East London NHS
NHS Foundation Trust

Community Health
Newham Directorate

Extended Primary Care Services Operational Policy

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1.1	May 2014	Petra Nittel		16.3 Requirement for Waterlow assessment to be carried out for all patients on admission.
2.0	September 2016	Julia Callus/Timi Ogunlowo		Review of document in view of service redevelopment- Implementation of Rapid Response. Implementation of Triage desk and Single Point of Access. Restructuring of the Extended Primary Care Services.
3.0	September 2017	Julia Callus / Timi Ogunlowo		Revision of appendix D.

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1. Introduction

1.1 The key function of the Extended Primary Care Service is to treat people in their homes through the establishment of integrated multi-disciplinary teams, working across two localities with strong inter-disciplinary relationships and broader partnership arrangements with other service providers. Intervention and treatment will be pro-active and based on the utilisation of a range of diagnostic tools and referral criteria to ensure fast track and efficient use of the community based resources.

1.2 The following policies and procedures reflect the changed relationships, new patterns of working and increased collaborative approaches envisaged in Transforming Community Services (Department of Health DH 2009) and Equality and Excellence – Liberating the NHS (DH 2010).

1.3 This policy covers the general principles pertaining to the operation of the Extended Primary Care Service and the multi-disciplinary teams.

2. Philosophy of Care

2.1 Newham Model for Integrated Care – Operational Model

The model of delivery is based on the principle of "Right care, right time and right place". It reflects the philosophy that providing the right kind of support to help people manage their existing long term condition and provide support to help them through any exacerbation of that condition is the surest way to avoid them being admitted into hospital.

Through an increased emphasis on health education and promotion people can be supported to stay well and develop independence and broader skills toward self-care. The service design for Extended Primary Care Services enables the provision of care and support to vulnerable people with the most complex medical and social needs in a range of community settings.

Clients within this cohort will have long term needs and will require integrated support from multidisciplinary teams and identified specialist intervention. They will continue to be supported in the community and will be actively managed by the appropriate professionals. There is recognition that these patients will have highly complex needs including rehabilitation, long term condition management and end of life care needs.

A diagrammatic representation of the Newham model for integrated care is shown on page 8 of this Policy.

2.2 Self care

Patients who can care for themselves, and can be cared for at home or other community based environment. These patients are registered in a primary care setting and have strong primary care support.

2.3 Supported Self Care

These clients will be able to care for themselves in the community but will need support through enablement services to facilitate greater independence.

The service interaction is envisaged to be infrequent but appropriate to the support needs identified by the individual and Tele-Health could be a strong component of this care offer. Strong linkages with primary care and the GP attached to the multi-disciplinary team in addition to District Nurse and Clinical Lead and other clinical rehabilitation specialists will support any long term need.

2.4 Patients with highly acute needs

These patients will be managed by the Rapid Response Service (Please see Rapid Response SOP).

2.5 End of life

The EPCT will look after patients at end-of-life to enable them to die at home if that is their wish and their carers will be supported. This will be achieved by close working with the hospice service and maintenance of an end-of-life register.

2.6 Supported Discharge through In-reach

The In-Reach Team provides support in the community and acute setting and facilitates an early discharge service to patients in the Acute Hospital.

The team works alongside the hospitals clinical team in identifying patients that are suitable for an early supported discharge home and arrange that patients will be visited at home by the Extended Primary Care Services.

2.7 Telehealth

Newham Telehealth services can be provided via the service users Television (TV), a mobile phone using SMS messaging or simply through using structured questions over the phone. The TV version is known as Motiva and the phone version is known as Florence or Flo.

Typically a service user will measure their vital signs relevant to their long term condition(s) on a regular basis and transmit these to a Telehealth Assistant Practitioner. The readings are monitored to look for trends that could indicate deterioration in health and exacerbations of the condition and will advise the service user in accordance with agreed protocols.

In addition to monitoring vital signs, a TV based Telehealth service can provide instructional videos and questionnaires that seek to educate the patient about their condition/s. Telehealth is offered via three key areas of provision, i.e. core Telehealth, simple Telehealth and the Diabetic Specialist Nurses.

Newham model for Integrated Care

Appropriate support, in the best place at the right time

Risk Stratification	Patient choices & reported outcomes	Telehealth (Coach, Monitor, Review) & telecare	STEP DOWN	Hospital In reach team	STEP UP	GP Management	Specialist Nurse & therapist services	Work with hospital to minimise avoidable admissions and facilitate discharge
				Rapid Response				
				Extended Primary Care Services				Longer term support to help people cope in the community, including training in self-care.
				Informally supported self care		GP Practices		Support by informal carers.
		Stand-alone devices		Self-care				Patients who can care for themselves and will seek GP services if needed.
Integrated systems			**PATIENT PATHWAY Informed patients, making choices and giving feedback**			**Integrated services**		
Patient choice supported by information and guidance.						Service improvement through feedback and constant monitoring of service delivery & outcomes		
Practice Clusters working through Clinical Commissioning Groups to secure the best health outcomes possible for the people of Newham								

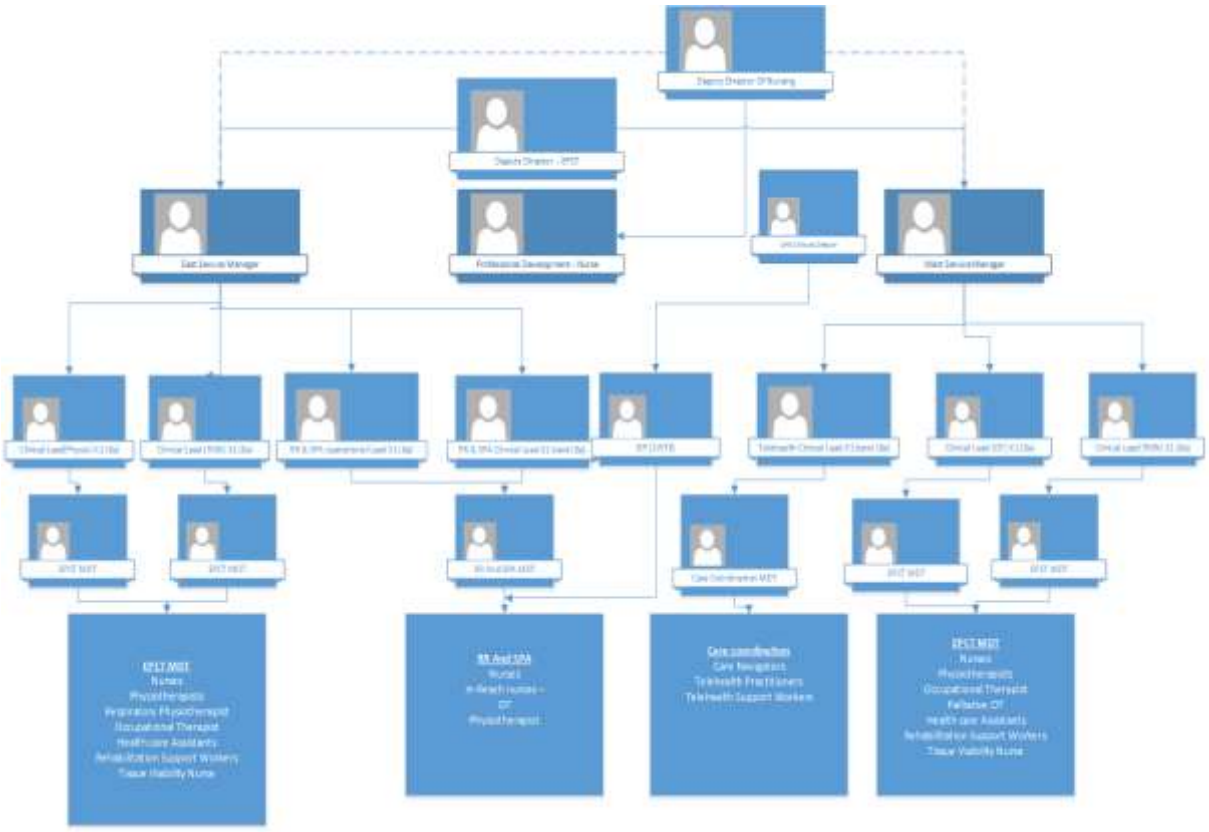
3. Staffing

3.1 Key Principle

The Extended Primary Care Service will comprise of personnel from differing clinical and operational disciplines. Whilst each member may carry distinct roles and responsibilities, case loads and input into the team, the general principle will be one shaped by patient need, collaborative practice and collaborative decision making.

3.2 Structure and operational management

The Extended Primary Care Service is divided geographically across four quadrants the Borough of Newham. The organisational chart below sets out the operational structure.



3.3 Individual Professional Responsibilities

For detail see job descriptions and professional codes of conduct as per specific professions by grades. All staff must adhere to Trust Policies and Procedures.

3.4 New members of staff (Permanent/temporary/Agency)

All new staff within the Extended Primary Care Services will have a local induction. Induction proforma Appendix A will be used with all new permanent member of staff and Appendix B with temporary/Agency staff.

4. Conduct and professional responsibility

4.1 Key governing principles

Each professional group represented in the multi-disciplinary team will follow and adhere to their respective professional code of conduct, e.g. Nursing & Midwifery Council (NMC), Health and Care Professionals council (HCPC).

All members of the Extended Primary Care Service will adhere to Trust policies guaranteeing inclusion and non-discriminatory practice both in terms of those working in the team, those accessing its services and those partners with which it operates.

All members of the multi-disciplinary team will work in partnership with patients and their carers and other provider agencies and professionals to ensure that care packages minimise duplication and omissions.

All staff within the Extended Primary Care Services will have equal responsibility to ensure the services commitment in upholding the trusts guidelines on misconduct. Any breach will be reported through the agreed Trust reporting structures.

All members of the Extended Primary Care Services will work flexibly across localities where necessary.

4.2 Conduct for staff working in Peoples' homes

Staff will wear badges indicating their name and role at all times when carrying out duties for Community Health Newham Directorate.

Staff not wearing uniform will dress appropriately for the work they undertake and respect the cultural differences in the population they serve. A professional presentation will be maintained all times in line with existing policy on dress code in community settings. All staff will keep in line with the Trust Dress code policy.

Staff will ensure home based visits are planned in advance in agreement with the patients and their carers. Where visits are cancelled for any reason staff will, unless good grounds for exception exist, provide clear notice to patients and other professionals.

4.3 Conduct between professionals

Relationships at all times within the multi-disciplinary team will be directed toward meeting the key objectives of the service and needs of patients referred to it.

Formal multi-disciplinary team meetings and ward rounds will provide a formal arena for clinical problem solving, sharing best practice, assessment and discharge.

5. Communication

5.1 Key principle

Communication between staff employed in the Extended Primary Care Services, and other professionals working in collaboration with each of the multi-disciplinary teams will be central to its success.

This will equally apply where inclusion of other statutory, voluntary and private sector providers becomes a pre-requisite in ensuring long term care and support goals are met beyond the period of acute phase of interventions previously delivered through EPCT or secondary care.

5.2 Communication within the multi-disciplinary team

Key decision making in regards to assessment and referral of new and existing patients will be made through discussion at meetings with representation where possible from all disciplines and staff attached to each locality. The views of each professional discipline will be sought in identifying the appropriate package of care and any potential "step up" to Rapid Response or other specialist service.

Handover is a significant element of care delivery and members of the EPCT will be handing over information about patients in a timely and comprehensive fashion and highlight urgent or unresolved issues.

5.3 Communication with professions outside of the Extended Primary Care Service

Community Health Newham recognises that the success and the broader sustainability of the Extended Primary Care Services will be co-dependent on the input and support of other organisations and agencies.

Key agencies central to the successful delivery of the service will include though not exclusively:

- London Borough of Newham Adult Services
- Newham GPs
- Clinical Commissioning Group Clusters
- Barts Health Trust
- Other directorates in ELFT
- ICES
- Newham Voluntary Sector
- Other Community Health Newham specialist service providers

All members of the Extended Primary Care Services will work collaboratively with other professionals and agencies to ensure appropriate support is offered and delivered to clients, their families and carers. Responsibility will rest with Clinical Leads and other team members to identify key individuals responsible for maintaining these links, working relationships and problem resolution for each of its key partners from within their operation field of responsibility.

6. Times of Operation

6.1 Key Principle

The Extended Primary Care Service will not exclude patients requiring input from secondary care, and comprehensive support will continue to be offered in line with agreed safe clinical guidelines with any future discharge in to the care of other appropriate community teams governed by the needs of the patient.

6.2 Hours of Business

The hours of business during which the Extended Primary Care Service will be in operation are as follows:

District Nursing:

Monday to Sunday

08.00 – 22.00

Therapy Services:

Monday to Friday – Physiotherapy and Occupational Therapy

08.30 – 16.30

Saturday/Sunday/Bank Holiday – Physiotherapy only

08.30 – 16.30

Telehealth Team:

7 days a week (Monday – Friday)

08.00 – 16.00 hours

Saturday 08.00 – 12.00 hours

Sunday and bank holiday 08.00 – 11.30 hours

Dressing Clinic

Refer to Dressing Clinic SOP

Rapid Response

Monday – Friday 08.00 – 20.00 hours

Saturday - Sunday 08.00 – 16.00 hours

7. Referral and Admission

7.1 Single point of Access (SPA)

Simplification of referral into the Extended Primary Care Service will ensure decisions regarding assessment and admission are taken quickly. All referrals to the EPCT are through the triage desk which is a component of the SPA. The referrals are screened and assigned to individual teams and professionals. The triage team clinically decides the level of urgency required to respond to the

referral. The process aims to reduce confusion for those using the service and ensure fast clinical response from multi-disciplinary professionals within the service.

There is one contact number to the service which is to be used at all times. Telephone contact is through 0208 709 555. This is phone is manned by dedicated administrators between 0800 hours and 2000 hours. The telephone line is automatically diverted to the Clinical Lead on call between 2000 hours to 0800 hours.

8. Eligibility Criteria

8.1 Eligibility Criteria for EPCT District Nursing Service/Therapy Services

Urgent referrals will receive a response within 24 hours; non urgent referrals will be contacted within 72hours.

Hospital discharge referrals; i.e. for those patients who will require a nursing follow up after a period of acute hospital treatment, the referrals should be emailed to the Single Point of Access (SPA) epct.spa@nhs.net no later than 48 hours prior to the discharge of the patient.

All EPCT Staff can be contacted via the SPA ON 0208 709 5555.

District Nursing is usually reserved for individuals who are over 16 years, are Newham residents and housebound – that is they can only leave the house by ambulance, or there should be some other reason why a home visit is deemed necessary. District Nurses cannot carry out 'check' visits; all referred patients must have a recognised nursing need. For referrals to Therapists, the individual referred is not necessarily housebound, however, must have rehabilitation potential and is motivated to participate in rehabilitation programmes.

Appointment times are not usually given, but a time band will be offered to patients on the district nurses caseload. Time bands will be either am/mornings (0800 – 1200 hour), pm/afternoons (1200 – 1600 hours) or evenings 1600 – 2200 hours) PM.

District Nursing is **not an emergency service**. District nurses service would not be used to collect prescriptions; this should be done by family carers or delivered by pharmacists.

9. Discharge

9.1 Key Principle

A patient's discharge will not be time determined, and they shall remain under the support of the Extended Primary Care Service for the length of the treatment episode. The Extended Primary Care Services is committed to planning discharge in partnership with the client and their family/ carers. Discharge arrangements will be according to the CHN Discharge and Transfer Policy, whereby a discharge letter is sent within 24 hours to the GP and the patient issued with a copy.

Each member of the service team recognises the importance of a more flexible approach in terms of self-directed care, rehabilitation and independence in

regard to discharge (where appropriate) for patients treated under its provision. This policy additionally recognises the central role of the Extended Primary Care Services in supporting long term care and the role of Tele-Health in facilitating step-down and self-care.

9.2 Mechanism for Discharge from the Extended Primary Care Service

From the commencement of treatment on the Extended Primary Care Services and throughout the course of the team's intervention, the MDT will assess and discuss the likely point at which discharge will take place.

Discharge from the Extended Primary Care Services will be directed by agreement between the patient and all members of the multi-disciplinary team. Patients will only be discharged after the appropriate care package is identified and in place.

Discharge planning takes into consideration the need for referral to other statutory and voluntary services. Staff must be proficient in identifying specific individual client needs and committed to ensuring high quality arrangements with other local services.

10. Admission to East Ham Care Centre

Please see East Ham Care Centre Admission SOP.

11. Provision of diagnostics and equipment

11.1 Key principle

The provision of supplementary services for the provision of medication, diagnostics, pharmaceutical supplies and equipment is critical to developing a sustainable model of delivery for clinical interventions enabled through the Extended Primary Care Services. Each plays an essential role in supporting these interventions from within the multi-disciplinary teams and the broader goal of reducing the need for a hospital bed.

11.2 Equipment

The central provider of equipment to the EPCT will be the Integrated Community Equipment Team (ICES). The Extended Primary Care Services will build on existing relationships between Community Health Newham and ICES to ensure delivery of support and clinical interventions to patient in the community.

Equipment will be ordered where clear clinical need has been identified by the clinicians in the Extended Primary Care Services. Orders will be placed on the electronic system within 24 hours of the need being identified.

Once the order has been placed, the practitioner who placed the order will liaise with the ICES and about availability and suitable dates for delivery and ensure that equipment is in place in a timely manner. Where specialised equipment required is not available, the practitioner will identify what alternative equipment can be used in the interim and ensure that additional care interventions are documented on the care plan. Also, that this is escalated

to the Clinical Lead and other related teams and services such as the Tissue Viability Team.

Once installed, relevant members of the Extended Primary Care Services have a duty to ensure that the equipment is fully functional and evaluated that the patient's needs are met as set out in the care plan. Where this is not the case, a new assessment will be made and alternative solutions identified.

Staff from the Extended Primary Care Service should check that equipment is functioning on each visit/ any fault should be reported to ICES.

Equipment lent to the patient will be ordered from Integrated Community Equipment Service via the electronic ordering system ELMS or purchased by the patient if a patient does not meet the necessary criteria for a loan. Where there is no longer a clinical need for equipment it will be collected by the Integrated Community Equipment Service, either through patients and carers contacting the service directly or through members of the multi-disciplinary team entering a request on ELMS. This should be done in a timely fashion in order for it to be available for re-use.

11.3 Phlebotomy

Blood tests can be requested by the Clinical Leads or the Rapid Response GP. Patients' GP can request blood tests for patients at home and in nursing/residential settings where there is regular and on-going Community Health Team intervention as part of patient's on going package of care.

During daily operating hours of the Phlebotomy service it will be the responsibility of members of the Extended Primary Care Services taking the blood to ensure samples are delivered safely to the appropriate collection centre.

12. Safeguarding and Mental Capacity

12.1 Principle

The need for Extended Primary Care Services staff to have awareness of the vulnerability of patients to become the victims of abuse and neglect by other people, be they family, members of the public, or staff members is imperative.

Safeguarding and mental capacity are fundamentally different matters and different policies and procedures apply.

However, within the context of care provided by the Extended Primary Care Services, considering the ability of patients when they make decisions about their care in terms of mental capacity and applying the relevant procedures will support appropriate clinical decision making and prevent actions or omissions that could be interpreted as neglect and will ensure the team work within the appropriate legal framework.

12.2 Safeguarding Procedure

The Trust Safeguarding Vulnerable Adults at Risk Policy provides guidance for staff. Where abuse or neglect is identified or suspected, this must be immediately reported on the Datix incident database and a Safeguarding

Adults Alert (SA1) completed and forwarded to the London Borough of Newham. Patients may need to be moved to safety or arrangements put in place that create a safe environment and safeguards their physical and emotional wellbeing.

12.3 Mental Capacity

The Trust's Consent to Treatment Policy provides guidance on when a patient's ability to make decisions needs to be assessed. It must be remembered that a patient's decision not to follow care that has been advised or prescribed does not automatically indicate that there are mental capacity issues and performing capacity assessments needs to be carried out. In the first instance, where a patient does not wish to comply with advice, the clinician needs to ensure that full explanations of the proposed treatment plans and the consequences of the choices made have been given and are fully understood. This can be achieved by undertaking a test of capacity, details of which are set out within the trusts 'consent to treatment' policy or in chapter 4 of the 'Mental Capacity Act Code of Practice'. Both are available on the intranet.

In the event that patients still do not wish to proceed, suitable alternatives must be explored. This needs to be fully documented in the health care record.

Where a mental capacity assessment has been performed and the patient has capacity, the clinician needs to proceed as described above and explore alternative solutions.

Where the mental capacity assessment shows that the patient does not have capacity to make the particular decision regarding their care and/ or treatment that needs to be made, the Consent to Treatment Policy needs to be followed to ensure that the patient's interests are maintained. The trust has a mental health law team who are available to provide further expert advice and support regarding the use of the mental capacity act in clinical practice. They can be contacted on 02076554046

13 Care Planning, Care Delivery, Handover and Record Keeping

13.1 Principle

All record keeping should be in accordance with Trust Policy and Professional Codes.

13.2 Care Planning

All patients admitted to the Extended Primary Care Service will have a care plan based on the initial assessment and any problems identified from this. All care plans must be individualised and goal oriented, the care plan is to be agreed with patients, family members and carers.

All mandatory fields of the initial assessment must be adequately completed. Special attention should be paid to the risk assessment and plans should be made if risks are identified in order to protect both staff and patients. Its focus

is holistic, and is based on the clinical judgment of the practitioner, using assessment data collected from the initial assessment.

It is based upon identifiable diagnoses (actual, risk or health promotion) - clinical judgments about individual, family, or community experiences/responses to actual or potential health problems/life processes.

It focuses on client-specific care intervention outcomes that are realistic for the care recipient

It includes care interventions which are focused on the etiologic or risk factors of the identified diagnoses.

It is a product of a deliberate systematic process and it relates to the future.

All care plans just be reviewed at least 4 monthly.

13.3 Specific considerations for care planning and care delivery

All members of the EPCT are required to ensure that suitable care plans are in place that reflects the needs associated with the original referral but also additional needs as part of a holistic assessment. The initial care plan as well as all subsequent changes are explained to and agreed with the patient as well as any relevant carers or family. All members of the EPCT are required to escalate to their line managers any issues that impede on the optimal delivery of the care plan.

- The ability of patients or their carers to communicate requires specific consideration and members of the EPCT need to assure themselves that the chosen method employed to overcome communication difficulties is effective. Language Line should be engaged where there is any doubt that informal translation arrangements are ineffective.
- Goals that are expected to be achieved as a result of the care intervention will be discussed and agreed with the patient and this will be documented in EMIS and on the home notes.
- When carrying out care interventions such as skin assessments or pressure area checks, members of the Extended Primary Care Services will be making their own observations rather than relying on statements from carers.
- Where patients require changes to their pain control, this is pro-actively managed on behalf of the patient by contacting the relevant prescriber and the effectiveness of any changes made followed up.
- A jointly signed copy of the care plan is kept at the patient's home and patients are aware of this.
- Members of the Extended Primary Care Services will ensure that comprehensive handovers are given, with urgent issues highlighted. Any changes to care plans or risk assessments must be recorded in the patients EMIS notes and discussed at handovers.
- Within a time band, the time of visits is agreed with patients and/or carers. Where a visit is delayed, the patient and/or carer is notified as much in advance as possible.

13.4 Formal Carers and Shared Care Agreement

Where formal carers supplied by London Borough of Newham are engaged as part of care packages, the Extended Primary Care Services acknowledges a responsibility to ensure that there is effective liaison. This includes

- Implementation of the Shared Care Agreement **(Appendix C).** Carrying out training such as monitoring skin for pressure areas and escalating any concerns
- Proactively obtaining progress updates or information from formal carers about patients
- Giving instructions on care activities

13.5 Informal Carers

Where the patient or their family or friends wish to carry out care activities for patients under the care of the Extended Primary Care Services, the EPCT acknowledges a responsibility to ensure that there is effective liaison. This includes

- Monitoring that care activities carried out are of sufficient standard to safeguard the well-being and safety of the patient at all times
- Carrying out training such as monitoring skin for pressure areas and escalating any concerns
- Carrying out training for specific care activities and assuring that these are carried out competently
- Obtaining contact details for those carers that do not live on the same premises as the patient
- Agreeing with those carers that they are present to give access to the patient on a pre-agreed schedule
- Proactively obtaining progress updates or information from formal carers about patients

13.6 Access Issues

Where care activities cannot be carried out as scheduled because members of the EPCT cannot gain access, they will follow the No Access Action Protocol **(Appendix D)**

13.7 Electronic EMIS Record

The electronic EMIS record is the health care record used for all patients admitted to the Extended Primary Care Service. All visits and care interventions need to be documented in the EMIS record either on the same day but no later than 24 hours, all healthcare records need to be comprehensive enough to facilitate appropriate care by all EPCT team members as well as other CHN services.

Where temporary staff have carried out care and do not have access to EMIS, the Team Leader will ensure that such staff are buddied up with a team member with EMIS access and ensure that a healthcare record is completed for each care episode carried out by the temporary member of staff.

Any paper based forms or assessments have to be uploaded on the EMIS record.

13.8 Healthcare Records Kept at Patients Homes

Patients and their carers will have a current version of their care plan that is kept the patient's home. A copy of the discharge summary will be added either before or at the point of discharge.

13.9 Pressure Ulcer Prevention and Management Documentation

Please refer to the Integrated Pressure Ulcer Action Plan.

14. Performance Data Recording Capture

14.1 Key Principle

KPI's and CQUINS are reviewed yearly. Performance data will be collected from the electronic systems. All staff should provide information as required. Clinical Leads should be aware of the CQUINS and KPI's.

15. Surge and Business Continuity Planning

See EPCT Business Continuity Plan.

16. Clinical Governance

16.1 Key Principle

The Extended Primary Care Services recognises that in order to deliver safe and effective care and support continuous service improvement, both the Extended Primary Care Services will fully engage with the Trust's Clinical Governance Strategy and the Trust's Quality Improvement Initiative.

16.2 Clinical Governance

The EPCT will participate with trust wide audits and develop and implement remedial action plans where shortfalls have been identified.

The EPCT will develop an annual local audit calendar that is tailored to specific activities or issues identified within the Extended Primary Care Services and implement remedial action plans where shortfalls have been identified.

The Clinical Leads will be leading on the reflection on issues identified in complaint and incident reports with their team members to facilitate service improvements.

The Clinical Leads will be leading on evaluating patient feedback (PROMS and PREMs) with their teams and identify and implement remedial actions.

Locality General Managers will gain assurance from the Clinical Leads that action plans have been implemented.

APPENDICES

Appendix A

LOCAL STAFF INDUCTION PROFORMA

First Name:		Surname:	
Job title/ Grade:		Department & Location:	
Line Manager:		Name & Grade of staff member conducting local induction:	

This form has been developed to ensure that all staff receives a local induction within the service/ department in which they work.

Newly appointed staff should be given this induction checklist by their Manager on commencement. The Manager should ensure that it is completed and signed within four weeks.

The Manager, and/ or those delegated, will facilitate and assist the new member of staff through all the topics listed in this checklist.

In order to get your name badge, please ensure that each of the headings is signed and dated and that once completed a copy of this page and the next page is returned to the Training and Development Department on the last day of your Induction.

Induction Confirmation

I have a clear understanding of the topics covered in induction and agree to abide by Trust Policies & Procedures. If in doubt about any of this, I know to ask.

Signed by new staff member…….. Date ……..

I am satisfied that all the subjects in induction have been completed to my satisfaction and that of my staff member.

Signed by line manager …….. Date …….

Training Nominations

In order for the Trust to be able to report on training compliance we need you to let us know if newly appointed staff need to attended the following training courses. Please type yes to nominate your staff and no to exempt staff.

Course Name	**Details of Specialist Group**	**Training Date (s) Requested**
Fire Marshall Training	All Staff Appointed as Fire Marshall	
Systematic investigation using Root Cause Analysis	All members of staff involved in incident investigation	
Investigation of Complaints	Staff with responsibility for investigating complaints	
Immediate Life Support	Duty Senior Nurses	
Clinical Risk Assessment	All care co-ordinators and clinical staff in multidisciplinary teams except Consultants and Senior Trainees in Forensic Services	
Staff Supervision	All staff who supervise other staff, except doctor with train the trainer programme	
Health & Safety for Risk Officers & Facilitators	All risk officers	
Equality & Diversity Level 2	All Managers Band 6 and above	
Consent to Treatment, Capacity and Deprivation of Liberty	All professionally qualified clinical and social care staff	
Receipt & Scrutiny of statutory forms	Qualifies staff who accept statutory forms (must have 1 year post registration experience)	
CPA	All clinical staff in the community and inpatient settings with delegated responsibility	
Food Hygiene	Any Clinically based staff who handle food or drink	

1 Day Breakaway	All staff with patient contact who are not required to undertake 3 or 5 Days PMVA	
5 Days PMVA Acute & Forensics	Ward based nursing staff in forensic and Acute Services	
3 Days PMVA MHCOP	Ward based nursing staff in Older People Services	
Safeguarding children Level 2 & 3	All clinical staff except HQ staff nominated by HGC Chair	

Please provide us with Budget Code _____

Supervisor: Please Date and Sign following training

New staff Member: Please Sign to acknowledge training

Area	Date	Employee Initials	Supervisor Initials
1. GENERAL			
Staff identity card and swipe card for ward door issued			
Introduction to colleagues and multidisciplinary team			
Allocation of mentor/ preceptor			
Lines of communication			
Accountable to and reports to:			

Conditions of employment/ contract explained			
Hours of work, arrangements for breaks/lunch. Catering arrangements			
Shift times/ duty roster/ requests for duty roster explained			
Shift co-ordinator – role and responsibilities			
Daily ward routine			
Standard of appearance and behaviour			
Smoking policy			
Requests for annual leave entitlement and study leave bookings			
Completing unsocial hours and bank timesheets			
Trust induction day			
Keys to locker/ changing room			
Staff meetings/ staff supervision			
Ward/ office/ drug keys			
Reporting sickness and absence. Self-certification and when to obtain a doctors certificate			
Special leave request			
Arrangements for returning to work			

2. GEOGRAPHICAL ORIENTATION			
Familiarisation of the work area – ward/ office lay out where things are kept			
Introduction and orientation of the unit			
Introduction to other wards			
Location of bathrooms			
Location of staff car park			
3. COMMUNICATIONS			
How to use and operate the telephone system			
How to use the pager system			
The internal phone number is:			
Security number is:			
Cardiac Arrest Number is:			
Emergency fire number is:			

Any other special arrangements for emergencies explained (please state):			
Postal system delivery and collection			
E-mail and internet usage			
4. FIRE SAFETY			
Fire precautions			
Fire assembly point is:			
Actions in event of a fire:			
Actions to take when the alarm sounds:			
Trust fire policy			
Location of Fire Alarms			
Location of Fire Extinguishers			
Location of Fire Doors			
Location of Fire Exits and Fire Doors			
Location of emergency and fire equipment			

All staff must attend a fire lecture at least every 12 months: Course Date:			
5. FIRST AID			
The first aider on my ward is:			
Location of the first aid box:			
Resuscitation training (every 12 months): Course Date:			
6. SECURITY			
Security site and department			
Security of equipment and materials (including documents of all descriptions)			
7. ACCIDENT OR INCIDENTS TO PATIENTS, VISITORS OR STAFF			
Procedures for incidents/ accidents Action to be taken:			
Who must be informed:			
Recording of accidents/ incidents			

Reporting of serious untoward incidents			
8. THE MENTAL HEALTH ACT			
Informal patients			
Detained patients			
Patient rights			
Human Rights Act			

9. LIFTING AND MOVING IF PATIENTS OR LOADS			
I have been made aware of the hazards of incorrect lifting and moving techniques and shall not undertake any activities associated with lifting and moving without first receiving supervised instructions in the safe and approved methods. Signed:			
10. PATIENT CARE			
Medical records system. How to obtain/ return notes to the Medical Records Department			
Confidentiality of patients records			
The nursing process: Documentation/ storage/ disposal			
Admission and Discharge procedures/ documentation			
Administration of medicines – competence to be observed			
In the event of a death procedure and who to contact			
How and when to order supplies for the ward			

Chaplaincy service			
Procedure for contacting Duty Doctor			
On Call & Senior Manager system			
Policy for searching patients and their property – recording/ care/ disposal			
No fixed abode day – areas covered by each ward			
Contacting works services Department regarding repairs/ maintenance Number to call:			
11. PRIVACY OF PATIENTS			
Doors and windows			
Service users rooms and locks to their doors			

12. TRUST POLICIES & PROCEDURES **Please read and sign**			
Location of trust/ Ward policies			
Hospital/ unit policies			
Confidentiality/ data protection – application to patients/ Colleagues			
Procedures for Clinical Practice			
Human Resources Policies and Procedures			
Clinical risk assessment & management			
Clinical Policies			
Trust policy on handling money/ personal property			
Illicit drugs & alcohol			
Cardiopulmonary resuscitation			
Safe working for staff working			
Supervision			
Observation			
Policy for children visiting parents			
Seclusion			
Admission policy for acute adults			
AWOL			
Complaints procedure			
Arranging outpatient appointments			
Care programme approach			
Refer to other agencies e.g. Drugs dependency unit, Alcohol advisory service			
Training facilities available to staff e.g.: student induction/ mentorship			

Night Reports			
Ordering and storing medication			
Ordering and storing of provisions/ supplies			
Ordering transport e.g.: taxi/ ambulance			
Delegation of work according to grade			
OTHER (Please list)			

Appendix B

Local Induction Checklist for Temporary Bank/Agency Staff

To be completed by all Bank and Agency staff when working on the ward/in the department for the first time or following a gap of three months or more. The checklist is to ensure that all aspects of your induction are covered in a timely and effective manner. It should be completed on arrival of the place you have been appointed to undertake work. If you feel that any area has not been covered adequately or missed, please bring it to the attention of your line manager.

Once completed and signed, scan a copy and email it to training&development@elft.nhs.uk or fax it to 0207 655 4027

I confirm that I have received the Trust Staff Induction Handbook and have read and fully understand the policies and procedures outlined in the booklet. I understand that failure to comply may result in immediate termination of a booking. Please tick if in agreement: ☐

I confirm that at the commencement of work, I have been shown and explained (please refer to overleaf and tick below. **Enter 'N/A' where not applicable**);

(See notes 1-14 overleaf)

Area Covered	**Clinical Staff**	**Admin Staff**
Identity Check		
Confirmation of mandatory training completed		
Hours of work/shift patterns/breaks		
Familiarisation of work area – where things are kept, bathroom, car park, canteen, post		
Cleaning, catering, facilities, waste disposal, postal system		
Email and Internet usage		
Location of Trust/ward/department policies		

Introduction to Team

Emergency telephone numbers

On call and bleep system – Doctors, emergency

Alarm system – Fire, ward alarms, personal alarms

Observations ***(note 1)***

Fire ***(note 2)***

First Aid ***(note 3)***

Codes/keys/security pass/badge ***(note 4)***

Ward environment safety ***(note 5)***

Infection Control ***(note 6)***

Patient Care ***(note 7)***

Social Therapist ***(note 8)***

Medicines safety procedures – Sops, protocols

Incident reporting procedures/forms

Standards of behaviour ***(note 9)***

Manual Handling ***(note 10)***

Confidentiality/record keeping ***(note 11)***

Resuscitation procedures/equipment

Reporting to and contact details

Specific Duties and responsibilities ***(note 12)***

Local Lone Working Procedure ***(note 13)***

All other matters ***(note 14)***

SIGNED:

_____

_____

(Bank/Agency Staff)

NAME:_____
_____

POST
TITLE:_____
_____

(NAME OF AGENCY EMPLOYED UNDER)

DEPARTMENT:_____START
DATE:_____

SIGNED:_____
_____

(Trust member of staff delivering induction)

DATE:_____

Please note: If your booking is extended for a further period, you will need to refer back to the checklist with your Manager, as any sections that may not be applicable now, may become applicable.

Note

1	**Observations:**	describe levels and identify patients on Level 1, 2, 3 and 4 and shown where and how to document observations and have had the reasons for observations explained to me.
2	**Fire:**	where the exits are, the fire procedure, equipment, alarms, telephone numbers and assembly points.
3	**First Aid:**	First Aider and location of box
4	**Codes/Keys/security pass/badge:**	the importance of keeping locked rooms locked at ALL times and not to give out codes to patients. Wear ID badge at all times.
5	**Ward environment safety:**	for example ensuring that no sharp or potential ligatures to be left around, trip and fall hazards.
6	**Infection Control:**	Hand hygiene, I.C. Status. Infection prevention and control. All ward areas to be kept clean and tidy. Toiletries and towels not to be left in bathrooms.
7	**Patient care:**	which patients allocated to you for your shift and ensure they are engaged with and their needs met and all interactions/interventions are documented in their notes.
8	**Social Therapist:**	To report ANY concerns regarding patients to the Nurse in Charge. Not to administer or dispense any medication.
9	**Standards of Behaviour:**	No back to back shifts, dress code, no alcohol, no smoking, no illicit drugs, no violent or abusive behaviours, gross negligence, inappropriate relationship with client.

10	**Manual Handling:**	Moving and handling procedures/equipment. Be careful when lifting heavy goods and handling clients.
11	**Confidentiality / Record Keeping:**	Lock computer when not in use, do not leave files unattended, keep filing cupboards locked when not in use, be careful who you disclose information to.
12	**Specific duties and responsibilities:**	Please indicate other post specific information given.
13	**Local Lone Working Procedure:**	Discuss potential hazards of working alone and assess the risks involved and put measure in place to avoid or control the risks.
14	**All other matters:**	If you are not sure about something then ask Nurse in Charge/Supervisor. *(if you are a Nurse in Charge, you will be told how to contact the Clinical Co-Ordinator)*

Appendix C

Shared Care Approach to Pressure Ulcer Prevention

SSKIN Bundle

Guidelines for Staff

1. Introduction

The purpose of this guideline is to provide health and social care staff working within community services with information in relation to a shared care approach to pressure ulcer prevention in the community.

Joined up health and social care is essential to improve the quality of care people receive and to ensure 'harm free care'. Pressure ulcers are a key quality indicator and all staff involved in caring for patients in the community should ensure that care is appropriate, safe and in the best interests of the person.

Health and social care in the UK is undergoing rapid change as organisations restructure the delivery of services in order to provide the most efficient and effective care to service users. This has led to not only utilising health care workers in different ways to provide additional duties of care, but also has implications for informal/ formal carers in terms of the advice they are given and specific roles they are asked to perform as part of the actual care of the patient.

East London Foundation Trust and their partners in social care are committed to working together to ensure patients do not develop avoidable pressure ulcers and have produced this document to promote best practice in pressure ulcer prevention and support an integrated approach to care.

It is recommended that the community nurse/team leader works with the patient and their carers to identify the patients risk of developing pressure ulcers and puts in place a care plan to meet the patient's needs. This will involve ensuring that patients and carers have the necessary understanding to reduce risk factors and identify the early stages of pressure ulcer development. The following checklist should be used to support the discussions and observations of practice to ensure pressure ulcers are prevented.

Pressure Ulcer Prevention: Shared care checklist

Please indicate with ✓ if active and date and sign	✓	Date	Signed District nurse	Signed Social carer
Please ensure information and procedures specific to the patient's condition are explained, taught and observed. All aspects of specific care plan for pressure ulcer prevention discussed and explained to patient and carers. Ensure the patient has mental capacity to make decisions regarding their care. I have discussed with the carer: • The importance of undertaking a full skin inspection especially over bony prominences, looking out for any redness, discolouration, localised heat, odema or induration • The importance of regular repositioning, ensuring pressure relief • How to check the mattress and cushion to ensure it is functional • The importance of a healthy diet • How to contact the team if concerned about skin integrity • An information leaflet on prevention has been provided The carer has observed • The nurse undertaking a full skin inspection and what signs to look out for. • The nurse performing the basic repositioning techniques. • The nurse checking the mattress and cushion • They have a good awareness of what a healthy diet entails. • I have observed the carer performing a skin inspection and re positioning the patient. They feel competent to do this. I feel they are able to deliver this care with on-going support.				

Review Date:	Team Leader responsible:

Pressure Ulcer Prevention and treatment plan. Each patient should have an individualised care plan to address their needs. The community nurse will go through the care plan with the patient and carers following the check list below.

SSKIN BUNDLE
PREVENTION

Surface – Make sure your patients have the right support surface	S	• Appropriate mattress ordered from ICES and in place and being used? • Mattress calibrated to correct weight of patient if required • Appropriate cushion ordered from ICES and in place and being used? • Wheelchair user: check when last seen by wheelchair service • Patient education on use of equipment
Skin – Inspection	S	• Has skin assessment been completed and documented?
Keep Moving	K	• Does the patient have a repositioning chart?
Incontinence/ Moisture	I	• If patient is incontinent use of appropriate skin care • Does the patient have correct equipment to manage incontinence? • Refer to continence advisor if complex needs
Nutrition	N	• Is the patient eating and drinking • If Weight loss refer to GP/Dietician for supplement advice

SSKIN BUNDLE
TREATMENT

Surface – Provide the right surface	S	• The mattress/cushion is still being used • Check at each visit equipment is in working order • Review equipment as to its effectiveness
Skin - Inspection	S	• Pressure ulcer graded and reported and referred as per guidelines • Are skin assessments completed at each visit? • Wound size recorded at initial assessment and re-measured every 4 weeks • Care plan in place to guide treatment • Record pain and document effectiveness of pain relief if required
Keep – moving and repositioning	K	• Repositioning schedule document in care plan • Check carers are following the repositioning schedule • Does the patient understand the need for repositioning
Incontinence	I	• If incontinent is this addressed in the care plan • Is treatment effective?
Nutrition	N	• Check weight. Measure arm circumference if bed bound or immobile • Encourage balanced diet to aid wound healing • Refer to GP/Dietician if any concerns

Appendix D

Unexpected Access Problems Protocol