring all permanent staff are booked onto corporate induction
- Process for checking all staff complete mandatory training (including induction)
- Process for following up staff who fail to attend mandatory training (including induction)
Induction /Mandatory Training

- Process for checking all staff complete Local Induction (Permanent and Temporary)
- Process for follow up staff who fail to complete Local Induction (Permanent and Temporary)
- Process for developing training needs analysis and development of action plans
- Development of annual training prospectus
- Process for coordinating training records
- Process of recording DNA’s and compliance.

END
DISCIPLINARY (CONDUCT) PROCEDURE

PROCEDURE REFERENCE NUMBER | HRPG27A
VERSION NUMBER | 1
REPLACES SEPT DOCUMENT | SEPTRPG27A
REPLACES NEP DOCUMENT | Not applicable
KEY CHANGES FROM PREVIOUS VERSION | Not applicable
AUTHOR | Debbie Prentice HR Manager
CONSULTATION GROUPS | Interim Partnership Committee
IMPLEMENTATION DATE | April 2017
AMENDMENT DATE(S) | Nov 18 (GDPR)
LAST REVIEW DATE | March 2018
NEXT REVIEW DATE | March 2021
APPROVAL BY Workforce Transformation Group | March 2018
RATIFIED BY | Not applicable
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PROCEDURE SUMMARY
This procedure sets out the framework for the Trust's approach to the management of conduct, behaviour and practice concerns and the process to be followed in dealing with disciplinary (conduct or negligence) matters. Where issues of concern relate to capability (performance) these should be dealt with in accordance with the Trust's Capability Performance Policy and related procedure. This procedure should be read in conjunction with the Disciplinary (Conduct) Policy.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
This procedure is subject to monitoring and review as set out in the Disciplinary (Conduct) Policy and through review and agreement with the Trust’s Partnership Committee.

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The Director responsible for monitoring and reviewing this procedure is the Executive Director of Corporate Governance and Strategy.

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## APPENDICES

**APPENDIX 1 – DISCIPLINARY HEARING PROCESS**

**APPENDIX 2 – DISCIPLINARY RULES**
This procedure aims to ensure that Essex Partnership University NHS Foundation Trust ['the Trust'] sets out and maintains high standards of conduct and performance amongst its employees to ensure high standards of conduct, behaviour and practice.

The procedure sets out the Trust’s principles in approaching disciplinary issues relating to conduct and performance, ensuring they are dealt with in a timely, fair, reasonable and consistent manner, within the legislative framework and in accordance with the ACAS Code of Practice and Guidance.

The management of disciplinary procedures within the Trust will be built on and demonstrate the Trust’s corporate values and behaviours. These values being:

- Open
- Compassionate
- Empowering

In doing so support the achievement of its strategic priorities to:

- Continuously improve patient safety, experience and outcomes, and reduce clinical variations
- Attract, develop and enable high performing individuals and teams
- Enable service improvement plans with system partners
- Achieve top 25% performance for operational, financial and productivity measures

1.0 INTRODUCTION

1.1 This procedure introduces the Trust's principles in relation to resolving disciplinary matters. Disciplinary rules and procedures are necessary for promoting positive employee relations and for safeguarding of patients.

1.2 The Trust recognises that disciplinary issues can relate to conduct (complying with Trust policy, rules and procedures), including negligence. The disciplinary procedure will be invoked by management in circumstances where it is alleged that conduct has fallen below the required standards.

1.3 Consideration should be given at an early stage as to whether any such issues relate to the individual’s conduct (or negligence) or capability (performance). Advice should be sought from HR to best determine the application of the appropriate procedure.

1.4 Unless otherwise stated, this procedure does not form part of an employee’s terms and conditions of employment but is a statement of the Trust’s current practice and may be changed from time to time.
1.5 The Trust recognises its responsibility in ensuring that all employees are aware of their obligations whilst at work and the behaviour and conduct expected of them. Employees also have a responsibility to familiarise themselves with the general rules and procedures referred to in their conditions of service and as related to their specific area of work and as required of them by their professional code(s) of conduct and NHS Constitution.

1.6 It is recognised that instances may arise however in which managers (or others) may be dissatisfied with the conduct or behaviour of an employee. There is therefore need for formal procedures, through which the issues can be identified and appropriate action, within given timescales, can be taken in a consistent, fair and reasonable manner.

1.7 This procedure applies to all employees of the Trust with the following provision:

a. Medical and Dental staff – this policy does not apply to issues concerning professional conduct and / or competence of Medical and Dental staff who are subject to the provisions of the Maintaining High Professional Standards Policy.

b. Temporary staff (including bank workers) – temporary workers are required to maintain the Trust’s expected standards of conduct, behaviour and practice. Any issues of conduct will be addressed using the relevant temporary workers procedure.

c. Trades Union Officials – such staff are subject to the provisions of this procedure. However, in most cases no formal action will be taken until a senior trade unions representative or full time official has been informed.

1.8 Where the disciplinary process is implemented due to suspected fraud, corruption or bribery this will be reported to the Local Counterfraud Specialist in conjunction with the Executive Chief Finance and Resources Officer. Where the disciplinary process is implemented due to suspected theft this will be reported to the Local Security Management Specialist in conjunction with the Executive Chief Finance and Resources Officer.

Where appropriate the Trust will refer cases identified to the Local Counterfraud specialist (LCFS) or Local Security Management Specialist (LSMS) prior to the Trust investigating or taking action.

1.9 Where potential conduct involves Safeguarding issues for a patient(s) it is important that, where appropriate to do so, a co-ordinated approach takes place to ensure the Safeguarding investigation and conduct process run in parallel in conjunction with the relevant local Safeguarding Boards.

a. A Safeguarding case may be concluded whilst the conduct process continues.

b. The Safeguarding Team must be informed by Human Resources [HR] of the outcome of conduct investigations.
c. The relevant adult and children safeguarding policies and procedure [SETSAF] should be adhered to.

### 2.0 GUIDING PRINCIPLES

2.1 The HR service must be fully consulted prior to any action being taken in relation to this procedure.

2.2 Regular communication will be maintained at each stage of the disciplinary procedure, to ensure its effective implementation and application.

2.3 In usual circumstances employee(s) affected will be made aware of the nature of the allegations made prior to the instigation of this procedure.

2.4 Where there are allegations of misconduct, or negligence, the Trust will conduct an investigation as soon as possible, having due regard to all the circumstances.

2.5 All employees and parties involved in disciplinary procedures must ensure the confidentiality of events and discussions. An unreasonable breach may be considered as a disciplinary offence in itself.

2.6 In addition to their statutory rights all employees have the opportunity to be accompanied at suspension or investigatory meetings by a work colleague, a recognised trade union representative, or an official employed by a recognised trade union. The Trust will not normally agree a request for an employee to be accompanied by an individual deemed to be a witness or who could compromise any investigation including cause unnecessary delay.

2.7 All employees have the right of Appeal against any formal disciplinary action taken (see Section 11) in accordance with the Appeals Procedure.

2.8 The Trust will ensure that a written record is maintained at all stages in the disciplinary procedure.

### 3.0 INFORMAL ACTION & RESOLUTION

3.1 It is important that managers do not see the formal disciplinary procedure as the only way to deal with an employee whose standard of behaviour or conduct is unacceptable, there is likely to be less recourse to the formal procedure if deficiencies in an employee’s conduct, including standards of performance are brought to their attention at the earliest possible opportunity by the line manager in the course of the employee’s normal duties.

3.2 An informal discussion should never turn into a disciplinary interview/meeting/hearing. Any informal discussion should be terminated immediately if it becomes obvious that formal disciplinary procedures might be required; in such cases the individual should be advised accordingly, for example as part of the management supervision process.
3.3 Informal action may include counselling; a verbal caution, written ‘management advice’; standard and/or objective setting or retraining. Where any informal action of this nature is taken it is imperative that the individual is in no doubt that their conduct and/or behaviour has to improve or change, how it has to improve or change and where applicable, of the support available to them to help them do so.

3.4 An appropriate record should be kept of any informal cautions and actions that occur and the content of any discussion as to expectations of standards of behaviour and/or conduct for future reference. A copy of this record will be sent to the employee within five days of the discussion taking place.

3.5 This does not form part of an individual’s disciplinary record, but will serve to demonstrate what support has been provided to assist the individual to meet the required standards.

4.0 SUSPENSION

4.1 An employee may be suspended from duty on full pay whilst an investigation is carried out into any suspected misconduct in the following circumstances:

i. when it is necessary for the support of the employee;
ii. where the employee’s continued presence will or could interfere with, hinder or compromise the investigation;
iii. where management are of the opinion that there is, or may be, a risk to client/patient safety, or there is, or may be a risk to the health and safety of others;

4.2 During the period of suspension the employee will receive their full contractual pay. Full pay will be calculated on the basis of average earnings for the preceding three months (excluding bank work), and will continue for the duration of the suspension. No further payments, contractual or otherwise, will be made to an employee in the event of an appeal where he/she is summarily dismissed.

4.3 Such suspensions will be carried out by the appropriate person, working with responsibility and authority at the relevant time. Should suspension occur out of office hours, this should be in consultation with the on call manager, and with HR having been informed at the earliest possible opportunity. All suspensions will be subject to written confirmation by the appropriate senior manager within 24 hours.

4.4 Suspension is not a disciplinary sanction or punitive in nature and therefore does not imply guilt or blame. Suspension should only be invoked as a last resort when all other options have been considered. The Trust will consider alternatives to suspension where this is appropriate, which may include:

- A period of special leave whilst a preliminary investigation is undertaken, this would normally be for no longer than 24 hours.
- Temporary redeployment (subject to mutual agreement) to an alternative area of work for which the employee is suitably skilled and qualified.
- Restricted scope of duty or adjusted duties.
- Increased supervision.

4.5 When considering the suspension of clinical staff managers may use a tool to inform decision making which must then be recorded. Any decisions made must have patient safety at the forefront in the assessment of risk.

4.6 If an employee is suspended, wherever possible he or she will be informed of this in a face to face meeting with the relevant manager, along with the reasons for it. Where a face to face meeting is not possible and suspension is necessary the employee will be informed verbally by a manager with relevant authority to suspend.

4.7 The fact of suspension and the reasons for it will also be confirmed to the employee in writing usually within five working days of the suspension taking effect.

4.8 At the suspension meeting the following points should be explained to the affected individual(s). Written confirmation of these points will be provided usually within five working days of the suspension taking effect:

- Wherever possible the specific reason for the suspension and matters for investigation.
- The terms of the suspension
- The date that suspension takes effect.
- That suspension does not imply guilt or blame and does not imply prejudgement of the outcome of investigation.
- Right to representation during investigation process.
- Details of the investigating officer (where known).
- Support available during investigations.
- Provided with a copy of the Trust’s Disciplinary (Conduct) Policy & related procedure.

4.9 The Trust will aim to ensure that suspension is for as short a period as possible. Where suspension continues for more than a short period, for example due to the complexity of the investigation, then the suspension will be subject to regular review and the Trust will endeavour to keep the employee informed of the progress of the investigation.

4.10 An employee may make a request to be accompanied at a meeting at which suspension is to be confirmed by a recognised Trade Union representative or current work colleague but the meeting will not be delayed if a chosen representative is unable to attend at the given time.

4.11 Periods of suspension should be kept to a minimum. Suspension will usually be subject to the following reviews:

i. First review after two weeks after which the suspension will either be lifted or continued. If it is to be continued a full written explanation must be provided to the employee.
ii. Second review after four weeks.
iii. Third review after eight weeks.
iv. At the fourth review after twelve weeks the Commissioning Manager will be involved. The employee and their representative will be able to make written representations. If it is to be continued a full explanation must be provided to the employee and confirmed in writing.

v. Further regular reviews as set out by the Commissioning Manager (if deemed appropriate).

4.12 Where an employee falls sick during a period of suspension, the normal contractual sick pay entitlements will apply in accordance with the occupational sick pay scheme.

4.13 Where an employee wishes to take annual leave during a period of suspension, the normal arrangements for the authorisation and taking of annual leave will apply.

4.14 Employees who are suspended are required to be available to attend investigatory meetings during normal working hours which are considered to be Monday – Friday 9am to 5pm.

4.15 If during the course of investigation it becomes clear that the evidence gathered does not warrant continued suspension, it will be discontinued with immediate effect.

5.0 PRELIMINARY INVESTIGATION

5.1 Where an incident or concern comes to light, the manager will need to consider whether an initial preliminary investigation is warranted, or if the facts of the matter are clear and established, whether a decision can be made to proceed immediately to a more formal investigation as detailed in Section 7 below, HR Advice should be sought as necessary.

5.2 If it is the former, this requires either the manager or the most senior person on duty at the time of the incident, to undertake some initial fact finding – e.g. what happened, when it happened, who saw the incident in question etc. and what was done.

5.3 Having communicated with the main witness(es), the fact finder, in consultation with HR, would then come to a conclusion as to whether a more full and thorough investigation is necessary in keeping with the relevant policy (i.e. performance or conduct) and refer to the relevant Commissioning Manager, or whether it is something that can be managed more informally, locally.

5.4 It does not require any statements to be taken at this stage, or all of the witnesses to be spoken to, and should normally be completed within a maximum period of 72 hours.

5.5 This is an opportunity to utilise the ‘agreed outcome’ framework (see Section 8) where an individual accepts and admits they have acted inappropriately.
6.0 INVESTIGATING OFFICER

6.1 Where an employee’s conduct or standard of performance warrants formal investigation, an investigating officer will be appointed by the Commissioning Manager.

6.2 The Commissioning Manager will be the appropriate senior manager within the service that the employee works and with the authority to act.

6.3 The Commissioning Manager will write to the employee (where not previously suspended) to confirm they are subject to disciplinary investigation, the letter will include:

- Wherever possible the specific reason for the investigation and details of the allegation(s).
- Wherever possible the Terms of Reference for the investigation
- Right to representation during investigation process.
- Details of the investigating officer.
- Support available during investigations.
- Provided with a copy of the Trust’s Disciplinary Policy & Procedure.

6.4 When appointing an appropriate investigating officer, the commissioning manager will need to be satisfied that the investigation can be undertaken without unnecessary delay. The commissioning manager will therefore need to consider the investigating officer’s current workload and how this can be managed whilst the investigation is being undertaken.

Wherever possible the investigating officer will not be a person within the direct line management structure of the employee subject of investigation.

6.5 At a disciplinary hearing, the investigating officer will be required to be available to attend as a witness, but will not be involved in making any decisions as to the final outcome. The investigating officer will respond to questions from the employee, their representative and the hearing panel.

6.6 In some, exceptional, circumstances the Trust may consider bringing in external consultants to both carry out the investigation and present their findings as a witness at any subsequent Disciplinary Hearing. In these cases the investigation will be overseen by a Trust manager and the Trust will retain responsibility for any inappropriate or discriminatory behaviour. Any external consultant appointed by the Trust to undertake an investigation will follow the Trust’s Disciplinary Policy and Procedure and deal with the case fairly in accordance with the ACAS Code of Practice.
7.0 CONDUCTING AN INVESTIGATION

7.1 The purpose of an investigation is to gather information in order to determine whether or not there is a case to answer by way of formal disciplinary proceedings.

7.2 If so, it is for the investigating officer to present this information as a witness at any subsequent Disciplinary Hearing and to respond to questions related to the investigation.

7.3 HR will assist the investigating officer with all investigations to ensure a fair, reasonable and consistent process and to advise on matters of procedure.

7.4 The Trust will endeavour to ensure that the investigation is undertaken in a timely and sensitive fashion. In doing so the investigator will be provided with clear terms of reference for their investigation in order to ensure they remain focussed and avoid unnecessary delay. Any preliminary report that is produced as part of an initial fact finding investigation will provide the basis for the terms of reference.

7.5 Investigations need to be undertaken without unreasonable delay. It is important that the investigation is undertaken promptly before memories fade.

7.6 The investigation should ideally take no longer than six weeks to conclude, however the Trust recognises that it is of key importance to ensure an investigation is completed thoroughly. If the investigation cannot be completed within this timescale, the commissioning manager will confirm in writing to the employee and their representative, the reasons for any delays and the expected completion date. If the employee is suspended from work a review of the terms of suspension will also be undertaken at this time.

7.7 The reporting and any involvement of any incident(s) or event(s) involving the police or other statutory body should not normally preclude the carrying out of an internal investigation by the Trust. However in all instances where this occurs, advice should be sought from HR.

The investigation will include:

- An investigation meeting with the employee
- Obtaining statements from all relevant witnesses
- Reviewing all appropriate policies, procedures and codes of practice / conduct
- Reviewing all written records and documentation

7.8 In exceptional circumstances it may be necessary to interview members of the public, current or former patients. Advice should be sought from HR in all instances where this is considered necessary.

7.9 As part of the investigation, unless in exceptional circumstances, the investigating officer will interview the employee who is subject of the allegations. In such circumstances, the employee will be informed of the allegations which are being investigated and the purpose of the interview. If
the employee either refuses to attend an investigation meeting or provide a written statement the investigation will be concluded based on information collated.

7.10 Employees will normally have the opportunity to be accompanied at the investigatory meeting by a recognised Trades Union representative, or alternatively a current work colleague of their choice.

7.11 The employee should provide the name of their representative at the earliest opportunity.

7.12 Employees do not have a statutory entitlement to be accompanied at investigatory meetings, therefore should there be a delay in arranging representation which the Trust considers to be unreasonable, the investigation will proceed in any event.

7.13 Whilst it is desirable to meet with the employee as part of the investigation process, this is not a requirement under the ACAS code of practice. In order to ensure that the Trust is able to demonstrate its duty to deal with the matter fairly and without undue delay, it may therefore be decided that the employee will not be interviewed. Instead the individual will be given the opportunity to respond to questions/state their case at a disciplinary hearing, should it proceed to one. This may also apply where the individual is off sick and having sought advice from Occupational Health.

7.14 Statements should be obtained as necessary from any potential witnesses at the earliest opportunity. The status of any written statements is important and can be obtained as:

- An account, written independently by, and in the witnesses own words of the incident(s) or action(s) taken as soon as possible after the date of the event and signed and dated accordingly.

- An investigatory meeting which is recorded and the notes transcribed. If employees do not wish for the meeting to be recorded and transcribed they should contact the HR service at least five working days prior to the meeting in order for a minute taker to be arranged.

7.15 The investigating officer will request statements from all witnesses, only in circumstances where the investigating officer identifies gaps in the statement(s) or where further information needs clarification will investigatory meetings be required.

7.16 If further evidence arises during the course of the investigation the Commissioning Manager will review the initial allegations and consider whether these need updating, revision or addition. Any revised allegations should be communicated in writing to the employee under investigation by the Commissioning Manager so that he/she has an opportunity to respond. The employee will be given ample opportunity to state his or her case, including any mitigation they see as appropriate.
7.17 Once the investigation is completed the investigating officer will prepare a report for the commissioning manager within 15 days, unless there are exceptional circumstances. The report will include:

- Background
- Purpose of the investigation (allegations & terms of reference)
- Summary of employee statement
- Summary of witness statement(s)
- Summary of documentary evidence
- Findings and conclusion
- Appendices to include all witness statements and documents (including policies) referred to in the report

7.18 It will be for the investigating officer to conclude whether, or not, there is a case to answer at a Disciplinary Hearing. It will be for the Commissioning Manager to decide whether the matter should proceed to a disciplinary hearing (or agreed outcome meeting) and will write to the employee with confirmation that a Disciplinary Hearing will be convened.

7.19 Where the decision of the Commissioning Manager differs to the recommendation of the Investigating Officer the reasons for this should be communicated to the employee. In these circumstances the Commissioning Manager should also be available to attend a Disciplinary Hearing as a witness, where required.

7.20 At such point as it becomes likely the matter(s) will proceed to a disciplinary hearing without prejudice to any subsequent proceedings a provisional date will also be set for a disciplinary hearing. Wherever possible the availability of any known representative will be ascertained. This does not indicate pre-judgement of any facts or outcome of the case; rather it is the purpose to reserve dates and to avoid subsequent delays if a hearing is necessary. This decision will be made by the commissioning manager in consultation with the investigating officer and HR, none of whom will form any part of the disciplinary panel.

### 8.0 PRE-HEARING SETTLEMENTS/AGREED OUTCOMES

8.1 It is recognised that lengthy conduct proceedings can create anxiety for individuals. It is further recognised that lengthy processes, whilst often necessary, can create additional pressure on service delivery.

8.2 It is in no-one’s interest to proceed to a disciplinary hearing where both parties are in agreement not to do so. Where an employee admits an allegation and the facts are not in dispute, it may not be necessary for the investigating officer to carry out a lengthy investigation.

8.3 Where there is agreement in respect of issues of a case, the culpability of the employee and the possible sanction, a pre-hearing negotiated settlement may be the best way forward.
8.4 Pre-hearing negotiated settlements, more commonly known as “agreed outcomes” therefore provide an opportunity to with the matter as sensitively as possible.

8.5 Agreed outcomes cannot be used in any cases of potential gross misconduct where dismissal is a possible outcome unless in exceptional circumstances and where the employee has expressed admission of the alleged offence(s) and contrition for them.

8.6 Where an employee is already subject to a current warning for similar or related misconduct the agreed outcome process will not be followed or where it may conflict with, or compromise, “due process” e.g. audit or reports to a regulatory body.

8.7 Although not part of the Trust’s formal disciplinary procedure it is part of the disciplinary process and therefore the same principles and rules in respect of natural justice must be applied.

8.8 The employee will be invited to attend a meeting, as set out below, at which he or she should be given the opportunity to put forward his or her side of the story, along with any other points which he or she wishes to make. The meeting should only take place after the employee has had a reasonable period of time to consider the issues to be discussed at the meeting.

8.9 The employee should be informed in writing of the basis on which proposed disciplinary action is contemplated and the issues which the Trust would like to discuss with him or her and informed of their right to be accompanied by a Trades Union representative or work colleague of their choice.

8.10 The meeting will be conducted by a senior manager; this will usually be the investigation commissioning manager with the authority to act. The meeting will not be conducted by the investigating officer, an HR will also be in attendance.

Prior to the meeting all available relevant information will be available to those attending.

8.11 Where an employee and/or their representative are unhappy with such a meeting, quite clearly it should not proceed along this route or where agreement is not reached during the meeting on matters of fact, evidence or accountability. In these circumstances a disciplinary hearing will be convened.

8.12 On conclusion of the meeting the relevant manager should consider whether, in the light of what has been said at the meeting, a disciplinary sanction should be imposed and, if so, what the sanction should be. The employee should then be informed of the outcome and confirmed in writing within seven working days.

8.13 The employee will be required to provide either written acceptance of their misconduct and the proposed disciplinary sanction, or written confirmation that they do not agree to the outcome. This is not an appeal. This must be received within 10 working days of the notice of the action.
8.14 In the event that an employee does not agree to the outcome, a disciplinary hearing will be convened. No one involved in any decisions at an agreed outcome meeting will form part of the disciplinary hearing panel.

8.15 Once the employee has been informed of the outcome, he or she should be asked to sign a written notification. This notification confirms acceptance of his/her misconduct and the relevant disciplinary sanction proposed. Once accepted there is no right of appeal.

9.0 DISCIPLINARY HEARINGS – EMPLOYEES’ RIGHTS

9.1 In all stages of the formal procedure, the employee has the following rights:

i. The circumstances regarding an allegation concerning conduct shall be investigated.

ii. The employee will be given a reasonable period of time to prepare and state his or her case which is not less than 10 working days prior to the date of the hearing.

iii. Before any disciplinary hearing the employee shall be advised of the details of any allegation in writing along with the basis for the allegations.

iv. The employee shall be informed of his/her right to be accompanied at any disciplinary hearing.

v. The employee will be informed of their right of appeal where formal disciplinary action results (See Section 11).

9.2 Employees are entitled to be accompanied by either an existing work colleague or a Trade Union representative at a disciplinary hearing or appeal hearing. The trade union representatives must have been certified in writing by their union as having experience of, or having received training in, acting as a worker’s companion at disciplinary hearings. The Trust does not permit legal representation at any stage during the disciplinary process.

9.3 To exercise the right to be accompanied workers must make a reasonable request to the relevant manager. It would not normally be reasonable for a worker to insist on being accompanied by a person whose presence may prejudice the hearing or to ask to be accompanied by a companion from a remote geographical location if someone suitable and willing was available on site, or from closer vicinity.

9.4 The chosen representative or work colleague will be allowed to address the hearing to put and sum up the workers case, respond on behalf of the worker to any views expressed at the meeting and confer with the worker during the hearing. They do not, however, have the right to answer questions on the workers behalf, address the hearing if the worker does not wish it or prevent the employer from explaining their case.
**10.0 DISCIPLINARY HEARINGS**

10.1 The purpose of a disciplinary hearing is to consider all facts and enable the employee an opportunity to answer the case against them and provide any justification or mitigating circumstances that should be considered before a decision is made on what, if any, action should be taken.

10.2 If the Commissioning Manager has decided that there is a case to answer, a disciplinary hearing will usually be held as soon as possible. The hearing will normally take place within 30 working days of this decision being made.

10.3 An employee required to attend a disciplinary hearing will receive not less than 10 working days’ notice of the hearing. Employees, and where known their representative, will be provided with full written details outlining the grounds for the hearing and setting out the allegations and confirming:

1. the date, time and venue of the hearing;
2. the nature and details of the alleged misconduct;
3. an indication of the possible disciplinary sanction which may be imposed if the employee does not provide a satisfactory explanation;
4. the name and status of the manager hearing the case and disciplinary panel;
5. the names of any witnesses to be called, which will include the investigating officer;
6. their right to be accompanied

and will be supplied with:

1. copies of all statements and documentation which the disciplinary panel will be relying upon;
2. a copy of the Trust’s Disciplinary Policy in force at the time.

No later than three working days prior to the hearing the employee will:

1. Submit their written statement of case and any other documentation on which he/she intends to rely;
2. confirm the name and status of any representative and details of any witnesses he/she intends to call.

10.4 If the employee or employee’s representative is unable to attend on the given date, the employee has a right to propose an alternative date, which must be not later than five working days after the original hearing date.

10.5 A Disciplinary Hearing or Appeal can be re-arranged a maximum of two times, where an employee or their representative is unable or unwilling to attend a disciplinary hearing or appeal on two occasions, the Trust will consider all the facts and come to a reasonable decision on how to proceed, which could include convening the disciplinary hearing in the employee’s absence. Where this is the case the employee will be given the opportunity to state their case in writing or send a (recognised) representative on their behalf, any such evidence must be submitted to the hearing officer no later than three working days prior to the disciplinary hearing.
10.6 If an employee chooses to resign following notification of a conduct investigation or disciplinary hearing, a decision will be made by the commissioning manager in consultation with HR on how to proceed. A decision will be made as whether any further action, including referral to statutory and / professional bodies is required and notified in writing.

10.7 The disciplinary hearing panel will comprise:

- ‘hearing officer’, a designated senior manager to conduct the proceedings and determine and sanction formal action.
- an ‘HR adviser’, a representative of HR to advise the hearing officer on employment matters;
- In allegations regarding professional misconduct where the hearing officer does not have the relevant professional background or knowledge, a professional adviser will attend to give advice in relation to that profession.

NB: in cases where the formal action may be considered a ‘senior’ manager is deemed as being normally not less than the equivalent of a band 8a.

10.8 The Disciplinary Hearing (and Agreed Outcome Meeting) will be recorded and the notes transcribed. If employees do not wish for the hearing to be recorded and transcribed they should contact the HR service at least 5 working days prior to the hearing in order for a minute taker to be arranged.

Additional attendees may be permitted by mutual consent for training purposes.

The members of the panel shall not include anyone who has been involved in the decision to suspend (if relevant), the investigation nor as a witness.

10.9 Everyone involved in the hearing is responsible for maintaining the confidentiality of the information shared during the proceedings.

10.10 All parties should give careful consideration to who they call as witnesses, limiting the numbers to the minimum necessary to support their case and establish a finding of fact.

10.11 It is expected that the Commissioning Manager will attend as a witness where the manager has chosen to proceed to a disciplinary hearing where the findings of the Investigating Officer, is that there is ‘no case to answer’ at a disciplinary hearing.

10.12 It is the responsibility of the employee, or their representative, to arrange attendance of the witnesses being called to support their defence of the case.

10.13 Witnesses, including the investigating officer, will only be in attendance whilst they are giving evidence. Where possible witnesses will be provided with an approximate time of attendance so as to ensure minimum disruption to service provision.
10.14 Disciplinary hearings will be conducted in accordance with the procedure attached at Appendix One.

10.15 Variations to the disciplinary hearing procedure detailed above (including Appendices) can be made with the mutual agreement of the employee and / or their representative and the Hearing Officer.

10.16 The hearing will be adjourned while the relevant matters are considered by the disciplinary hearing panel. Once the disciplinary hearing panel has considered all matters, the hearing will usually be reconvened so that the Hearing Officer may give their decision.

10.17 The Hearing Officer will consider the allegations made as they relate to the Trust’s disciplinary ‘rules’ (see Appendix Two). These rules are not exhaustive and serve only as a guide, although do form part of the terms and conditions of employment.

10.18 Once a decision that allegations have, on the balance of probability, been proven the Hearing Officer will be informed of any ‘live’ disciplinary sanctions or previous related warnings which may need to be considered in the determination of sanction.

10.19 In all cases following a disciplinary hearing, all relevant parties will be notified of the outcome in writing usually within five working days. The employee will be notified of their right of appeal.

10.20 On conclusion of the Disciplinary Hearing the Hearing Officer will make a decision regarding whether a referral to the relevant professional and / or regulatory body should be made.

11.0 OUTCOMES OF DISCIPLINARY HEARINGS

The disciplinary hearing may result in any of the following formal actions:

i. No Action

The case was unsubstantiated or there was a case to answer but no action is to be taken as there are exceptional mitigating circumstances. The employee will be informed in writing and all records of the hearing and investigation will be removed from the employee’s personal file and destroyed.

The only exception would be where the allegation(s) related to issues around the abuse, care or bullying and harassment of patients, clients and/or employees, in which case the records of the hearing should be retained.

There is no right of appeal on this action.
ii  Further investigation required

This is where the hearing officer feels that they require further evidence to be obtained, by the investigating officer before making a final decision. If this is the case, the disciplinary hearing will effectively be adjourned and reconvened at a future date at which time the additional information can be considered and final outcome reached.

There is no right of appeal on this action.

iii.  Verbal Warning

This is the first formal disciplinary stage and will normally be for cases where there is minor misconduct, unacceptable conduct and/or failure to conform to standards following management advice.

A note confirming that a verbal warning has been given and that the employee has been notified of their right to appeal will be held as a record on the personal file. A verbal warning will be considered as spent after 6 months or any lesser period considered appropriate by the hearing officer.

iv.  Written Warning

This will normally be for cases where there is misconduct or unacceptable conduct or behaviour or where there has been a failure to conform to standards following previous management advice and /or previous verbal warning(s) which are not ‘spent’. It will warn that further formal action will be considered if there is no satisfactory improvement.

A written warning will normally be considered ‘spent’ after 12 months or any lesser period considered appropriate by the hearing officer.

iv.  Final Written Warning

This will normally be for cases where the misconduct or unacceptable conduct or behaviour is considered more serious or where there has been failure to conform to standards following a previous written warning(s) which is not considered ‘spent’. It will warn that dismissal will be considered if there is no satisfactory improvement.

A final written warning will be for a period of up to 24 months (but no less than 12 months) as determined by the hearing officer and will be considered ‘spent’ after this time.

v.  Dismissal

This will normally be for cases of misconduct or unacceptable conduct or behaviour following previous warning(s) or in cases of more a serious nature, which are not considered to be gross misconduct. The employee will be provided with written reasons for dismissal and the date on which the employment will terminate. The dismissal will be with notice or with pay in lieu
of notice and will include any accrued, untaken statutory annual leave to which they are entitled.

It should be noted that there is nothing in the ACAS Code of Practice that states that there has to be a similarity in the type of misconduct to justify a dismissal. This is particularly so where, as an outcome of a previous warning it has been made clear to the individual that any further misconduct is likely to result in disciplinary action which could include dismissal.

vi. Summary Dismissal

This will be for misconduct or unacceptable conduct or behaviour considered constituting gross misconduct or gross negligence (see disciplinary rules attached as appendix one). The employee will be provided with written reasons for dismissal and the date on which the employment is terminated.

In cases of gross misconduct or gross professional misconduct, the employee will normally be dismissed summarily i.e. without notice or pay in lieu of notice, although any accrued, untaken statutory annual leave to which they are entitled will be paid.

The dismissal will take effect from either the date of the hearing, where the individual was verbally informed, or if the decision was conveyed in writing, the date on which the Trust could reasonably expect the employee to have received the letter and therefore be informed of their dismissal.

vii. Transfer to an Alternative post (Dismiss & Re-engage)

In exceptional circumstances, as an alternative to the termination of employment and / or in conjunction with a written warning, the employee may be dismissed and re-employed in an alternative post or, with the employee express consent, transferred to alternative post. This may be at a different band, and if so the employee will assume the terms and conditions of the new post without protection of pay.

Where it is as an alternative to dismissal, if the employee does not accept the offer of re-employment then dismissal will be effective from the end of the notice period.

Where in conjunction with a written warning the employee will need to give express consent to the variation of contract and terms and conditions of employment.

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<th>12.0 DISCIPLINARY RECORDS</th>
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12.1 Normally the validity of disciplinary warnings will be considered to have expired after the specified period (see above). This is provided that there has been the desired and sustained improvement conduct and / or behaviour and there have been no further warnings or action taken against the employee during this time.
12.2 In these circumstances, previous warnings should generally be disregarded for future disciplinary purposes. In exceptional circumstances it may be permissible to take into account previous spent warnings in relation to subsequent disciplinary action.

12.3 These exceptional circumstances are where a clear reason to dismiss has already been established, and past misconduct would evidence that a lesser penalty would not be warranted.

12.4 Additionally, such circumstances could relate to where a pattern of behaviour emerges and/or there is evidence of abuse. However the circumstances in which this will be the case are rare and advice should be sought from HR when this is being considered.

12.5 All records of disciplinary action will be treated as confidential and be kept no longer than necessary in accordance with the Data Protection Act 2018.

12.6 Where an employee is absent during the course of a ‘live’ warning for a continuous period exceeding four calendar weeks, the warning will normally be extended by the length of the period of absence.

**13.0 APPEALS**

13.1 Employees have the right to appeal against any formal sanction issued under this procedure, with the exception of informal action(s), the decision to suspend and pre-hearing settlements (agreed outcomes).

13.2 Appeals will be conducted in accordance with the Appeals Procedure.

**14.0 SHARING INFORMATION**

14.1 Where a potential fitness to practice concern is identified a view will be taken by the appropriate Director whether the conduct, behaviour or practice is such that, on the grounds of public and/or patient safety, the Trust should notify any other organisation that the person is known to work in, or is moving to, of the circumstances concerned.

14.2 This will be in accordance with the National Guidance “Sharing Information of Healthcare Workers” 2013.

14.3 It will be for the Trust to determine at what stage it considers it appropriate to share information and to whom, normally this will be on the conclusion of any formal investigation, although in exceptional circumstances and on assessment of risk, this may be prior to doing so.

14.4 In all cases, the decision and the basis of the decision to share information will be recorded. The employee concerned will normally be advised of the intended communication and specifically what information will be communicated.

14.5 External communication will be co-ordinated by the relevant Director who will act as the initial recipient of information from other organisations.
15.0 SUPPORT

The Trust recognises that investigations, meetings and hearings can cause anxiety and/or distress to any party involved. Every attempt will be made to ensure that these proceedings are conducted with dignity, courtesy and respect.

Support to employees involved in disciplinary proceedings is available from:

a. Advice and support will be available from managers, Human Resources, recognised Trade Union representatives and Professional Leads.

b. Additional advice and counselling will be available through Occupational Health.

c. Employees can also access confidential support/career advice/counselling through the Trusts’ Employee Assistance Programme, workplace options

d. Any concerns can be raised in confidence with the Guardian Service who will provide information and emotional support in a strictly confidential, non-judgemental manner.

16.0 VARIATION TO TIMESCALES

16.1 Time scales regarding the procedural steps indicated in this procedure and within the disciplinary hearing procedure at Appendix One are subject to reasonable variation.

16.2 Any references to ‘working days’ mean Monday to Friday, excluding weekends and bank holidays.

END
EMPLOYEE WELLBEING PROCEDURE

PROCEDURE REFERENCE NUMBER: HRPG26a
VERSION NUMBER: 1
REPLACES SEPT DOCUMENT: Employee Wellbeing Procedure HRPG36a
REPLACES NET DOCUMENT: Not applicable
KEY CHANGES FROM PREVIOUS VERSION: Not applicable
AUTHOR: HR Business Partner
CONSULTATION GROUPS: Interim Partnership Committee, Workforce Transformation Group, HR Team, Finance & Performance Committee
IMPLEMENTATION DATE: April 2017
AMENDMENT DATE(S): Not applicable
LAST REVIEW DATE: Not applicable
NEXT REVIEW DATE: April 2020
APPROVAL BY: Interim Board of Directors
RATIFIED BY: Not applicable
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PROCEDURE SUMMARY
The procedure sets out the framework for the Trust’s approach to achievement and maintenance of employee wellbeing in the workplace. It confirms the commitment to ensuring that measures taken to achieve workforce wellbeing will be fair, equitable and reasonable in the circumstances. The procedure should be read in conjunction with the Employee Wellbeing and sickness absence Policy and the Stress Management Procedure.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
This procedure will be subject to review as per the agreed review schedule of Trust HR policies and as agreed by the Trust’s Partnership Committee. Compliance with this procedure will be against the Trust’s agreed minimum requirements /standards as detailed within its Auditable Standards and Monitoring Arrangements, as well as the use of internal reporting and recording within the Workforce Directorate.

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The Director responsible for monitoring and reviewing this procedure is Executive Director of Corporate Governance & Strategy.
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMPLOYEE WELLBEING PROCEDURE

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End
1. ASSURANCE STATEMENT

1.1 Essex Partnership University NHS Foundation Trust (the 'Trust') is committed to following best practice in its approach to the wellbeing of its workforce.

The Workforce Wellbeing and Stress Management Procedure has been designed to ensure that the organisation takes a proactive approach to creating and maintaining a healthy workforce. This will be achieved by

- Identifying, assessing and reducing organisational factors which could affect health & wellbeing.
- Providing employee education, training and support aimed at building resilience and reducing the impact of personal and workplace pressure on health & wellbeing
- Encouraging staff to take advantage of the personal support and counselling available to them through Occupational Health and counselling support.
- Providing managers and individual members of staff with information on what processes to follow should workplace employees need support in managing their health & wellbeing.

1.2 This procedure aims to establish a framework for a common understanding of the processes to achieve and maintain the wellbeing of the workforce by management, staff and staff representatives. The Trust is committed to ensuring that the arrangements to achieve this are fair, equitable and reasonable in the circumstances.

1.3 The promotion of workforce wellbeing within the Trust will be built on and demonstrate the Trust’s corporate values and behaviours. These values are in being:

- Open
- Compassionate
- Empowering

In demonstrating these behaviours and values, supporting the achievement of its strategic priorities to:

- Continuously improve patient safety, experience and outcomes, and reduce clinical variations
- Attract, develop and enable high performing individuals and teams
- Enable service improvement plans with system partners
- Achieve top 25% performance for operational, financial and productivity measures
2. **INTRODUCTION**

2.1 Poor physical and mental health is a major concern for NHS Employers and can place significant pressure on not only individuals but also services if health conditions are not managed and treated promptly. The Trust recognises the importance of good mental health, and the inherent potential risks of working within a pressured environment, such as the NHS. The Trust is therefore committed to supporting the physical, psychological and social health and wellbeing of all members of staff.

2.2 This procedure should be read in conjunction with the Employee Wellbeing and Management of Sickness and Absence Policy and Management of Sickness and Absence Procedure.

2.3 The Trust is committed to maintaining the health and wellbeing of all staff. This procedure covers our commitment to employee health, the responsibilities of managers and others for maintaining health, health promotion initiatives, communicating and training on health issues, the range of support available for the maintenance of health and wellbeing, and our commitment to handling individual issues.

2.4 The aim of this procedure is to describe our commitment to the health and wellbeing of employees.

2.5 The Trust has legal obligations under health and safety legislation to manage risks to the health and safety of employees. In addition to reducing safety risks, this means operating services in a way that minimises harm to employees' health, for example by ensuring that the demands of jobs are not unacceptable and having policies and procedures in place to support those experiencing ill health at work. The organisation will put in place measures to prevent and manage risks to employee wellbeing, together with appropriate training and individual support. It will also seek to foster a healthy culture by incorporating these principles into line manager training and running regular initiatives to raise awareness of health and wellbeing issues at work.

3. **DUTIES**

3.1 **Trust Board**

Trust Board carries the ultimate responsibility for the health, safety, welfare and wellbeing of staff

3.2 **Executive Directors/Service and Operational Directors**

All Directors have a responsibility to ensure that Workforce Wellbeing and Stress Management procedure is effectively enforced within their areas.

They will ensure that a range of staff events based on the health and wellbeing of staff is organised.
They will encourage proactive risk assessment for workplace factors which may contribute towards the health & wellbeing of the workforce and is supportive in assisting in risk reduction measures.

They are committed to working in partnership with Trade Unions representatives to ensure that effective resolutions and outcomes are in place that support staff in relation to this procedure.

3.3 Managers

Managers will promote a working environment which supports health and wellbeing of staff and encourages staff to take personal responsibility for their own health and wellbeing. They will:

3.3.1 put measures in place to minimise risks to employee wellbeing, particularly from negative pressure at work. Managers must familiarise themselves with the Health and Safety Executive's stress management standards, and use these to mitigate psychological risks in their teams. For example, managers should ensure that employees understand their role within the team and receive the necessary information and support from managers and team members to do their job. Managers must also familiarise themselves with the Trust's policies on diversity and tackling inappropriate behaviour in order to support staff, for example on bullying and harassment issues.

3.3.2 In particular, line managers must ensure that they take steps to reduce the risks to employee health and wellbeing by:

- ensuring a documented risk assessment is carried out (appendix one) and appropriate actions taken
- ensuring that the right people are recruited to the right jobs and that a good match is obtained between individuals recruited and job descriptions/specifications
- keeping employees in the team up to date with developments at work and how these might affect their job and workload
- ensuring that employees know who to approach with problems concerning their role and how to pursue issues with senior management
- ensure that each employee is aware of the Trust's objectives and culture; and that all new staff have a comprehensive induction programme which incorporates health promotion
- ensure that suitable and sufficient risk assessments for stress and other contributing factors are conducted and implemented in their working areas. e.g. Workstations
- send a copy of all Risk Assessment for Workplace Ill Health (Appendix
2 of the procedural guideline) to the Performance Department for inclusion on the People Management Risk Register.

- ensure that there is good communication between management and staff particularly when there are organisational and procedural changes including consultation documents, team brief, Trust Today etc.

- Ensure that all staff are appraised annually and that regular managerial and clinical supervision (where appropriate) is maintained and that staff know who to approach about their role and how to pursue issues with senior management

- Recognise and offer support to staff who may be experiencing ill-health or workplace or personal stress.

- Managers have a responsibility for identifying and reducing workplace stressors. Assessment of workplace stressors should be ongoing not just following a traumatic event.

- Maintain a good and close supervisory and support relationship with their employees so that they are in touch with their personal needs and able to offer other support and guidance which will lead to improved health and wellbeing.

3.3.3 Managers must ensure that no staff are discriminated or disadvantaged as a result of a ‘protected characteristic’ when applying this procedure. Managers should liaise with HR to ensure the Trust is not open to claims of discrimination as a result of applying this procedure.

3.4 Staff

Staff are expected to engage and play an active role in maintaining their own wellbeing. Staff will:

- have a responsibility to inform their manager if they are experiencing difficulties at work.

- In circumstances where it is not appropriate to speak to the line manager in the first instance, support and guidance should be sought from Human Resources.

- Undertake relevant mandatory training relating to health and wellbeing e.g. fit for work e-learning

Where appropriate, staff should:

- discuss with Occupational Health any physical or psychological symptoms they are experiencing that may be affecting them at work.

- accept opportunities for counselling/ treatment if recommended.
employees must take responsibility for managing their own health and wellbeing, by adopting good health behaviours (for example in relation to diet, alcohol consumption and smoking) and informing the Trust if they believe work or the work environment poses a risk to their health. Any health-related information disclosed by an employee during discussions with managers, the HR department or the occupational health service is treated in confidence.

3.5 Human Resources (HR)

The HR Service will provide advice and support to managers and staff on all aspects of this procedure, with due regard to the employment legislation framework. It is HR’s responsibility to ensure that the Wellbeing and Stress Management Procedure is applied fairly, equitably and consistently throughout the Trust. HR will

- provide guidance when requested to managers on the Workforce Wellbeing and Stress Management Procedure
- assist in the monitoring the effectiveness of measures relating to stress by collating sickness absence statistics when required.
- provide continuing support to managers and employees in a changing environment and encourage referral to Occupational Health Services where appropriate.
- give support to the employee in circumstances where it is not appropriate to gain support from the line manager.

3.6 Occupational Health Department (OHD)

will

- provide specialist advice as required.
- provide a comprehensive service designed to help employees stay in work, or to return to work, after experiencing ill health problems. This will include preparing medical assessments of individuals’ fitness for work following referrals from line managers and the HR department, liaising with GPs and working with individuals to help them to retain employment / re-deployment
- play a critical part in developing rehabilitation plans for employees returning to work after absences related to ill health, and work with GPs and line managers on designing jobs and working environments to ensure that rehabilitation is successful. Occupational Health and counselling professionals will also participate in the design and implementation of health promotion and lifestyle behaviour management programmes, including initiatives on managing pressure and ongoing health conditions
at work.

- support managers in taking a positive approach to mental and physical health issues at work and provide guidelines on implementing risk assessments (and where physical health impacts on mental health).

- provide appropriate advice to line management and interventions based on research and evidence of good practice.

- flag up concerns about employees under their consultation and provide guidance and support.

- in consultation with the line manager identify and refer employees where appropriate to a range of specialist services where their needs cannot be met internally. This will be negotiated on a case-by-case basis.

- provide training materials and session support for managers in the identification and management of work related stress hazards.

- ensure that individual employees, groups and teams will have easy access to the service and that queries are responded to quickly and sensitively

- provide expert advice and guidance in any organisational matters concerning the health and wellbeing of the workforce, e.g. Procedure reviews, etc.

3.7 **Health and Safety Representatives**

will be

- consulted on any changes to work practices or work design that could precipitate physical or mental ill-health

  - able to consult with staff members on the issue of health & wellbeing, including workplace surveys.

  - involved where appropriate and required in the risk assessment process.

  - provided with paid time away from work to attend any trade union meetings relating to workplace duties.

3.8 **Employee Experience Team**

will

- signpost managers and staff who need advice on health and wellbeing issues

- provide a range of organisation-wide health and wellbeing initiatives to promote personal healthy living and health at work
• An annual staff survey will take place which includes key information about Health & Wellbeing at work. Results of this survey are presented to the Trust Board. An action plan is developed and progress for this is monitored through the relevant HR function forums.

4. SCOPE

4.1 This procedure applies to all staff employed by the organisation (including bank and seconded staff, but excluding agency staff).

5. DEFINITIONS

For the purposes of applying the provisions contained in this document a glossary of terms that are used within the procedure are as follows:

| Protected Characteristics | Characteristics as defined by the Equality Act 2010. These are ethnic origin, nationality, race, disability, gender, marital or partnership status, age, religion or belief, sexual orientation or transgender status. |

6 PRINCIPLES

6.1 • The procedure will be used to guide managers in managing and maintaining the wellbeing of their staff

The Trust aims to:

• comply with its duty of care under current legislation

• promote a culture of consultation, participation and open communication throughout the organisation

• provide opportunities for staff to maintain and promote their health and wellbeing

• aim to reduce the adverse effects of contributing factors such as workplace stress on staff and promote wellbeing through effective strategies, procedures and training.

• monitor and audit occupational wellbeing regularly

6.2 The Trust will adhere to the appropriate legislation and other frameworks such as Agenda for Change, local agreements and ACAS code of practice. ACAS is the Advisory, Conciliation and Arbitration Service.

6.3 The Trust seeks to promote fair, reasonable and consistent employment practices referring to relevant policies such as the Equality, Diversity and
Human Rights Policy.

In drawing up this procedure, aspects of discrimination have been considered so that particular groups are not disadvantaged.

## 7 OCCUPATIONAL HEALTH SUPPORT

### 7.1 A comprehensive occupational health service is available, from individual health screening to the design of return-to-work plans for those rehabilitating after a period of long-term sickness absence.

Workplace wellbeing services provided by the occupational health team include:
- pre-employment screening
- fitness-for-work assessments
- in-work screening for health risks, including for coronary heart disease
- immunisations
- post-incident support
- designing and advising on health promotion initiatives

Further information is available in the Occupational Health Policy.

### 7.2 If employees believe that their work, or some aspect of it, is putting their wellbeing at risk they should, in the first instance, speak to their line manager or the HR department. The discussion should cover workload and other aspects of job demands, and raise issues such as identified training needs.

### 7.3 A referral to the occupational health team will be made if this is considered appropriate after an employee’s initial discussion with his/her manager or the HR department. Discussions between employees and the occupational health professionals are confidential, although the occupational health team is likely to provide a report on the employee’s fitness to work, and any recommended adaptations to the working environment, to the HR department.

## 8 HEALTH PROMOTION INITIATIVES

### 8.1 The Trust will develop and run a range of health promotion initiatives designed to raise awareness of health and lifestyle issues affecting health and wellbeing. The Employee Experience Team and Occupational health professionals will have primary responsibility for leading these programmes, but line managers and employees will be expected to participate. These programmes will be evaluated to determine their effectiveness.

The programmes will cover:
- mental health and wellbeing including stress management;
- disability awareness;
- bullying and harassment;
- handling violence and traumatic incidents at work;
- lifestyle behaviours, with voluntary screening (for example in relation to alcohol, drugs and smoking); and
- physical activity and fitness.

8.2 Employees will also be encouraged to establish clubs and groups designed to foster wellbeing, for example lunchtime walking or dancing clubs.

9 TRAINING AND COMMUNICATIONS

9.1 Line managers and employees will regularly discuss individual training needs to ensure that employees have the necessary skills to adapt to ever-changing job demands. An examination of training needs will be particularly important prior to, and during, periods of organisational change.

9.2 Managers and employees are encouraged to participate in communication/feedback exercises, including staff surveys and the Staff Friends and Family Test. All employees are expected to be aware of the importance of effective communication and to use the media most appropriate to the message, for example team meetings, one-to-one meetings, electronic communications and Trust-wide methods.

9.3 The Trust will consider special communication media during periods of significant organisational change.

10 OTHER MEASURES TO SUPPORT HEALTH AND WELLBEING

10.1 The Trust is committed to the health and wellbeing of staff and can provide advice and information about a range of other measures to support employees including

- an employee assistance programme including counselling provision
- procedures for reporting and handling inappropriate behaviour (for example bullying and harassment)
- discounted gym/sports facilities
- no smoking support
- cycle to work scheme
• online training tools – some of which are mandatory
• PFD champions scheme
• special leave arrangements
• opportunities for flexible working
• grievance policy

11 **MONITORING OF IMPLEMENTATION AND GOVERNANCE**

11.1 Monitoring of the implementation and effectiveness of this procedure will be undertaken by the Employee Experience Team in conjunction with the Occupational Health Service, the outcomes of which will be shared with the Workforce Business Support Management Service Board and the Corporate Affairs SMT.

The Occupational Health and Counselling services will provide monthly / quarterly information about patients / trends and reasons for employee ill-health to the Employee Experience Team. They will make recommendations on how to improve health and reduce sickness as part of this

11.2 This procedure is subject to review as per the Trust HR review schedule and as agreed by the Trust’s Partnership Committee.

11.3 Compliance with this procedure will be against the Trust’s agreed minimum requirements / standards as detailed within its Auditable Standards and Monitoring Arrangements

12 **PROCEDURE REFERENCES / ASSOCIATED DOCUMENTATION**

• Employment Rights Act 1996
• Equality Act 2010
• Rehabilitation of Offenders Act 1974
• Human Rights Act 1998
• Employment Relations Act 1999
• Health and Safety at Work Act 1974
• Management of Health and Safety at Work Act 1999
• Working Time (Amendment) Regulations 2003

13 **REFERENCE TO OTHER TRUST POLICIES / PROCEDURES**

This procedure should be read in conjunction with other policies in place that may be relevant. These include:

• Flexible Working
• Zero Tolerance
• Sickness Absence
- Appraisal
- Occupational Health
- Adverse Incidents (including SIs)
- Induction/mandatory training policy
- Equality & Diversity
- Grievance
- Leave

END
# RESTRICTIVE PRACTICE POLICY

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<tr>
<td>REPLACES SEPT DOCUMENT</td>
<td>Policy for Preventing and Managing Interventions That May Lead To the Use of Restrictive Practices</td>
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<tr>
<td>REPLACES NEP DOCUMENT</td>
<td>Prevention Management and Reduction of Violence and Aggression Policy</td>
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<td>AMENDMENT DATE(S):</td>
<td>May 2014, October 2014, Director change Nov 2016 may 2017</td>
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<td>APPROVAL BY CLINICAL GOVERNANCE AND QUALITY COMMITTEE:</td>
<td>20 September 2017</td>
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## POLICY SUMMARY
This policy aims to ensure that all staff are provided with the information required to enable them to adhere to the principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive practices within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (Code of Practice, 1983) current best practice guidance.

The Trust monitors the implementation of and compliance with this policy in the following ways:
Through the monitoring of Datix forms compliance figures for training and as part of the sign up to safety work stream.

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The Director responsible for monitoring and reviewing this policy is Executive Director of Corporate Governance and Strategy
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6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION
7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES
RESTRICTIVE PRACTICE POLICY

Assurance Statement

The Trust provides a service to people who are liable to present with behavioural disturbances and this policy and associated procedural guidelines aims to promote a positive and therapeutic culture aiming at preventing behavioural disturbances, early recognition and de-escalation.

The governance arrangements identified to enable demonstration that the Trust takes all reasonable steps to prevent the misuse and misapplication of restrictive interventions is identified within procedural guidelines.

The policy aims to outline and define restrictive practices and enable the practitioner to ensure that the practice is lawful, necessary, reasonable and proportionate. Being the least restrictive option available and will aim to ensure that open communication, ensuring that dignity, respect, accountability, autonomy and fairness are the fundamental elements of the management of challenging behaviour.

Restrictive practices could involve containment physically with or without the use of mechanical aids or these may be environmental restriction preventing a patient / resident from leaving. Other more subtle forms of restriction may be the placing of a walking aid outside of the patient / residents reach or not supporting an immobile patient / resident if they wish to move or leave. Chemical restraint used for short or long term management.

To ensure recognised national terminology is used throughout this document the national reporting system term “patient safety” is used in some references and refers to service users, residents or patients. Where ‘Patient’ is used this will refer to a patient, resident, client or service user.

1.0 INTRODUCTION

1.1 The Trust recognises and acknowledges that staff need to support people whose needs and risk histories may present with behaviours that challenge. This can be in an emotional or physical way and can be challenging.

1.2 Recovery Based Approaches are used to delivery care in accordance with the principles of a positive, safe and supportive environment.

1.3 Restrictive practices may have to be used to safely manage challenging behaviours. This may involve the physical containment of an individual. For example door locks to ensure patient / residents cannot leave a designated building or area. There may be other examples of more subtle restrictive practices which may be harder to acknowledge such as prescribed medication in the form of a chemical restraint by means of sedative medication on a short or long term basis, inappropriate use of blanket rules.
1.4 The Trust advocates, that any violence and aggression will not be tolerated. The Trust recognises that staff have a right to work, and patients / residents have a right to be cared for, in safe environments. See Trust policy Criminal Behaviour within a Mental health Environment CP22 (Zero Tolerance).

1.5 The most common reason for needing to consider the use of restrictive interventions are:
- Physical assault by the patient / resident
- Dangerous, threatening or destructive behaviour
- Self-harm or risk of physical injury by accident
- Ensuring and maintaining privacy and dignity where an individual’s mental state prevents independent self-management
- Extreme and prolonged over activity that is likely to lead to physical exhaustion
- Attempts to escape or abscond (where the patient / resident is detained under the MHA or deprived of their liberty under MCA).

2.0 DUTIES

2.1 The Chief Executive has overall responsibility for ensuring the principles of this policy and associated guidelines set out by statutory and regulatory authorities such as the Department of Health, Commissioners and the Care Quality Commission and other associated policies are implemented across the organisation. The duty to ensure that all measures needed for the therapeutic prevention, monitoring and management of restrictive practices is delegated to Directors within their areas of responsibility. The Chief Executive has overall responsibility to ensure that patient / residents are protected from abuse and appropriate resources exist to meet the needs of this policy.

2.2 The Board of Directors are fully committed to a safety culture within the organisation and will ensure the effectiveness of restrictive intervention reduction plans. The Board of Directors has to ensure the development of action plans in response to the audit of annual positive behavioural support plans.

2.3 The Executive Director of Mental Health is the Executive Lead for the therapeutic prevention and management of challenging behaviour including restrictive practices and restrictive practice reduction plans. This will ensure:

- Policy and procedures are embedded into clinical practice as well as ensuring they are monitored and updated regularly using latest recommendations.
- Implementation and regular review of this policy.
- That the board receives information and develops action plans in response to the annual audit of behavioural support plans and restrictive practice statistical data. (Looking at the quality design and application)
- That executive board members who authorise the use of physical interventions undertake awareness training so they are fully aware of the techniques their staff are being taught.
- All operational managers are aware of this policy, understand its requirements and support its implementation with relevant staff.
2.4 Executive Medical Director / Consultants

- The Executive Medical Director and consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of this policy.

2.5 The Trust’s Risk Management Team is responsible for:

- Ensuring there is a restrictive practice group which monitors and considers Datix reporting regarding restrictive practices.
- Managing statistical incident information and identifying trends across the organisation.
- Acting as an advisor on non-clinical risk management in the workplace and reporting actions required to reduce or eliminate the risk to staff.
- Providing reports to service commissioners on the use of restrictive practices
- Recording episodes of restrictive practices (planned or unplanned) and capturing information on the level of intervention to ensure that the least restrictive option has been used.
- Ensuring accurate internal data is gathered and reported through the mandatory reporting mechanisms
- Provide information and reports when requested on statistics in relation to restrictive practices, or to show staff how to download reports from the system.

2.6. Directors and Senior Management will:

- Monitor the implementation of this policy by their teams.
- Take action to ensure that all staff are appropriately trained in restraint techniques relevant to their role and responsibility (subject to health related exceptions)
- Ensure that there are a minimum of 3 restraint trained staff on duty on mental health wards if it is not possible to staff the ward in line with agreed establishments.
- Lead and monitor the use of risk reduction plans by their teams
- Investigate Datix incidents relating to restrictive practices where there is an identified significant risk or where injuries have been sustained.
- Ensure that appropriate incident prevention and management processes are in place, implemented and monitored in their teams.
- Ensure the least restrictive practices are used at all times
- Ensure that patient / residents are protected from abuse.

2.7. Local Security Management Specialist is responsible for:

- Leading on day to day work in the Trust to tackle violence against staff and professionals in accordance with the NHS Protect national framework and guidance.
- Having professional awareness of the complex reasons for violence within services and participation in strategic planning to promote the Trusts pro-security culture.
Restrictive Practice Policy RM05

- Providing reports and trend analysis to the Health, Safety & Security Committee regarding violence and aggression incidents.
- Providing advice and support to Trust staff on undertaking risk assessments and risk reduction plans related to challenging behaviour including violence and aggression.
- Providing post incident support to all staff that have been assaulted as well as any member of staff affected by an incident of violence.
- Liaison with the police as appropriate in relation to potential criminal prosecution.

2.8 Workforce, Development & Training Department is responsible for:

- Ensuring that any changes in professional knowledge and practice are regularly discussed and updated.
- Ensuring that they remain up to date in current, practice and guidance in the use of restrictive physical interventions.
- Ensuring that all Trust Teams are appropriately notified of all current information on practice.
- Ensuring that training is delivered and monitored with records continually updated. The identification and implementation of training and educational needs arising from any relevant policy/guidance documentation.
- TASI trainers and manager will review all Datix forms linked with restraint and feedback comments and seek clarity when required and add report to Datix.
- TASI trainers will also review any incident of prone restraint and add report to Datix if required.
- TASI trainers will review with teams when there has been 5 incidents with one patient/resident in a week and add report to Datix.

2.9. Managers and other Persons in Charge will:

- Monitor the implementation of this policy.
- Take action to ensure that all staff are appropriately trained in physical intervention techniques relevant to their role and responsibility (subject to health related exceptions).
- Ensure that there are a minimum of 3 physical intervention trained staff on duty on mental health/ld wards if it is not possible to staff the ward in line with agreed establishments (unless local staffing is less than this number).
- Ensure that the Trust Risk Management Team is appropriately notified of all incidents via Datix as per incident reporting policy.
- Actively review information recorded via Datix incident forms and investigate incidents appropriately, as well as evidence implementation of this policy and procedural guidance on the Datix form. Ensure that appropriate incident prevention and management processes are in place, implemented and monitored in their teams.
- Manage discussion related to incidents, staff attitude and responses to challenging behaviour and restrictive practices in supervision as standing agenda items.
- Ensure that post incident aftercare management includes appropriate and timely support for staff and patient/residents involved. (Debrief).
Restrictive Practice Policy RM05

- Where required undertake a critical incident analysis for lessons learned to be shared via appropriate reporting structures.
- Ensure staff attend and receive appropriate and correct training relevant to their role and presenting risks.
- Complete and review appropriately a Workplace Risk Assessment for Violence & Aggression for their service and area of responsibility (See Trust Risk Assessment Policy) ensuring that systems and procedures are in place for the effective management of any identified risk.
- Ensure specific risk assessments for individual staff in relation to specific threats of violence (harassment/stalking/threats of violence).
- Oversee the completion and review of appropriate clinically driven risk assessments and risk reduction plans to ensure that staff are protected from violence:
  - The assessment of the patient / resident is a fundamental risk management process for prevention and management of challenging behaviour, including violence and aggression. However, some patient / residents may present with unpredicted behaviour that places themselves or others at risk and unplanned restrictive practice may have to be used. Triggers of violence should be identified, care plans modified to reduce the risk. Other signs in patient / residents’ behaviour may indicate the possibility of an outburst and the arrangements for care should include the most appropriate form of action to take if violence is threatened or occurs.
- Ensure that all staff members involved in a patient / residents’ care, and relevant others where a patient / resident has consented, will be made aware of the results of these assessments and risk reduction plans.
- Where required ensure staff have access to security devices / alarms. (Lone working devices and pinpoint).

2.10 Individual staff:

- Individual clinical team members have a responsibility to comply with the requirements of this and associated policies and have a legal duty to have regard to it when working with, or caring for adults / children who may lack capacity to make decisions for themselves.
- All members of staff have a legal and moral duty of care to go to the assistance of their colleagues and provide assistance utilising minimal levels of force under the guidance of senior staff to manage any incident where staff are placed at risk of harm.
- All individuals have a duty of care to ensure that least restrictive intervention possible is practiced.
- All individuals have a duty of care to ensure that patient / residents are protected from abuse.
- Must assess risks and take precautions where they believe that a situation could result in a violent or aggressive incident and where required record information about a patient / resident and brief other relevant staff as necessary to maintain their safety.
- Must take all necessary actions to prevent personal attacks to themselves and others and to defend themselves if appropriate using the minimal amount of force to ensure their safety and escape.
- Must adhere to this policy, associated policies and guidelines and related local procedures and systems of safe practice.
● Undertake appropriate and approved training as outlined in the procedural
guidance.

● Must ensure that they report all incidents surrounding prevention and
management of violence and aggression using Datix as well as discussing
with the line manager if there is a change in clinical risk.

● Where an individual has been issued with a lone worker device, or other
safety devices, they must use it in compliance with the training and instruction
provided and to report any problems using the device. (RM17 Lone Worker
Policy/Procedure).

● Are accountable for attending appropriate training in line with Induction &
Mandatory Training Policy.

● Have a dual responsibility with The Trust for their health and safety in relation
to patient / residents’ challenging behaviour including violence and
aggression.

● Will always respond in a safe and timely manner to emergency incidents to
ensure the safety of staff and others.

● Will report all incidents on Datix

● Will appropriately report and share information regarding risks of challenging
behaviour, including violence and aggression.

● Will immediately report non availability of required alarms or other safety
equipment

● Must ensure positive and proactive support plans are written, implemented
and reviewed as appropriate.

● If patients / residents wish to formally raise a concern they will be reminded of
how to access the local complaints process and independent advocacy
services. They will be made aware of how to request the Trust policy’ on
restrictive interventions.

● The safeguarding team will be informed whenever a patient / resident raises
concerns about restrictive interventions. Patient / residents who need
alternative support will be offered this support to access and use the
complaints procedure.

3.0 DEFINITIONS

3.1 The Trust follows the Department of Health guidance and definition of
Restrictive Practice set out in the Positive and Proactive Care: Reducing the
Need for Restrictive Interventions, 2014 document:

‘Deliberate acts on the part of other person(s) that restrict an
individual’s movement, liberty and/or freedom to act independently in
order to:

● Take immediate control of a dangerous situation where there is a real
possibility of harm to the person or others if no action is undertaken;
and

● End or reduce significantly the danger to the person or others; and

● Contain or limit the person’s freedom for no longer than is necessary’
3.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

“Making someone do something they don’t want to do or stopping someone doing something they want to do.”

The Mental Health Act Code of Practice advises it is “any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person. More specific examples are available in the associated guideline.

4.0 PRINCIPLES

4.1 This policy and associated procedural guidelines apply to all employees (permanent or temporary) of the Trust and includes students, volunteers, agency staff and contractors, regardless of grade, occupation or responsibility.

4.2 This policy applies to all patient / residents who require restrictive practices whilst receiving treatment; this could include those patient / residents lacking capacity to make specific decisions about their own health and personal safety.

4.3 The Trust provides a wide range of services, including community services; this will necessitate some staff working on their own. Arrangements for ensuring the safety of lone workers are to be found within the Trust’s Lone Working Policy and Procedures; however, the principles of safety and prevention contained within this policy and associated guidelines will apply.

4.4 The policy covers the creation and ownership of all risk reduction plans and their implementation.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 This policy will be made available across the organisation via the Trust Intranet site and all staff must adhere to this policy and associated policies and clinical guidelines.

5.2 The Executive Director of Mental Health & Executive Nurse will be responsible for overall monitoring and review together with the Restrictive practice leads, training manager and Local Security Management Specialist.

5.3 This policy will be reviewed at least every 3 years taking into account emerging research, local audit recommendations and lessons learnt from reports, enquiries and positive practice initiatives.

5.4 Any amendments to this policy will be submitted to the following for consideration and endorsement prior to being ratified:
- Clinical governance Committee
- Health Safety & Security Committee
- Workforce Development & Training Department
- Trust Lead Nurses Advisory Group
5.5 This policy will be monitored for its effectiveness by Restrictive Steering Group and the training team.

**6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION**

DOH Positive and Proactive Care; reducing the need for restrictive interventions 2014

Mental Health Act (MHA) 1983: Code of Practice revised 2015

Royal College of Nursing consultation Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools 2014

Meeting needs and reducing distress, guidelines on the prevention and management of clinically related challenging behaviour in NHS settings 2014


A positive and proactive workforce. Skills for Health 2014


NPSA guidance document, *Seven Steps to Patient / residents Safety step 5* - “Involve and communicate with patient / residents and the public”.

National Institute of Clinical Excellence (NICE) Violent and aggressive behaviours in people with mental health problems (QS154) June 2017

NIMHE Mental Health Policy Implementation Guide Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient / resident settings; 2004

The Independent Inquiry into the Death of David Bennett; 2003

NHS Security Management Service (SMS) Promoting Safe and Therapeutic Environments, 2005

Mental Health Act 1983 (amended 2007)

Nursing and Midwifery Council The Code of Professional Standards of Practice and Behaviour 2015
7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

Clinical Risk Assessment and Management
Restrictive Practice Policy RM05
Adverse Incident Policy CP3
Advance Decisions and Statements CG6
Induction and Mandatory Training Policy HR21
Lone Working Policy RM17
Workforce Wellbeing and Stress Policy HR26
Searching a Ward and Service Users Property & Person (Including the Use of Drug Detection Dogs) Clinical Guideline, CG75
First Aid Policy RM08
Seclusion and Long-Term Segregation Policy and Procedure CP & CLP41
Zero Tolerance Policy and Procedural Guidelines CP22 & CPG22
Enhanced Observations - Trust Guidelines Observation and Engagement CG8
TASI Procedural Guidelines
Zero Tolerance Policy and Procedural Guidelines CP22 & CPG22
Risk Assessment Policy
Seclusion and Long Term Segregation Policy & Procedure CP & CLP41
Searching a Ward and Service Users Property & Person (Including the Use of Drug Detection Dogs) Clinical Guideline, CG75
Self-harm Prevention Clinical Guideline CG29
Handcuff Protocol SSOP 31
Pinpoint operational Procedure Guideline

END
RESTRICTIVE PRACTICE PROCEDURE

PROCEDURE REFERENCE NUMBER: RMPG05
VERSION NUMBER: 5

REPLACES SEPT DOCUMENT
Procedural Guidelines for Preventing and Managing Interventions That May Lead To the Use of Restrictive Practices

REPLACES NEP DOCUMENT
Prevention Management and Reduction of Violence and Aggression

AUTHOR:
Restrictive Practice Steering Group

CONSULTATION GROUPS:
HSSC

IMPLEMENTATION DATE:
16 November 2017

AMENDMENT DATE(S):
October 2011, May 2014 (Director Change), October 2014, November 2016

LAST REVIEW DATE:
October 2017

NEXT REVIEW DATE:
July 2020

APPROVAL BY CLINICAL GOVERNANCE AND QUALITY COMMITTEE:
20 September 2017

RATIFICATION BY QUALITY COMMITTEE:
16 November 2017

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Restrictive Practice Steering Group

PROCEDURE SUMMARY
These procedural guidelines aim to ensure that staff are provided with the current evidence based information and guidance to prevent and manage restrictive practices.

THE TRUST MONITORS THE IMPLEMENTATION OF AND COMPLIANCE WITH THIS PROCEDURE IN THE FOLLOWING WAYS:
The monitoring of the use of physical interventions through Datix forms, regular Audit undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team. Also by the dissemination of information from lessons learnt from physical intervention incident analysis.

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The Director responsible for monitoring and reviewing this procedure is Executive Director of Corporate Governance and Strategy
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APPENDIX 7 PHYSICAL INTERVENTION & RESTRAINT
APPENDIX 8a VIOLENT PATIENT MARKERS PROTOCOL
APPENDIX 8b VIOLENT PATIENT MARKERS ALERT FORM
1.0 INTRODUCTION

1.1 The aim of this procedural guidance is to encourage a culture across the organisation that is committed to enhance the therapeutic environment where the use of restrictive practices / interventions are minimised and used in a transparent, legal and ethical manner.

1.2 This procedural guidance will provide an overview of restrictive practices to all staff. It will also look at the process for managing behavioural disturbances using primary, secondary and tertiary approaches including reporting and evaluating the use of restrictive interventions/practices.

1.3 When episodes of challenging behaviour do occur these guidelines provide clear and effective strategies as recommendations for actions staff may take to deescalate, manage or intervene to bring the episode to a safe and rapid conclusion.

1.4 The Trust recognises the need to support staff at all times, and especially following an episode of challenging behaviour. The guidance, therefore, must be read in conjunction with Trust guidelines for Employee Wellbeing and Sickness Absence HR26 and associated documents which set out systems and processes to ensure that staff feels supported and that lessons are learnt and shared following incidents.

2.0 DEFINITIONS

2.1 The Trust follows the Department of Health guidance and definition of Restrictive Practice set out in the Positive and Proactive Care: Reducing the Need for Restrictive Interventions, 2014 document:

‘Deliberate acts on the part of other person(s) that restrict an individual’s movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person’s freedom for no longer than is necessary’
2.2 The Skills for Care and Skills for Health, a Positive and Practice Workforce (2014) provide a simple definition:

“Making someone do something they don’t want to do or stopping someone doing something they want to do.”

### 3.0 PRACTICE STANDARDS

3.1 Restrictive practices are not only confined to physical interventions and physical restraint. It refers to the actions or inactions that contravene a person’s rights. Below are some categories of restrictive practices and how these are applied. Any restrictive practice must be lawful and have a legitimate right and reason to do so. This is not an exhaustive list.

3.2 Physical Restraint

“Any direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of the body, or part of another person” (Positive and Proactive Care: reducing the need for restrictive interventions. DoH April 2014).

3.3 Environmental Restrictions

This is to limit people’s ability to move as they might wish, such as locking doors or parts of the building. This includes the use of electronic keypads with numbers to open doors, complicated door locking mechanisms and door handles.

3.4 Chemical Restraint

This refers to the use of drugs to modify a person’s behaviour. Medication that is prescribed to be taken as and when required (PRN) can be used as a form of restraint unless applied responsibly.

3.5 Forced Care

Actions to encourage / coerce an individual into acting against their will, for example having to be restrained in order to comply with instruction or request, or non-application of section 5/4 following advising an individual you will use it if they attempt to leave.

3.6 Cultural Restrictions

Preventing an individual from following the behaviours and beliefs characteristic of a particular social, religious or ethnic group chosen by them.
3.7 Decision making

Making a decision on the person’s behalf or not accepting or acting on a decision the person has made.

3.8 Community contact

Preventing an individual from participating in community activities, including working, education, sports and community events or from spending time in the community such as parks, leisure centres and shopping centres.

3.9 Contact with family and friends

Preventing or limiting contact with the individual’s peer groups, friends or family. For example not allowing the person to receive visitors, make phone calls or allowing them contact with specific friends or family member.

3.10 Blanket Rules

Blanket restrictions refers to policy rules or customs that will restrict a patient / residents’ rights and liberty that are routinely implemented to all patient / residents within a service without an individual risk assessment to justify its application. There needs to be justification for the implementation of blanket restrictions. They should be avoided unless there is specific justifications which are deemed appropriate and necessary to address the risk or risks identified for particular individuals, the impact of a blanket restriction on each patient / resident should be considered and documented in their records.

3.11 Deprivation of access to normal daytime clothing

Individuals must never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living (COP 26.161). However there are circumstances where it will be appropriate and necessary to use restrictive clothing in order to prevent risks to self-i.e. using anti ligature clothing. Where this is implemented, a rationale for this must be recorded, the patient must be informed of reasons, reviews must be evidence (including least restrictive alternative strategies) and the use must be for the shortest amount of time.

4.0 UNACCEPTABLE METHODS OF RESTRAINT/RESTRICTIVE PRACTICES

4.1 The following methods of restriction are unacceptable, especially if the individual requests or is consenting to any of the following. It may be considered and applied as appropriate, this must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following is not an exhaustive list.
4.2 Inappropriate bed height

This is unacceptable form of restraint as it could also lead to an increased risk of falls to the patient and risks to staff.

4.3 Inappropriate use of wheelchair safety straps

Straps supplied with wheelchairs should always be used when provided for the safety of the user. Although patient / residents should only be seated in a wheelchair when this type of seating is required and not as a means of restraint or to restrict the individual’s movement when there are lesser options available.

4.4 Using low chairs for seating

Low chairs should only be used when their height is appropriate, they should not be used with the intention of restraining a person, low chairs also pose a risk to staff in relation to manual handling.

Chairs by way of construction immobilise an individual e.g. Reclining chairs, bucket seats. This type of chair should be used for the comfort of the individual and not for the purpose to restrict movement.

4.5 Locked doors

Where units have locked doors for identified risks, there should be clear signage displayed informing individuals and visitors that the doors are locked and who they need to speak to gain exit from the area. If an individual wished to leave and is being prevented by the locked door that patient / resident is being restricted.

4.6 Arranging furniture to impede movement

Furniture should only be used for its intended purpose

4.7 Removal of outdoor shoes and other walking aids or the withdrawal of sensory aids e.g. glasses

As with the above they should be enabled to prevent confusion and disorientation.

4.8 Planned prone physical restraint

Planned prone restraint should not be used other than in exceptional circumstances, e.g. medical reasons, potentially to exit from seclusion room or administration of prescribed medication, when the medical lead has—prescribed medication following consideration of site. Utilisation of supine, seated de-escalation or the release of the patient / resident in a controlled manner if it is deemed appropriate and safe to so enabling them to move of their own volition to an area mutually agreed with them and staff as alternatives.
5.0 ASSESSMENT AND DECISION MAKING

5.1 Risk Assessment and decision making is an integral part of providing care and treatment.

5.2 Risk Factors (Appendix 1) and Antecedents and Warning signs (Appendix 2) must be taken into consideration in the assessment and decision making process.

5.3 Risk Factors to consider when placing patients on observation are set out in Appendix 4. Also see Observation and Engagement Policy and Procedure.

5.4 Risk Factors to be considered when a patient has specific needs are set out in Appendix 5.

5.5 Individual assessment should be carried out in partnership with the individual and considers the following.

- The individual's behaviour and underlying condition and treatment, understanding a patient / resident’s behaviour, responding to their individuals identified needs and mutually agreeing a way forward. This should always be at the centre of individualised care. All individuals require a rigorous assessment to establish a positive and proactive support plan to identify appropriate management process.
- The patient / resident's mental capacity and mental health. The individual's mental capacity requires consideration as consent must be gained to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Health or Capacity Act.
- The environment should be made to reduce the negative effects a care environment. Negative effects of a care environment include high levels of noise and disruption, inappropriate temperature control, inappropriate levels of stimulation, negative attitudes of care staff and poor communication skills.
- The risk to patient / residents and others, when using restrictive practices a balance needs to be achieved that minuses the risk of harm or injury to the individual and others within the area whilst maintaining the dignity, choice and personal freedom of the individual.
- Assessment should always place the individual at the centre of the process, involving them and those important to them as practical to do so. Evidence of personal centred care should always be documented and signed by the individual and identified staff member undertaking the assessment.

5.6 If a restriction is deemed appropriate the following must always be considered.

- The practice needs to have a legitimate goal, it must be necessary to protect the health and wellbeing of the individual or to protect the safety or human rights of others in the area. This should always be the least restricted option.
• Individuals effected by the restriction must be involved in the decision making process to the fullest extent of their capacity.

• The restrictions that are being instigated must be proportionate to the level of risk identified and the least restrictive option to achieve a safe outcome.

• The principles of dignity and respect must be observed at all times and especially at times when restrictive interventions are being implemented.

• There must be continuous review and evaluation of the practice being implemented to ensure that it is used for the shortest possible time period and that it is necessary and the most effective practice at this time.

5.7 If the individual has capacity and can give valid consent and their agreement can be gained without pressure, then the restriction can be put in place as long as it does not contravene the law. The individual has the right to withdraw consent / agreement at any time and it is required that they are informed of this right at the outset.

5.8 If the individual withdraws their consent but it is felt that the restriction should continue but it is deemed that the practice should continue, this can only be achieved if the restriction is supported by the Mental Capacity Act or the Mental Health Act, Criminal Law or the Public Health Act.

5.9 Appendix 8a outlines the process for when considering placing of a risk of violence marker on a patient record, Appendix 8b provides staff with the referral form in doing so.

6.0 PRIMARY PREVENTATIVE STRATEGIES

6.1 Pinpoint Alarms are a primary prevention strategy.

6.2 Behavioural disturbance and the use of restrictive practice can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), primary preventative strategies should typically include the following, depending on the individual’s assessed needs:

• Engaging with individuals and their families
• Care and support
• Considering the regulatory framework
• Patient / resident Community
• Patient / resident Characteristics
6.3 People who are identified as being at risk of presenting with behavioural disturbance which could include challenging behaviour must be given the opportunity to have their wishes and feelings recorded in an advance statement, if they have the capacity to do so (Trust Policy Advance Decisions and Statements CG6).

6.4 Staff should ensure that patient / residents who are assessed as being liable to present with behavioural disturbances have a care and treatment plan which includes primary, secondary and tertiary preventative strategies. In some services such a plan is referred to as a positive and proactive support plan or management plan. These individualised care plans, should be available and kept up to date and include the primary, secondary and tertiary interventions.

6.5 All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of aggression or violence. This includes the right to defend themselves using the justifiable, appropriate and reasonable force to ensure they can escape to an area of safety.

6.6 All clinical staff (and other staff identified by risk assessment) will have access to personal alarms (Lone Worker devices, ASCOM and PIT), where appropriate and determined by risk assessment. Training through induction is given. It is the responsibility of each member of staff to familiarise themselves with the use and circumstances in which alarms should be used.

**7.0 SECONDARY PREVENTATIVE STRATEGIES**

7.1 De-escalation is a secondary preventative strategy.

7.2 De-escalation techniques are set out in Appendix 3.

7.3 It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance which could include challenging behaviour.

7.4 De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.
8.0 TERTIARY INTERVENTIONS

8.1 Physical interventions / restraints are a tertiary preventative measure.

8.2 A physical intervention / restraint is defined as:

“Any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person”

8.3 Therapeutic and Safe Intervention (TASI previously referred to as PMVA) is set out in Appendix 7.

8.4 All staff that utilise these interventions must be aware of the legal framework that authorises their use. The main guidance is given in Chapter 2 of the Mental Health Act Code of Practice 2015 and should be followed for every incident. Where departures from the guidance occur they should be rigorously recorded and justified as being in the patient / residents best interest.

9.0 LEGAL CONSIDERATIONS

9.1 All staff that utilise these interventions must be aware of the legal framework that authorises their use. The main guidance is given in Chapter 1 of the Mental Health Act Code of Practice 2015 and should be followed for every incident. Where departures from the guidance occur they should be rigorously recorded and justified as being in the patient's best interest.

9.2 The use of Physical intervention must be as a last resort, defensible in law and within Trust Policy and Procedures.

9.3 The use of “Reasonable Force” is legally permitted. All staff must be aware that their own personal safety is paramount in any situation where they are faced with episodes of challenging behaviour. In a one on one situation removal of yourself to a safe area is the first course of action.

9.4 Staff need to ensure that the risk is assessed prior to carrying out any physical intervention to maintain the safety of themselves and service users.

10.0 PHARMACOLOGICAL MANAGEMENT OF ACUTELY DISTURBED BEHAVIOUR CLINICAL GUIDELINE (RAPID TRANQUILISATION COP 26.91 – 26.102)

10.1. For information regarding the use of medication in the management of acutely disturbed behaviours, staff must refer to the following Trust policies:

- Formulary and Prescribing Guidelines, Chapter 8 - Pharmacological Management of Acutely Disturbed Behaviour Clinical Guideline (PMAD-B)
- Safe and Secure Handling of Medicines Guidelines
11.0 SECLUSION AND LONG TERM SEGREGATION

11.1 For information regarding the use of seclusion and long-term segregation in the management of acutely disturbed behaviours, staff must refer to the Trusts Seclusion Policy and Procedure CP41 & CLPG41.

11.2 Staff must also be familiar with and follow the guidance given in the Mental Health Act Code of Practice 2015.

12.0 WEAPONS AND HOSTAGE TAKING

12.1 Where a patient/resident presents with a weapon (of any description) or has taken a hostage as part of an episode of challenging behaviour the police must be called immediately. Staff must remove all persons from the area and isolate the patient/resident concerned. Safety of the staff and others takes priority in this matter.

12.2 The procedure described in Appendix 6 should then be followed.

12.3 In all Community Services where a patient/resident presents with a weapon, the staff member will safely withdraw and dial 999 requesting emergency assistance or call a red alert on their lone worker device. (Please refer to the Trust Lone Working Policy and Procedure).

13.0 INCIDENT REPORTING AND RECORD KEEPING

13.1 All incidents and the interventions used are to be fully recorded in the patient/residents healthcare records and on Datix, see Adverse Incident Procedure and Online Incident Reporting Datix Guidance, Appendix 5.

14.0 SUPPORTING STAFF, PATIENT / RESIDENTS

14.1 Support for staff, patient and relatives are detailed in Management of Stress Procedure HRPG26D.

15.0 POST INCIDENT REVIEWS / CRITICAL INCIDENT ANALYSIS

15.1 Post Incident for staff is detailed in Management of Stress Procedure HRPG26D.

15.2 Managerial decisions will determine the level of post incident review dependant on the seriousness of the incident event. Good practice determines that where tertiary interventions are used and or where significant injury to persons or damage to property result then post incident reviews should occur.

15.3 These discussion should only take place when those involved have recovered their composure.
15.4 The aim of post incident reviews should be to seek to learn lessons, support staff and patient / resident, and encourage the therapeutic relationship between staff patient / residents and their careers.

15.5 Post incident reviews should take place as soon as possible, but in any event within 72 hours after the incident. The review should look objectively at the lead up to the incident, the dealing of the incident and the aftermath of the incident.

15.6 The post incident reviews should wherever possible be led by a person not directly involved in the incident event and address:

- Any precursors, causative factors and trigger points;
- What happened during the incident;
- Sequence of events;
- Address individual’s roles and their decision making processes;
- How a successful outcome was achieved and how the event ended;
- What went well and demonstrated good practice;
- What lessons can be learnt;
- An evaluation of the effectiveness of response times surrounding the incident;
- What strategies / interventions could be used if the incident were to reoccur;
- Issues that senior managers or the MDT need to be aware off;
- Where possible, recommendations should be made as to future management plans for the service user or the organisation.

16.0 TRAINING

16.1 The Trust will provide education and training surrounding physical interventions through, the Workforce Development & Training Department as guided by risk assessment of staff roles and individual service areas. (See Induction & Mandatory Training Policy / procedure appendix 1 for the training matrix).

16.2 All new nursing staff to inpatient mental health areas will undertake initial training in physical interventions.

16.3 Senior clinical staff are responsible for team based training and ensuring ongoing competency of staff in managing risks associated with lone working. Each team must ensure staff are informed about current policy requirements, through team based induction, preceptorship and supervision.

16.4 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Clinical Governance and Quality, Service Management Teams and Health Safety and Security Committee.
Managers are responsible for checking that training has been undertaken by a member of staff and is valid, so as to aid in maintaining the minimum of 3 physical intervention trained staff per shift, unless specified in local operational procedures.

Staff who are booked onto mandatory training and are, for whatever reason, unable to attend, MUST inform their line manager and ensure that their training is rebooked at the earliest opportunity.

Staff who do not attend a mandatory training course will be recorded and reported as a DNA unless prior notification was given in line with Induction and Mandatory Training policy.

A withdrawals and DNA report will be produced monthly as part of the mandatory reporting system.

Managers must determine if additional training is required in any element of restrictive practice.

**17.0 MONITORING AND REVIEW**

The monitoring of the use of physical interventions is an essential part of managing a ward, area, unit or department, therefore all incidents involving physical interventions will be recorded as per Adverse Incidents including Serious Untoward Incidents Policy and monitored by the Ward Manager/Nursing Home Manager Team Leader and Clinical Manager.

Audit is undertaken in conjunction with Workforce Development & Training Department and Risk Management Team and supported by the Clinical Audit Team with results presented to the Clinical Governance Committee and Health, Safety & Security Committee. This will include as a minimum:

- Duties
- Requirement to undertake appropriate risk assessments
- Arrangements for ensuring the safety of lone workers (see Lone Working Policy)

Analysis of physical intervention incidents will be undertaken by the Restraint and Seclusion Review Group to identify trends and patterns of activity in the use of physical interventions.

Any lessons learnt from physical intervention incidents that are recognised through the reporting process and the Restraint and Seclusion Review Group will be fed into the Clinical Governance Committee for sharing across the organisation.

Monitoring of training compliance will be undertaken by Workforce Development and Training.
17.6 Datix forms involving physical interventions will be reviewed by trainers, using the Datix communication processes. Also if there are 5 incidents with 1 patient in a week the area will be contacted by the trainers so support can be given.

18.0 POLICY REFERENCES/ASSOCIATED DOCUMENTS

Mental Health Act 1983 (amended 2007)
MHA Code of Practice 2015
Restrictive Practice Policy RM05
Adverse Incident Policy CP3
Advance Decisions and Statements CG6
Induction and Mandatory Training Policy HR21
Lone Working Policy RM17
Workforce Wellbeing and Stress Policy HR26
Searching a Ward and Service Users Property & Person (Including the Use of Drug Detection Dogs) Clinical Guideline, CG75
First Aid Policy RM08
Seclusion and Long-Term Segregation Policy and Procedure CP & CLP41
Zero Tolerance Policy and Procedural Guidelines CP22 & CPG22
Enhanced Observations - Trust Guidelines Observation and Engagement CG8

END