

## Trust Induction Policy for New Staff

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## **Content**

<b>Section</b>	<b>Title</b>	<b>Page No.</b>
		<b>5</b>
<b>1.0</b>	<b>Introduction</b>	
	1.1 purpose of Policy on Induction for new Staff	
	1.2 Scope	<b>6</b>
	1.3 Duties within the organisation	
<b>2.0</b>	<b>The Five Day Trust Induction</b>	
	2.1 Access and Booking Procedure	
	2.2 Part Time Staff	
	2.3 Programme Content- Day One	
	2.4 Induction Information Stalls	<b>6-9</b>
	2.5 Programme Content- Day Two	
	2.6 Programme Content – Day Three	
	2.7 Programme Content – Day Four	
	2.8 Programme Content- Day Five	
<b>3.0</b>	<b>Induction for Rotational Doctors in Training</b>	<b>11</b>
<b>4.0</b>	<b>Monitoring of Attendance</b>	<b>11</b>
	4.1 Non Attendance	
<b>5.0</b>	<b>Local Induction Proforma</b>	<b>11-12</b>
	5.1 Completion of Local Induction	
	5.2 Monitoring of Local Induction	
<b>6.0</b>	<b>Bank /Locum / Agency / Contractors Temporary Staff Training</b>	<b>12</b>
<b>7.0</b>	<b>Bank Locum / Agency / Temporary Staff Induction</b>	<b>13</b>
	7.1 Monitoring the Completion of the Local Induction Proforma for Temporary Staff	

<b>8.0</b>	<b>Staff Employed on Short-term Contracts/ Secondments</b>	<b>14</b>
<b>9.0</b>	<b>Further Advice</b>	<b>15</b>

## **Appendices**

**I**

**II**

<b>III</b>	<b>Trust Induction Programme Timetable</b>	<b>14</b>
------------	--	-----------

<b>IV</b>	<b>Procedure for booking staff on the corporate induction programme</b>	<b>15</b>
-----------	---	-----------

**V**

	<b>Local Staff Induction Pro forma</b>	<b>18</b>
--	--	-----------

<b>VI</b>	<b>Doctors in Training Induction Timetable</b>	<b>29</b>
-----------	--	-----------

	<b>Local Induction Checklist for Temporary, Bank / Agency Staff</b>	<b>32</b>
--	---	-----------

	<b>Temporary Staffing Mandatory Training Handbook</b>	<b>34</b>
--	---	-----------

## **Induction Policy for New Staff**

### **1.0 Introduction**

Induction on a Trust-wide basis and departmentally is the process of receiving and welcoming employees as they first join the organisation and giving them the basic information they need to settle in quickly and start working effectively. This process of induction is extremely valuable to both the individual and the Trust. As such, induction has five main aims; namely:

- To smooth the preliminary stages when everything is likely to be strange and unfamiliar to the new employee.
- To establish quickly a favourable attitude to the Trust in the mind of the new employee so that they are more likely to stay.
- To obtain effective output from the new employee in the shortest possible time.
- To provide the new employee with as much information as possible to be able to carry out their duties to a high standard.
- To provide an introduction to key standards, policies and procedures relating to the management of risk

New employees are most likely to leave an organisation in the early weeks of employment – a period often described as *induction crisis*. Induction is one of many initiatives which the Trust believes can be used to enable employees to settle in to the organisation as soon as possible, thereby enabling new employees to maximise their full potential.

#### **1.1 Purpose of Policy on Induction for New Staff**

The purpose of the Policy on Induction for New Staff is to set in place a programme that ensures that all new staff receive a consistent and comprehensive induction which enables them to settle into the organisation as soon as possible.

#### **1.2 Scope**

The policy sets out the structure and content of the corporate induction programme as well as arrangements for Local Induction in a staff member's place of work.

#### **1.3 Duties within the Organisation**

The Deputy Chief Executive and the Medical Director have strategic responsibility for the implementation of this policy. At operational level, Service Directors and Service/Line Managers have operational responsibility for policy distribution, implementation and compliance throughout the organisation. Individual staff have responsibility to attend and participate in the programme.

### **2.0 The 5 Day Trust Induction Programme**

The Trust is committed to both the provision of Trust-wide and Local Induction, as it believes that this is an important investment to make in its staff. Wishing to make this commitment a reality, it is the policy of the Trust to allow all newly appointed staff a guaranteed induction period. During this time the new member of staff will be supernumerary to allow them to undertake local induction and Trust-wide Induction. To facilitate this process, all staff will commence their employment on the first Monday of the month. All new staff are expected to attend the first two days and the last day of the programme and attendance on day three will be determined by an individual's job/role.

This will be governed by staff training requirements as set out in the Trust's Risk Management Training Needs Analysis.

A copy of the Trust Induction programme can be found in appendix I. This policy does not apply to student nurses who are supernumerary at all times and are subject to university induction procedures.

## **2.1 Access and Booking Procedure for the Trust Induction**

The Human Resources Department will inform the Training Department when a member of staff has been appointed by sending a copy of their final offer letter. The training department will then, through consultation with the manager, provide the staff member with a suitable induction programme for the month that the staff member is commencing employment. Details will be sent to the staff member's home address and to their line manager. It is the line manager's responsibility to ensure all new employees participate in the induction.

Attendance will be monitored by the training and development department and non-attendance rigorously followed up. Please see Appendix II for a detailed explanation of the procedure for booking staff on the corporate induction programme.

## **2.2 Part Time Staff**

Staff working on a part time basis will need to complete the minimum induction programme. On appointment, it should be agreed that new staff will attend for the additional time required but managers will be responsible for paying the staff member for the additional hours worked.

## **2.3 Programme Content - Day One**

The first day of the programme will equip staff with specific information about the Trust as well as giving them the opportunity to meet some of the senior members of staff within the Trust. The content of this programme is as follows:

- An introduction to East London NHS Foundation Trust by the Trust's Chief Executive and Chair
- An address the Associate director for People Participation underlining the importance of, empathy, patient understanding and customer care in Mental Health Care
- Information on the Patient Advice Liaison Service (PALS)
- Overview of the Trust's Health and Safety, Risk Management, Reporting and Complaints handling practices and policies.
- A outline of the measures rules and policies regarding Counter Fraud in the NHS
- Food Hygiene
- Safeguarding Children – Level 1
  - At the end of the session each participant should:
    - recognise that they have a professional responsibility for safeguarding children in need of support and protection and know what to do if they have concerns about a child known to them including.
      - Legal framework
      - London Child Protection Procedures
      - Local protocols
      - Who to contact
      - Further training

## **2.4 Induction Information Stalls**

- An introduction to major Human Resources policies and procedures and staff
- Information and advice on joining a Trade Union.

- Communications within the Trust
- Support systems including the Employee Assistance Programme
- Information regarding payroll and the NHS pension scheme
- Information about Occupational health and the service it provides

## **2.5 Programme Content - Day Two**

Day 2 of the programme is mandatory for all staff to attend and focuses again on risk management training to ensure that all staff are able to ensure the safety of themselves, colleagues and the service users in their care.

### **General Fire Training**

This session will give staff the legislative background to fire safety as well as practical information regarding fire prevention. This training is applicable to all staff.

### **Risk Management**

Participants will gain an overview of the assurance framework, clinical governance and risk management, incident and serious incident reporting, complaints litigation and clinical audit.

### **Information Governance**

This course covers what information governance is, what we are protecting, the legal and management framework as well as individual roles and responsibilities.

### **General Manual Handling**

The principles of lifting and handling Office ergonomics Posture and movement advice  
The causes of pain, strain and injury The importance of Trust policies and incident reporting.

### **Infection Control**

This session covers the role of the Infection Control Team, how to contact the Infection Control. Nurse and when to seek advice, Hospital Acquired Infection, risk factors for acquiring infection, Management of IC problems within the Trust, the importance of hand hygiene, collecting specimens to aid diagnosis, sharps safety good practice and clinical waste management.

### **Health and Safety**

For staff to gain a basic understanding of Health and Safety (H&S) and the introduction of the H&S at Work Act.

### **Sign on with Payroll**

Payroll sign on will take place on the second day of the Induction Programme. All new starters are

informed ahead of their Induction to bring with them the below documents

- Passport or Birth certificate
- National Insurance Number
- P45 from previous job if available
- Bank or Building Society details

## **2.6 Programme Content - Day Three**

Day three of the programme is designed for clinical staff to attend and consists of 3 component parts as outlined below.

### **Medicines Safety**

Medicines safety is paramount in any NHS Trust. The National Patient Safety Agency (NPSA) has reported that medication errors on in-patient wards are increasing. This session

will give an overview of how this Trust aims to minimise risk around medicines, thus putting patient safety first. One of the systems in place to minimise risk around medication is the Trust Medicines Policy, which came into effect on the 3rd March 2003. The purpose of the policy is to define standards, which ensure that the medication process is safe and secure and complies with legal requirements. Since the Trust carries legal liability for the safety, care, storage and administration of medicines, staff must comply with this policy at all times.

### **Overview of the Mental Health Act**

This session is suitable for all clinical staff requiring an introduction or update to the Mental Health Act.

It covers:

- Basic overview of the Mental Health Act (1983)
- Open Forum to discuss particular issues/experiences

### **CPR/ Adult Basic Life Support**

Staff that attend CPR training will gain an understanding of the Trust emergency procedures and resuscitation policies, in and out of hospital, basic life support skills including use of automated External de-fibrillation, and skills in the recognition and treatment of choking.

## **2.7 Programme Content - Day Four for All inpatient mental health registered and un-registered staff**

This course is mandatory for all clinical staff working in mental health inpatient settings

### **Observation of Service Users – incorporating ‘working creatively with Service Users’**

After this session participants will be able to:

- Understand the principles of observation and its rationale.
- Understand the various levels of observation as identified in Trust Policy.
- Use the appropriate decision making process for prescribing levels of observation and the review process.

## **2.8 Programme Content - Day Five**

The last day of the programme all staff will attend Equality and Diversity Training and Safeguarding Adults level-1 training.

### **Equality & Diversity**

This course will enable participants to:

- Understand why equality and diversity are relevant issues within the NHS.
- Know the key elements of current and forthcoming equality legislation and their implications.
- Understand what behaviours constitute harassment and bullying and how everyone can treat others with dignity and respect.
- Clarify their role in supporting equality and fairness at work.

### **Safeguarding Adults Level One Training**

This course aims to provide staff with a basic awareness of safeguarding adults concerns and procedures and to then to identify gaps in their knowledge and seek further training subject to their work role and responsibility.

### **3.0 Induction for Doctors in Training Programme**

All rotational Doctors in Training will undertake a 2 day induction specifically tailored for their own requirements. This will closely mirror the standard corporate induction and a copy of the agenda can be found in Appendix III. Any other relevant components will be organised by Local College Tutors as part of their local induction. This process is overseen by The Doctors in Training Programme Director for Barts and the Royal London Rotational Doctors in Training Scheme in Psychiatry.

### **4.0 Monitoring of Attendance**

Signed attendance lists will be taken for every component part of the induction programme these are kept as a record of individual attendance and this information is also collected via the Training departments information system, AT -Learning. This ensures that attendance on induction forms part of a staff members overall training record and informs managers when an update is required.

Certificates of attendance will be issued to every member of staff for each session they attend on the induction programme.

### **4.1 Non attendance**

Those cancelling or failing to attend induction will be reported to the line manager and they will be placed on the next months induction programme. The training and development department will contact both the staff member and their manager to inform them of their non attendance and the dates when they should next attend. Those failing to attend individual parts of the induction will also be placed on the next available sessions and their attendance monitored.

If a staff member fails to attend subsequent sessions, they will be subject to the Trust training booking procedure as outlined in The Access to Training and Study Leave Policy, whereby non attendance will incur a £50 fine to the individual's service budget.

If the staff member fails to attend the induction after 3 consecutive months, an email will be sent to the Service Director of the staff member's manager advising them of the individual staff member's non attendance.

### **5.0 Local Induction**

Local induction is the induction or orientation programme arranged by the service in which the new employee will be working. Local induction is as important to an employee as the Trust-wide induction and the two should be seen as a comprehensive package for every new employee. Local induction provides the new employee with an insight into the service area or department in which they will be working, the working arrangements, rules and practices.

It clarifies the priorities and objectives of the service/ department and gives the employee an understanding of the direction of the department. It also promotes the internal practices and procedures in operation in the area where they are working and makes them feel a part of the team. By filling out the training nominations sections of the Pro-forma and returning the form, the Trust can be assured that all Risk Management Training needs have been identified and plans have been implemented to meet them. All non-clinical staff and non in-patient mental health clinicians should complete and return their proformas within the induction week. Clinicians required to attend the working creatively with service user session have until the first day of work on the 3<sup>rd</sup> week after Induction to return theirs.



The local induction will also include a programme of visits to key contacts for the new employee; including people from other departments with whom they will be working closely or who will help them to understand their new role more fully and quickly.

The development of a local induction programme for each new employee will be the responsibility of the service or line manager. The local induction for new employees who will have managerial responsibilities should include visits to:

- The payroll department;
- A senior member of each of the corporate departments; Human Resources, Finance and IM&T.
- Local induction should also include (where relevant):
  - Introduction to staff
  - Orientation to service areas
  - Expectations of post
  - Limitations of role
  - Familiarisation with equipment and procedures, and appropriate training requirements
  - Local health and safety procedures
  - Local fire procedures, emergency procedures, communication/bleep systems, resuscitation procedures
  - Key local policies and procedures
  - Medication common to the area and patient group
  - Sources of help and advice.

This list is not exhaustive and a number of local induction programmes can involve this and more. A local induction pro forma documenting local induction can be found in Appendix III for staff to use. The completion of local induction is mandatory for all rotational Doctors in training in any new ward/department that they are placed.

### **5.1 Completion of Local Induction**

Local Induction Proforma are issued to all staff and managers prior to the Corporate Trust Induction programme. The form is re-issued on the first day of induction programme with the instruction given that they must be completed and returned within a month of starting permanent employment in the Trust.

Non Clinical staff and clinical staff working in non inpatient settings are required to complete Local Induction at their workplace on Day Four of the Corporate Induction Programme.

Due to the inclusion of a clinical workshop on the Thursday of the induction and the need to attend a 5-day PMVA course in the week following induction, all inpatient mental health registered and un-registered staff do not have a day within the programme to complete the Local Induction Proforma are required to complete their proforma on their first day at their workplace. This should be in the 3<sup>rd</sup> week following induction. and an email an email reminder will be sent to them and their manager, requesting the completion and return of the Proforma.

### **5.2 Monitoring the completion of Local Induction**

In order that the Trust can be assured that local induction is taking place, managers are required to complete, sign and return a copy of the first page of The Local Induction Pro forma and the Training nominations page to the Training and Development Department at Trust Head Quarters on the last day of the Induction Programme Details of completed local

inductions will be kept on the Training departments data management system. Managers failing to return the pro forma will be contacted by the training and development Department using the following process:

**3<sup>rd</sup> week of the month: Reminder 1-** This correspondence is sent to managers, staff and copied into Service Directors

**4<sup>th</sup> week of the month: Reminder 2 -** This correspondence is sent to Sent to managers and staff

**5<sup>th</sup> week of the month: Reminder 3-**This correspondence is sent to managers, staff and copied into Service Directors

**6<sup>th</sup> week of the month: Reminder 4 -**This correspondence is sent to Service Director and copied to manager and staff member.

Where the above measures have not resulted in completion of the local induction; the member of staff may be escalated to executive level. Quarterly reports on attendance at induction will be received and discussed at the Workforce Committee and Quality Committee.

### **6.0 Bank /Locum / Agency / Contractors Temporary Staff Training**

All temporary, agency or Locum Clinical staff must have completed the required Risk Management courses before working any shifts in the Trust.

Before commencing bank work for the Trust, checks are made with the Training department that the required training has been undertaken.

- CPR
- Manual Handling
- Infection Control
- Breakaway or Conflict Resolution training as determined by bank role
- Fire training
- Observation Policy / Working Creatively with Service User workshop – (Mental Health in-patient nursing staff only)

Mandatory Training information is given to all bank and agency staff in the form of a training guide/ handbook. This handbook (appendix VI) is read by all temporary and agency staff that do not complete the Corporate Induction Programme.

All staff recruited for temporary work within the Trust must read and sign off their full understanding of the handbook. The Handbook covers a range of mandatory and statutory training subjects including:

- Medicines safety
- Information Governance
- Safeguarding Children
- Safeguarding Adults
- Health, Safety and Security
- Risk Management
- Equality and Diversity

## **7.0 Bank Locum / Agency / Temporary Staff Induction**

Staff employed on short term contracts or through agency, locum or casual arrangements must be introduced appropriately to every department worked in. This should be done on their first day of employment and should be undertaken by the senior member of staff on duty at the time. A thirty minute induction must take place on their first day of work and the bank or agency local induction check list must be completed in respect of each appointment at this time. (Appendix V). The form should be signed by the manager, then scanned and emailed to the Recruitment team in-box [tempstaffinduction@eastlondon.nhs.uk](mailto:tempstaffinduction@eastlondon.nhs.uk) for record keeping purposes.

In addition in any/all instances that the bank staff are returning for a shift after a period of absence of three months or more Local Induction Proforma must be completed and re-submitted.

### **7.1 Monitoring the Completion of Local Induction Proforma for Temporary staff**

- It is vital that all bank/temp/agency staff receive a local induction. This induction MUST be recorded on the "Local Induction Checklist" and signed by the manager and staff member.
- The checklist MUST accompany the first timesheet for any new place of work (or a return to a place of work where the staff member has not worked for the previous 3 months).
- Clinical areas should keep a copy of the signed checklist
- The checklist MUST be sent to the Recruitment Team in HR. These will be reconciled with both paper and E-timesheets on a weekly basis.
- The HR team will check paper and E-timesheets to ascertain whether the bank staff member has completed a checklist that relates to this location.
- Where a checklist has been received this will be recorded on a spreadsheet
- Where the checklist was required but has not been returned, the HR team will contact the relevant manager to determine whether a local induction has taken place or to seek a copy of the checklist if there has been an induction (just not recorded).
- Where local induction has NOT taken place the manager will be instructed to undertake the induction at the first possible opportunity and at least before the submission of the next timesheet.
- Where the induction HAS taken place the manager will be asked to send the form immediately.
- Outstanding forms will be chased weekly by email/phone.
- Where managers fail to follow this process the matter will be referred to the Service Director and reported to the Workforce Committee. The process for this will be a monthly report of all outstanding induction checklists to all service directors.
- Where consistent failure occurs consideration will be given, on a case by case basis, to withhold pay for the staff member. This will be authorised by the Assoc Director HR & Service Director.

## **8.0 Staff employed on short term contracts / Secondments**

In cases where staffs are working on a short term contract or seconded into the Trust managers should consider the tenure of contract and the requirements of the post to which

the individual staff member has been appointed. If any Trust manager considers attendance at the Induction programme appropriate, arrangements should be made with the HR recruitment Team for a place to be identified at the next available Induction programme

## **11 Further Advice**

For further advice on the content of local inductions please contact the Training & Development Department.

Appendix I Trust Induction Programme

Monday	Tuesday	Wednesday	Thursday	Friday
09.00 - 09.30 <b>Registration and welcome</b>	09.00-09.15 <b>Registration</b>	09.00-09.15 <b>Registration</b>	09.00-09.15 <b>Registration</b>	09.00-09.15 <b>Registration</b>
09.30am - 10.00am <b>Flord</b>	09.15am-10.45am <b>Fire</b>	09.15-10.15 <b>Medicine Safety Band 5 and Above Nurses and all clinical staff managing medication.</b>	<b>Observation Working Creatively with Service users</b>	09.15-12.30
10am - 10.30am <b>Welcome to the trust - chief exec / chair</b>	11.00am - 12.30 <b>Safeguarding</b>		All clinical, new starts inpatient staff	<b>Equality &amp; Diversity Group 1</b>
10.30am - 11am <b>PALS &amp; Litigations</b>	Level 1 12.45-12.45 <b>Lunch</b>	10.15 - 12.15 <b>CPR</b>		
11.00am - 11.30am <b>Fraud</b>	13.30-14.00 <b>Manual Handling</b>	All Clinical Staff & OT's except: Social Workers, Psychologist & Psychotherapists		
11.30am - 11.45am <b>Coffee Break</b>	14.00-14.45 <b>Health &amp; Safety</b>	and all other therapists & HQ staff nominated by HGC Chair		
11.45 - 12.45 <b>Information Governance</b>	14.45 – 15.000 <b>Coffee Break</b>	12.15pm - 12.45pm <b>Lunch</b>		12.30pm - 13.30pm <b>Lunch</b>
*12.45 - 13.45pm <b>Stalls and Lunch</b> Food bought out at 13.00pm	15.00 -16.00 <b>Infection Control</b>	12.45pm - 17.00pm <b>O.M.H.A</b>	<b>1st Day at work and Local Induction</b>	1.30pm - 4.30 <b>Safeguarding Adults</b>
13.45pm - 14.15pm <b>General Manual Handling</b>	<b>Payroll Sign on</b>	All clinical Staff and Managers, specialist services staff exempt - except those in Coborn unit		Group 2
14.15pm - 14.45pm <b>Health &amp; Safety</b>				All Clinical Staff and reception staff Sessions to swap over
14.45 - 15.45pm <b>Infection Control</b>				
15.45 - 16.00pm <b>Break</b>				
16.00 - 16.30 <b>Risk Management</b>				
16.30pm -17 .00pm <b>Payroll Sign on</b>				4.30pm - 5pm <b>Feedback Session Local Induction Proforma returned</b>
<b>KEY:</b>	All Staff - Clinical & Non Clinical	All Clinical Staff	All Clinical Staff and reception staff	Lunch / Break

## **PROCEDURE FOR BOOKING STAFF ON THE CORPORATE INDUCTION PROGRAMME**

## **1.0 Introduction**

This procedure outlines the processes and activities carried out within the Training and Development Department and the Human Resources Department for ensuring that effective processes exist for the booking of new staff onto the corporate induction programme.

In line with the requirements of the NHS Litigation Authority (NHSLA), clear mechanisms must exist and this procedure has been created to provide greater detail to the existing **Policy on Induction for New Staff**.

## **2.0 Staff joining the induction programme**

- 2.1 Staff in the Human Resources Department will place all new starters (not including medical staff in training), who have received full clearance onto 'the induction spreadsheet' held on the HR shared drive which both departments have access to. Staff in the training department will then provide the staff member with a suitable induction programme for the month that the staff member is commencing employment. Details will be emailed to the staff member and manager or posted to the staff member's home address if necessary.
- 2.2 The booking process for each staff member is complete when their details have been added to the AT learning training management system and this is documented on the induction spreadsheet.
- 2.3 The Induction Coordinator will ensure that the respective managers are made aware of the times and dates that their staff member is engaged in formal training in order that they are aware when to expect them at the workplace for their local induction.

## **3.0 Induction for medical staff in training.**

- 3.1 Medical staff in training start their employment with the Trust as part of their overall rotation programmes, which are organised by the Local College Tutors. For these staff a specific HR Advisor has responsibility for their full clearance and collation of names which they then pass onto the Induction co-ordinator who then ensures they are invited to and attend the induction for medical staff in training.

## **4.0 Exceptions**

- 4.1 Attendance on induction is compulsory but in some rare cases it may be necessary for a staff member to defer their induction or carry it out over a phased period. This may be due to very urgent service pressures and in this case this will be negotiated between the manager and Human Resources and communicated to the Training and Development Department. The Training and Development department will then organise the induction as required. In these cases, staff must complete their induction within 3 months.

## **5.0 Monitoring of Attendance**

- 5.1 Signed attendance lists will be taken for every component part of the induction programme. These are kept as a record of individual attendance and this information is also collected via the Training departments information system, AT – Learning. This ensures that attendance on induction forms part of a staff members overall training record and informs managers when an update is required.
- 5.2 Certificates of attendance will be issued to every member of staff for each session they attend on the induction programme.

## **6.0 Non attendance**

- 6.1 Those cancelling or failing to attend induction will be reported to the line manager and they will be placed on the next months induction programme. The training and development department will contact both the staff member and their manager to inform them of their non attendance and the dates when they should next attend. Those failing to attend individual parts of the induction will also be placed on the next available sessions and their attendance monitored.
- 6.2 If the staff member fails to attend the induction after 3 consecutive months, an email will be sent to the manager or service director of the staff member's manager instructing them of the individual staff members non attendance.
- 6.3 If a staff member fails to attend subsequent sessions, they will be subject to the Trust training booking procedure as outlined in **The Access to Training and Study Leave Policy**, whereby non attendance will incur a £50 fine to the individual's service budget.



**Appendix III Local Induction Pro forma**



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

All non-clinical staff and non in-patient mental health clinicians should complete and return their proformas within the induction week. Clinicians required to attend the working creatively with service user session have until the first day of work on the 3<sup>rd</sup> week after Induction to return theirs

**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 the this page and the next page is returned to the Training and Development Department within the specified deadlines above.**

**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 attend 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 Marshal Training	All Staff Appointed as Fire Marshall	
Systematic investigation using Root Cause Analysis	All members of staff involved in incident investigation	
Immediate Life Support	Duty Senior Nurses	
Clinical Risk Assessment & Management incorporating CPA	All Mental Health and Learning Disability band 5,6,& 7 nurses and any other professionals who take on care co-ordinating responsibilities including specialist staff at the Coborn Unit	
Staff Supervision	All band 7 staff and above as well as any other staff (except medical) who supervise others.	
Health & Safety for Risk Officers & Facilitators	All normal 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)	
Food Hygiene	OT, Catering and Domestic staff and all in-patient staff who handle food or drink	

Supervisor Signature \_\_\_\_\_

Staff Member Signature \_\_\_\_\_

<b>Area</b>	<b>Date</b>	<b>Employee Initials</b>	<b>Supervisor Initials</b>
<b>1. GENERAL</b>			
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			
<b>FIRE SAFETY</b>			
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:			

FIRST AID			
The first aider on my ward is:			
Location of the first aid box:			
Resuscitation training (every 12 months):  Course Date:			
SECURITY			
Security site and department			
Security of equipment and materials (including documents of all descriptions)			
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			

THE MENTAL HEALTH ACT			
Informal patients			
Detained patients			
Patient rights			
Human Rights Act			

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:			
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:			
PRIVACY OF PATIENTS			
Doors and windows			
Service users rooms and locks to their doors			



<b>4. TRUST POLICIES &amp; PROCEDURES</b> <b>Please read and sign</b>			
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 IV Doctors in Training Induction Program

<b>Day One</b>	
<b>09.15</b>	Introduction and Welcome to the Trust <b>Medical Director DOCTORS IN TRAINING Program Director</b>
<b>09:30</b>	<b>Mental Health Act</b> Associate Director Mental Health Law
<b>10.45</b>	Tea/Coffee
<b>11.00</b>	Educational Issues <b>Doctors in Training Program Director</b>
<b>11:30</b>	Medicines Safety <b>Chief Pharmacist</b>
<b>12.30</b>	Lunch
<b>13:30</b>	Infection Control <b>Bart's &amp; the London</b>
<b>14.30</b>	Complaints & Coroners Inquests Consumer Relations & Legal Affairs Manager
<b>15.00</b>	Human Resources <b>HR Advisor - Medical Personal &amp; Corporate</b>
<b>16.30</b>	Close

<b>Day Two</b>	
09.15	Introduction and Welcome to the Trust Medical Director DOCTORS IN TRAINING Program Director
09:30	Mental Health Act Associate Director Mental Health Law
10.45	Tea/Coffee
11.00	Educational Issues Doctors in Training Program Director
11:30	Medicines Safety Chief Pharmacist
12.30	Lunch
13:30	Infection Control Bart's & the London
14.30	Complaints & Coroners Inquests Consumer Relations & Legal Affairs Manager
15.00	Human Resources
16.30	Close

## Appendix V– Local Induction Checklist for Temporary, Bank / Agency Staff



### 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@eastlondon.nhs.uk](mailto:training&development@eastlondon.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);

<sup>1-14</sup> refer to overleaf

Area Covered	Clinical Staff	Admin Staff
Identity Check		
Confirmation of mandatory training completed		
Hours of work/shift pattern/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 phone numbers		
On call and bleep system – Doctors, emergency		

<b>Alarm system- Fire, ward alarms, personal alarms</b>		
<b>Observations<sup>1</sup></b>		
<b>Fire<sup>2</sup></b>		
<b>First Aid<sup>3</sup></b>		
<b>Codes/keys/security pass/badge<sup>4</sup></b>		
<b>Ward environment safety<sup>5</sup></b>		
<b>Infection control<sup>6</sup></b>		
<b>Patient care<sup>7</sup></b>		
<b>Social Therapist<sup>8</sup></b>		
<b>Medicines safety procedures – Sops, protocols</b>		
<b>Incident reporting procedures/forms</b>		
<b>Standards of behaviour<sup>9</sup></b>		
<b>Manual Handling<sup>10</sup></b>		
<b>Confidentiality/record- keeping<sup>11</sup></b>		
<b>Resuscitation procedures/equipment</b>		
<b>Reporting to and contact details</b>		
<b>Specific Duties and responsibilities<sup>12</sup></b>		
<b>Local Lone Working Procedure<sup>13</sup></b>		
<b>All other matters<sup>14</sup></b>		

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.**

<sup>1</sup>**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.

<sup>2</sup>**Fire:** where the exits are, the fire procedure, equipment, alarms, telephone numbers and assembly points.

<sup>3</sup>**First Aid:** First aider and location of box

<sup>4</sup>**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.

<sup>5</sup>**Ward environment safety:** for example ensuring that no sharp or potential ligatures to be left around, trip and fall hazards.

<sup>6</sup>**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.

<sup>7</sup>**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.

<sup>8</sup>**Social Therapist:** To report ANY concerns regarding patients to the Nurse in Charge. Not to administer or dispense any medication.

<sup>9</sup>**Standards of behaviour:** no back to back shifts, dress code, no alcohol, no smoking, no illicit drugs, no violent or abusive behaviour, gross negligence, inappropriate relationship with client.

<sup>10</sup>**Manual Handling:** Moving and handling procedures/equipment. Be careful when lifting heavy goods and handling clients.

<sup>11</sup>**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.

<sup>12</sup>**Specific duties and responsibilities:** Please indicate other post specific information given.

<sup>13</sup>**Local Lone Working Procedure:** Discuss potential hazards of working alone and assess the risks involved and put measures in place to avoid or control the risks.

<sup>14</sup>**All other matters:** If you are not sure about something then ask Nurse in Charge/Supervisor

(if you are the Nurse in Charge, you will be told how to contact the Clinical Co-ordinator).



TEMPORARY STAFFING...

CITY & HACKNEY  
NEWHAM  
COMMUNITY HEALTH NEWHAM  
TOWER HAMLETS  
FORENSIC SERVICE  
SPECIALIST SERVICES  
CORPORATE SERVICES

# TRUST STAFF

## TEMPORARY STAFF INDUCTION

### HANDBOOK

NURSING ASSISTANTS  
STAFF NURSES  
COMMUNITY PSYCHIATRIC NURSES  
JUNIOR DOCTORS  
CONSULTANT PSYCHIATRISTS  
THERAPISTS  
ADMIN & CLERICAL  
PSYCHOLOGISTS  
SPEECH AND LANGUAGE THERAPISTS  
PHYSIOTHERAPISTS  
PHLEBOTOMISTS  
CHILDREN'S SCHOOL NURSES  
HEALTH VISITORS  
DISTRICT NURSES  
URGENT CARE WORKERS



## Document Control Summary

<b>Title</b>	TRUST INDUCTION BOOKLET Temporary Staff
<b>Purpose of document</b>	To provide basic information to new Temporary Staff about the Trust's policies and procedures.
<b>Electronic file reference (network or intranet)</b>	P:/Human Resources/Bank/
<b>Version No.</b>	1.2
<b>Author(s)</b>	Bridget Schubert, Bank Coordinator

## Version Control Summary

<b>Version</b>	<b>Date</b>	<b>Comment/Changes</b>
1.0	June 2011	Issued to Bank only staff.
1.1	May 2012	Added sections: Infection Prevention and Control, Manual Handling Safety Essentials, Fire Safety at work. Updated Local Induction checklist and contacts.
1.2	Nov 2012	Title of document changed to 'Trust Induction Booklet Temporary Staff to incorporate Agency Staff.  Local Induction Checklist should be returned within 1 week  Local Induction Checklist updated.  Conflict Resolution added.

## Contents

One            **Introduction**

Two            **Mandatory Training**

1. PALS and complaints
2. Fraud
3. Information Governance
  
4. Health, Safety and Security
5. Healthcare Governance and Risk Management
6. Safeguarding and Promoting the Welfare of Children
7. Safeguarding Adults and Domestic Abuse
8. Equality, Diversity and Human Rights
9. Infection Prevention and Control
10. Manual Handling Safety Essentials
11. Fire Safety at work
12. Medicine Safety (for Qualified Clinicians only)
13. Observation Policy (for Nursing staff only)
14. Mental Health Act
15. Conflict Resolution
16. Contact List

***To be completed by Temporary Staff and returned to the Recruitment Team:***

Appendix 1      Local Induction Checklist for Temporary Bank/Agency Staff working on a ward/in a department for the first time or following a gap of three months or more.

## One

## Introduction

This booklet provides an overview of the Trust's policies and procedures which all new staff working for the Trust need to be aware of and comply to. This should be read carefully as part of your mandatory training. This booklet will give you the basic information you need to settle in quickly and start working effectively. More detailed information and guidance can be found on the Trust Intranet. In addition to this, for every assignment a local induction must take place. **The Local Induction Checklist for Temporary Bank/Agency Staff in Appendix 1 should be completed with the supervising manager on the first day of you working in order that you are trained in information locally where you will be working.** The completed form should be sent to tempstaff[induction@eastlondon.nhs.uk](mailto:induction@eastlondon.nhs.uk) or the Recruitment Team within 1 week of your start date. If your booking is extended for a further period, you will need to refer back to the checklist with your Manager as sections that may not have been applicable, may have become applicable. Please note that the Local Induction Checklist for Temporary Bank/Agency Staff needs to be completed every time you work on a new ward/in a new department or following a gap of three months or more.

## Two

## Mandatory Training

### 1. PALS and Complaints

**The Patient Advice and Liaison Service (PALS)** support people who come into contact with the NHS. PALS is a confidential service dedicated to listening to patient needs and helping people to address any worries or concerns they have about health and health care provision.

PALS provide a confidential service which aims to improve satisfaction and reduce any confusion or anxiety people may have. PALS support patients, relatives, carers, friends of patients or members of the general public to resolve concerns as quickly as possible before things become serious enough for people to want to raise a formal complaint.

PALS act on behalf of individuals when handling concerns. They liaise with staff, managers and, where appropriate, other relevant organizations, to negotiate speedy solutions and to help bring about changes to the way services are delivered. PALS will also refer patients and families to local or national support agencies, if appropriate.

PALS will

- act as quickly and creatively as possible to support patients, their carers and families to deal with concerns, before they become more serious

- help people to talk through their concerns so that they can identify the nature of the problem and work out options to resolve them. Concerns may be resolved by listening, providing relevant information, or by liaising on people's behalf with relevant colleagues
- provide options which may include making a complaint. PALS will try to resolve concerns and can explain how to get free, independent support from outside the NHS should people wish to consider this option.

Contact PALS by:

**Freephone:** 0800 783 4839

**Telephone:** 020 7655 4021 or 020 7655 4009

**Email:** [PALS@eastlondon.nhs.uk](mailto:PALS@eastlondon.nhs.uk)

### **Drop in or write to**

Patient Advice and Liaison Service

Trust HQ, EastONE

22 Commercial Street

London E1 6LP

## **The Complaints Procedure**

Under the **Local Authority, Social Services and National Health Service Regulations 2009**, the Trust must have arrangements in place for handling and considering complaints. In line with those provisions, the Trust must ensure complainants are treated courteously and involved in decisions about how their complaint will be handled; it must co-operate with other local authority and NHS bodies to respond jointly to complaints that touch upon more than one service and designate a Responsible Person to ensure compliance & that action is taken. The current complaint system is a two-stage process with the Parliamentary and Health Service Ombudsman as the final stage for the most intransigent complaints that cannot be resolved within the organisation

In addition, as a Trust we must report on our complaint handling as part of the Care Quality Commission's assessment. This requires us to have a system in place to ensure that patients, relatives and carers have information about, and clear access to, procedures to register formal complaints and feedback on the quality of services. We must have a system in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made. We must also have systems in place to ensure that patients, their relatives and carers

are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery

Legislation aside, the Trust's complaint procedure provides a forum for patients and other service users to express concerns about the service that they receive. It is one means of assessing and minimising risk, by ensuring a consistent and fair approach for all concerned. It is also a very valuable means for the Trust to review aspects of its practice, identify shortcomings and then learn and apply lessons for continuous improvement. As a foundation trust, we are also very committed to listening to what patients have to say and creating forums for them to do so and complaints are one way of ensuring that happens.

In responding to complaints, the Trust draws on the Parliamentary and Health Service Ombudsman's principles of good complaint handling. These are:

- Getting it right
- Being customer focused
- Being open and honest
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Under the complaints process, a patient and/or their carers or other family members may make a complaint. That said, if the complaint is not being made by the patient, the Trust's Complaints Department will need to seek the patient's consent to discuss confidential information with a third party. If that consent is not forthcoming, the Complaints Department will investigate the concerns and also respond, but in doing so we will ensure that no confidential information is disclosed.

A formal complaint can be made in writing or by telephone. The Complaints Department has a freepost address and freephone number. Help is available for service users to make complaints through PALS, ICAS and the Mind Advocacy Service.

When a complaint is made, the first stage is for the Complaints Department to contact the complainant to discuss how they would like their complaint handled and in particular, whether they would like a meeting with the Investigating Officer as part of the investigation of their complaint. A meeting provides an opportunity for the Investigating Officer to understand the complaint from the complainant's perspective. It is also an opportunity to clarify what the complainant would like to see happen and manage their expectations.

Practically speaking, when the Complaints Department receives a complaint, it is delegated to the locality for an Investigating Officer to be appointed. Typically the Investigating Officer

will be part of the service which is the subject of the complaint, but not someone named in the actual complaint. The Investigating Officer will identify key issues based on the paperwork and any interview with the complainant. The Investigating Officer will then gather and review relevant documentation, including patient records; conduct interviews with relevant staff, including those named in the complaint, any witnesses and senior managers if appropriate and review relevant policies and procedures to help identify whether there has been a breach. Their approach should be based around establishing the facts and their causes; identifying preventative steps to stop similar incidents happening again and linking those steps to sustained improvement

The Investigating Officer reports their findings back to the complaints section using an Investigation Report template. This forms the basis of the Trust's letter of response which is signed out by the Chief Executive. The Trust aims to respond to complaints within 25 working days. It may not always be possible to meet this deadline because of delays in setting up a meeting, or the complexity of the response. In such cases, the Complaints Department liaises with the complainant to negotiate an extension and ensure they are kept updated on the progress of their complaint.

The Complaints Department aims to be accessible to service users, as well as members of staff who are dealing with complaints. Leaflets and posters advertising the Complaints Department and explaining its complaints procedure are distributed throughout wards, Community Mental Health Teams and other centres run by the Trust. The Complaints Department can be contacted as follows:

**Claire McElwee, Complaints Manager**

**Freepost RLSH –BBHX-ZRRU**

Complaints Department

ELFT, Trust Headquarters

22 Commercial Street

London, E1 6LP

**Freephone 0800 085 8354**

## 2. Fraud

**Reporting suspicions of fraud, corruption and bribery**

Fraud is unacceptable, and diverts resources away from patient care. In line with the National Counter Fraud Strategy, the Trust is committed to reducing fraud to an absolute minimum.

The key aims of the organisation's Counter Fraud Strategy are:

- The creation of an anti-fraud culture
- Maximum deterrence of fraud
- Successful prevention of fraud which cannot be deterred
- Prompt detection of fraud which cannot be prevented
- Professional investigation of detected fraud
- Effective sanctions, including appropriate legal action against people committing fraud.
- Effective methods for seeking recovery of money defrauded

To deliver these aims the Trust will:

- Investigate all suspected cases of fraud in a professional, effective and efficient manner
- Integrate into systems, policies and procedures measures to prevent and detect fraud
- Proactively review identified high risk areas
- Work across the organisation to integrate an anti-fraud culture and maximise deterrence, detection, investigation, sanction and redress for all cases of fraud
- Work with other organisations to identify those who commit fraud
- Pursue and seek full redress from those who perpetrate fraud against the organisation
- Learn the lessons from how the fraud was committed and act on them
- Publicise action taken against fraud, including successful actions and prosecutions

Parkhill is the Trust's Local Counter Fraud Specialists (LCFS).

Please contact Parkhill if you have any concerns about fraud, corruption or bribery being committed within the Foundation Trust or against the Foundation Trust. Parkhill works with the Trust to strengthen the culture where staff feel confident to report fraud and where potential fraudsters are deterred.

They can be contacted on 020 7953 8432 or 07990-510-173.

For further information please refer to the Counter Fraud page on the intranet and the Trust's Counter Fraud and Corruption Policy and Response Plan, available on the intranet under Policies and Procedures.

### 3. Information Governance

All staff members of the Trust should be aware of their statutory, legal and professional responsibilities, Trust policies and best practice in respect of person identifiable, sensitive and confidential information. This is called the Confidentiality Code of Conduct. All staff across the Trust are required to abide by the **Data Protection Act 1998**. They must ensure when working with data that information is kept secure and never accessed unlawfully or inappropriately, that it is kept **confidential** and that information is never disclosed to anyone not entitled to see it. Staff should ensure that the information is accurate, legible and up to date; that it is obtained fairly, used ethically for the purpose it was given to you, and that you share it lawfully and appropriately ensuring consent is obtained before sharing. If information is requested by a third party, then the individual whose information is requested must give permission.

When managing records, never store information on a 'C' drive'/my documents'. Instead, please use one of the following; 'H' drive for your own information or work in progress; 'I' drive for departmental information; 'K' drive for person identifiable information. The 'P' drive is the public drive. Please use the Trust's filing and naming conventions, dispose of records only according to the Trust's record retention and disposable schedule, and follow the Trust's 'clear desk' policy – computer screens, notice boards, white boards etc containing service user information should not be visible to anyone approaching Nurses' stations or reception desks. Screens should only be visible to relevant staff. Service User's information should be locked away when not being used. Individuals should remember to lock their computer screen when moving away from the computer for short periods or log out for longer periods. Discretion should be used when discussing individuals in public places, including by telephone. Health records should never be taken outside the Trust or left unattended in open areas. Records should always be stored in a secure place and stores must be locked when unstaffed. Tracer cards should always be used when removing records from their store.

Please ensure emails are concise and business-like and virus check downloads are up to date. Ensure emails containing person identifiable or sensitive information are never sent outside the Trust using your East London email account as this is not secure. They can only be exchanged by email if :



- Sent from one nhs.net account to another
- Sent from an nhs.net account to a secure email account that includes an extra string of characters in the middle such as pnn, gsx, cjsm
- Included in an encrypted attachment and the password sent by a different means to email

File emails that are records in a secure network location using agreed naming and filing conventions. Avoid requesting, sending and forwarding or publishing illicit, illegal, offensive or libellous material. Change your password regularly. Never share passwords under any circumstances. Never use unencrypted USBs. Never discuss, comment or upload any Trust related information from personal communication devices on to blogging or social networking sites and never send person identifiable information to a personal or unencrypted account. When sending emails containing person identifiable information, never include the data subjects name in the subject header. Instead, mark the subject header 'confidential'.

When disclosing person identifiable information by telephone, always confirm the identity of the third party before disclosing. Ensure there is a valid reason for providing the data and if in doubt, use dial back arrangements to ascertain if the person is authorised to receive the information. Alternatively, ask for the request to be put in writing.

When posting data, clearly mark the envelope as 'private and confidential-addressee only'. Always add the Trust's return to sender message.

When faxing always use a safe haven fax. Advise the recipient you are sending it or agree the time before. Ensure the fax number is correct. Mark the cover sheet as 'private and confidential' and say who it is for. Don't use obvious person identifiable information. Instead, use an NHS number, Rio number or initials unless this could cause confusion. Don't leave information unattended whilst a fax is transmitting.

When sending data via courier, use an approved courier i.e. TNT or use the internal courier service. Keep smartcards safe and secure. Never leave a smartcard unattended in a reader and do not let anyone use your smartcard or password.

Please note that under the '**Freedom on Information Act (FOI)**', requesters are allowed access to all types of recorded information. Requests must be made in writing. Any requests for information about the organization are potentially FOI requests and as such should be immediately passed to the FOI Co-ordinator using the mailbox [foirequest@eastlondon.nhs.uk](mailto:foirequest@eastlondon.nhs.uk) as the Trust only has 20 working days to respond to a request. Remember you may be asked by the FOI Co-ordinator to provide information in response to a request.

Please report any incidences or breaches of confidentiality on Datix.

You should familiarise yourself with the Trust's information governance policies on the intranet.

Advice is available from the Head of Information Governance.

## 4. Health, Safety and Security

Under the **Health and Safety at work Act (1974)**, section 7a states that *'it shall be the duty of every member of staff while at work to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omission at work'*.

Healthcare workers, both clinical and non-clinical may be exposed to numerous issues which may affect their health and/or their safety. Health & Safety (H&S) is there to ensure (uncontrolled) risk to staff, patients and public, arising out of work, is at an acceptable level. The **Safety** agenda is to protect against physical harm or loss of property e.g. by floor surfaces/flooring, obstruction, moving & handling or violence and abuse. The **Health** agenda is to safeguard against threat to wellbeing e.g. by substances, equipment or stress.

The NHS Trust is legally obliged to provide safe systems of work, a safe place of work and safe plant and equipment. Managers must ensure that they manage H&S by implementing systems on the ground that fit-in with Trust systems. It is the responsibility of staff to co-operate with your manager and work to established procedures for safe and healthy working, to look after your own H&S and anyone else who may be affected by your work, to immediately inform your manager of any imminent risk of danger and not to interfere with safety arrangements.

A **hazard** is the potential for anything/anybody to cause harm e.g. spillages or trailing leads. A **risk** is the chance that someone /something could come to harm. The Trust is required, by law to undertake an annual work place risk assessment of all areas within the organisation. To enable staff to identify potential hazards and risk within the workplace, a 5 step approach can be adopted: 1) Identify the hazard 2) Decide who might be harmed and how 3) Evaluate the risks and decide on precautions 4) Record your findings and implement them 5) Review the risk assessment and update if necessary.

The law requires that safety signs are provided where risk to health and safety cannot be avoided by other means. There are four types of safety signs recognised in the EEU. They are **Prohibition**-something is illegal or dangerous; **Mandatory**- something must be done. Breach of this might result in a disciplinary e.g. wedging fire doors; **Warning**-alerts you to hazards; and **Safety instruction**. These are distinguished by their shape, colour, pictogram.

Be aware of hazardous material. This is any substance with the potential to cause illness or ill health including biological agents, bacteria and viruses (e.g. Legionella, hepatitis), chemical agents, fumes, dust, gases, liquids. Check for the hazard warning symbol. Entry routes into the body include by inhalation (most common), ingestion, skin absorption, penetration or open wounds and the eyes. It can lead to ill health and can be fatal. Any products that could be hazardous to health require registering and a comparison of actual use of product against datasheet information given by the manufacturer/supplier.

An **incident** is any untoward or unexpected event which led to or could have led to injury, suffering, loss or damage, either to a person, the Trust or the environment. ELFT encourages **all** untoward incidents and near misses to be reported and entered on Datix, not only so we can learn from incidents but also for other requirements.

Slips, trips and falls on the level are the most common cause of major injuries in workplaces and the second highest cause of over-three-day injuries. They can occasionally cause fatalities, e.g. through injury to the head. Causes of slips trips and falls include a contaminated floor – wet/dry, or slippery surfaces, environmental conditions such as a dark room, changes in elevation, climbing or descending stairways and housekeeping e.g. cluttered areas. Getting around requires planning, caution, and a little common sense. Insufficient light can make it difficult to see obstacles and notice changes in the walking surface and is associated with an increase in accidents. Moving from light to dark areas, or vice versa, can cause temporary vision problems that might be just enough to cause a person to slip on an oil spill or trip over a misplaced object. Even a change in walking surface of  $\frac{1}{4}$  –  $\frac{1}{2}$ " or greater will be sufficient to cause a trip. Curbs, cracks in the sidewalk, ramps and single steps are all examples of these hazards. Watch for bumps, potholes, sidewalk cracks or changes in elevation. Secure handrails and guardrails, even surfaces, even tread heights and make sure surfaces are free of deteriorating coverings such as frayed carpet. Take care when ascending and descending stairways. The chance of fall accidents in stairways increases with inattention, illness, fatigue and haste. Areas must be kept free of obstacles which can cause slips and trips. E.g. clutter, obstructions across hallways and material stacked or dumped in passageways, etc.

**First aid** is the treatment/care given before emergency medical help arrives. Each area in the Trust has a first aider. This is a person who has undergone a training course in administering

first aid at work and holds a current first aid at work certificate. Each area should also have an appropriately filled first aid box.

Staff should be aware of their working conditions and the impact it can have on their health. Any person that uses their workstation in excess of 50% of their working day can request a DSE (Display Screen Equipment). Risks of sitting in front of a computer screen for long periods at a time include musculoskeletal disorders (e.g. back pain and upper limb disorders, visual fatigue and mental stress). In order to keep safe, adjust the chair (height, tilt, back rest), organise the desk (screen, keyboard, mouse, phone) relationships to the user, reduce glare on screen, exercise/stretch, take regular breaks (5 minutes for every hour). The top of the screen should roughly be at eye level. Arms should roughly be parallel to the desk. Do not keep wrists excessively bent. The upper leg should roughly be parallel with the floor. Ensure the space under your desk is clear so you can move your legs.

## **Security**

From 2006 each NHS trust was required, under Secretary of State Directions, to ensure that staff, property and assets are robustly protected. In doing so the Security Management Service (now NHS Protect) instructed that each health body employ a Local Security Management Specialist (LSMS) to oversee these instructions. In doing so this nominated person is involved in all aspects of security and also reviews security incidents. Within ELFT the LSMS spends time looking at incident so violence and aggression (threatened and actual) and supports staff (and service users) in reporting these incidents to the police and also assisting the team in looking at actions that could minimise reoccurrence of such situations occurring again.

Please check the H&S section on the Intranet for more information and image examples of safety/hazard warning signs.

## **5. Healthcare Governance and Risk Management**

Healthcare Governance is a systematic approach to maintaining and improving the quality of patient care. The Care Quality Commission (CQC) makes sure that the care people receive meets essential standards of quality and safety and encourages ongoing improvements. The Trust is required to meet standards across the localities. Ongoing monitoring of compliance will take place, such as clinical audits. A clinical audit is the process of looking at the care that is being provided and the care providers asking; what should we be doing? Are we doing it? If not, how can we improve?

All incidents should be reported and recorded on an Incident Report form. This includes incidents of violence and aggression, accidents and injuries, errors and omissions, data loss and breaches of confidentiality, absence without leave, breaches of the mental health act etc... Incident reporting helps to ensure that the appropriate remedial action is taken and that appropriate support is available. It also allows the appropriate level of investigation in to accidents to take place and for the Trust to learn from adverse events and improve the quality and safety of the service it provides.

## 6. Safeguarding and Promoting the Welfare of Children

It is the duty of the Trust and to all staff to take all reasonable measures to ensure that the organisation and all staff minimise risk of harm to the welfare of children, and to take appropriate action when there are child protection concerns, by working to agreed local policies and procedures, in full partnership with other agencies.

**The Children Act 1989** states that *the welfare, safety and health of children must always be paramount*. It is reinforced by the **Children Act 2004** which places a statutory duty upon each NHS Trust *'to make arrangements to ensure that it has regard to the need to safeguard and promote the welfare of children in exercising its functions'*. **The London Child Protection Procedures 2010** states that *it is the duty of professionals, whether they are providing services to adults or children, to place the needs of the child first. All mental health professionals have a duty to discover whether any patient or client has responsibility for a child and to consider the impact his or her condition may have on that child and whether this requires a referral to Children's Social Care. Failure to safeguard and promote the welfare of children is a breach of statutory duty*.

The following is a list to help identify the types of child abuse; **Neglect**: Persistent failure to meet a child's basic physical and/or psychological needs; **Emotional Abuse**: Persistent emotional ill-treatment to cause severe and persistent adverse effects on the child's emotional development; **Physical Abuse**: Physical injury to a child by a parent or other person with responsibility for her/his care; **Sexual Abuse**: Forcing or enticing a child to take part in sexual activities (to meet the perpetrator's needs), not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

**Neglect** of a child by a parent/carer includes; persistent failure to meet a child's basic physical and/or psychological needs likely to result in serious impairment of child's health or development. It may occur during pregnancy as a result of maternal substance abuse. Failure to provide adequate food, clothing and shelter (including exclusion from home or abandonment). Failure to protect from physical and emotional harm or danger. Failure to

ensure adequate supervision (including the use of inadequate care-givers). Failure to ensure access to appropriate medical care or treatment. Neglect of, or unresponsive to, a child's basic emotional needs.

**Emotional abuse** of a child includes; persistent emotional ill-treatment to cause severe and persistent adverse effects on the child's emotional development. Conveying to children they are worthless, unloved, inadequate or valued only to meet needs of another person. Not giving child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. Age or developmentally inappropriate expectations imposed on a child: e.g. interactions beyond child's developmental capability, overprotection and limitation of exploration and learning, preventing the child participating in normal social interaction. Serious bullying (including cyber bullying). Causing a child frequently to feel frightened or in danger. Exploitation or corruption of children.

**Physical abuse** of a child by a parent/carer includes; hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, any other way of causing physical harm, parent/carer fabricates the symptoms of, or deliberately induces illness in a child, female genital mutilation.

**Sexual abuse** of a child includes; forcing or enticing a child to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening, physical, penetrative acts – e.g. rape, oral sex; use of objects for penetration; non-penetrative acts; - e.g. masturbation, kissing, rubbing and touching outside of clothing, non-contact activities: Involving children in looking at, or the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). Can be perpetrated by adult males, adult females and children.

The concept of '**significant harm**' is the threshold for justifying compulsory intervention in family life in the best interests of the child. The child is suffering, or is likely to suffer significant harm AND the harm or likelihood of harm is attributable to a lack of adequate parental care or control. The concept must be used by Children's Social Care for decisions around Section 47 Child Protection investigations, and staff attending Child Protection Conferences for their decision-making about whether a child should be subject to a Child Protection Plan.

Risk to children from parental mental health problems include; Features within parental delusions- this must be referred to CSC for a Section 47 child protection assessment; Features within parental suicide plan; Perinatal mental health risk of relapse in pregnancy or post natally; Involved in his/her parent's obsessional compulsive behaviours; Has caring responsibilities inappropriate to his/her age; May witness disturbing behaviour; Parent's poor self-care and poor insight into child's needs while unwell lead to physical and emotional

neglect ; May visit, or have contact with, an unwell parent; Unborn child of pregnant woman or male service user; May be child of service user's partner; Parent's mental illness is not identified by professionals (e.g. untreated post-natal depression can lead to significant attachment problems).

If you are worried about a child; Do not minimise your concerns or assume someone else will do something. Discuss concerns with your manager or an appropriate colleague. Consult a member of the Safeguarding Children Team. If you still have concerns you can discuss your concerns with senior colleagues in another agency (e.g. children's social care). Consider appropriate services. If you consider that the child may be a child in need or a child in need of protection, you should refer the children to Children's Social Care (CSC). Seek to discuss concerns and referral with the child (consider age and understanding) and with the parents- unless you consider that this would place the child at increased risk.

Making a referral to Children's Social Care: Telephone the relevant Children's Social Care. Follow up immediately with *Inter-agency Referral Form*. Agree with the recipient of the referral: 1) what the child and parents will be told 2) by whom and 3) by when. Children's Social Care should acknowledge your referral within one working day. If you have not heard back within 3 working days, contact Children's Social Care again to find out if/how it is being acted upon. If you are not happy that the response will safeguard the child and you are unable to resolve it, discuss with your manager or clinical lead. The Safeguarding Children Team is available to support staff about making a referral or if concerns need to be escalated.

Please consider that; poor sharing of information is a "key factor" in many serious case reviews. This includes no information shared, limited, restricted information shared, staff not understanding the significance of the information they hold, unsafe decisions made based on inadequate information; it's legal imperative, and child protection concerns always override confidentiality considerations and any concerns held by staff about potential damage to a therapeutic relationship.

## **7. Safeguarding Adults and Domestic Abuse**

As a member of staff involved in the health and social care workforce, you are required to be aware of the safeguarding adults procedures within the organisation in which you are working. If you witness, or suspect a service user, or other vulnerable adult, is being abused by another person, then you must report this to your manager. Your manager will then decide if the safeguarding adults procedures need to be followed – this usually starts by completing an alert.

The definition of a **vulnerable adult** is someone who is or may be in need of community care services by reason of mental or other disability, age or illness; who is or may not be able to take care of himself or herself; or is unable to protect him or herself against significant harm or exploitation.

**Abuse** is a violation of an individual's human and civil rights by another or persons. This can include physical abuse, financial/material abuse, sexual abuse, institutional abuse, psychological abuse, and discriminatory abuse. It may consist of a single act or repeated acts.

**Neglect** is not providing care or acting in a manner that no other reasonable person would. This includes the wilful failure to intervene, or consider implications of non intervention, in behaviour concerned, and allowing a person, judged by lack of capability to make decisions concerning their safety, and to take unwarranted and reasonable risks.

**'Significant Harm'** is the ill treatment, impairment of or an avoidable deterioration in physical mental health and the impairment of physical, intellectual emotional, social or behavioural development. No harm is completing an Incident Report when an accident occurs or if an individual expresses satisfaction, a PALS/complaints form is completed. Significant harm or exploitation considers vulnerability and impact on individual nature, extent and length of time of abuse, and risk of repeated or increasingly serious acts involved. If there is concern of abuse raised by anyone with or without proof, alert the CMHT manager or Safeguarding Team. If a concern of abuse is raised to hospital wards, the multi-disciplinary team will implement a protection plan and record safeguarding actions on Datix. If harm is caused by a staff member with or without intent – alert, plus employer's investigation will be carried out. If significant harm is caused by an individual with intent –alert, plus police investigation will be carried out.

A crime survey (Williamson 2000) shows 91% of incidents involved female victims of domestic abuse. Women are more likely to suffer injury, sexual violence, be afraid, attempt suicide, suffer from depression or anxiety, use weapons in self defence, seek talking therapies and benefit from self help.

The following is a list of the different types of abuse;

**Physical abuse** includes: murder, suffocation, shooting, stabbing, slapping, twisting arms, breaking bones, breaking fingers, using objects as weapon, banging head, kicking and biting, burning, forcing to take drugs, cutting, tying up, starving, pouring acid or petrol, beating so no bruising shows.



**Sexual violence** is anything from rape, forced prostitution, forced sexual acts with others/animals, cutting or disfiguring breasts, sexual insults, threats to force intercourse, refusal to practice safe sex, sexual abuse of children, genital mutilation, religious prohibitions ignored, deliberately infecting with STD.

**Psychological abuse** is anything from threatening actions, denying choices, putting you down, not listening or responding, breaking trust isolation from friends or family, controlling phone calls, harassment, threats, lying about you to others.

**Financial abuse** is running up debts in your name, applying for credit cards in your name, preventing you from working for your own money, forcing you to quit work, withholding housekeeping money if not comply with demands, taking control of your money, controlling your benefits.

#### **Your Role:**

If a person tells you that she is a victim of domestic abuse, you should take the disclosure seriously. Make safety the priority, consider his/her capacity to make decisions, respect his/her wishes, ensure they have access to the 24 hour helpline – **Freephone 0808 2000 247**, speak to your manager and record victims own words in secure notes. If a person tells you that they have perpetrated domestic abuse – you need to prioritise the personal safety of the victim and any children and not condone any form of violence. Also, make sure that you discuss the disclosure with your manager who will advise of the appropriate action to take.

There are pages on the Trust intranet site for both safeguarding adults and domestic abuse which have information about making alerts to safeguarding adults and contacting local authority domestic violence teams.

## **8. Equality, Diversity and Human Rights**

The Trust, like all other public bodies, has a legal duty to promote equality and eliminate discrimination. It is also legally required to foster positive relationships between different groups of people, eliminate harassment and involve people in decisions regarding their health and social care and their access to service.

The legal duty refers to a person's age, gender, disability, gender reassignment, race or ethnicity, their religion or belief or having no religious beliefs, their sexual orientation (e.g. if a person is gay, bisexual or lesbian), married or in a civil partnership or during pregnancy & maternity.

The Trust carries out this duty through a range of work which includes:

- Monitoring employment and working practices
- Policies and procedures
- Ensuring staff are appropriately trained
- Setting equality targets
- Informing staff through bulletins, telephone support, equality newsletters and
- Supporting staff to attend staff networks

We believe that ***'Equality should be like the writing in a stick of seaside rock'***, embedded at the core, linked to improving the quality of care and running through every part of the Trust. By doing so the Trust moves beyond mere compliance with legislation. Communities will know that regardless of where in the world a person originate from, their customs, cultures, beliefs, life choices, mental, physical abilities, language, gender and age positively shapes the care that they will receive and that diversity is valued as being a positive attribute that aids employment and career advancement, influencing and shaping work across the Trust.

As a member of staff you must be professional at all times, act in accordance with the law and report any breaches of equality or human rights law to a senior manager of the Trust.

The Trust has equality related policies which you need to familiarise yourself with, they include:

- Harassment & Bullying
- Recruitment & Selection
- Grievance & Dignity at work
- Disciplinary
- Equal Opportunities

**Practices that are not permitted under any circumstances are:**

- Bullying, harassing or victimising anyone (staff, service user, carer or family member)
- Proselytising – that is to preach or try to convert other people to your religion or life style/choice

- Discrimination in any form and against anybody

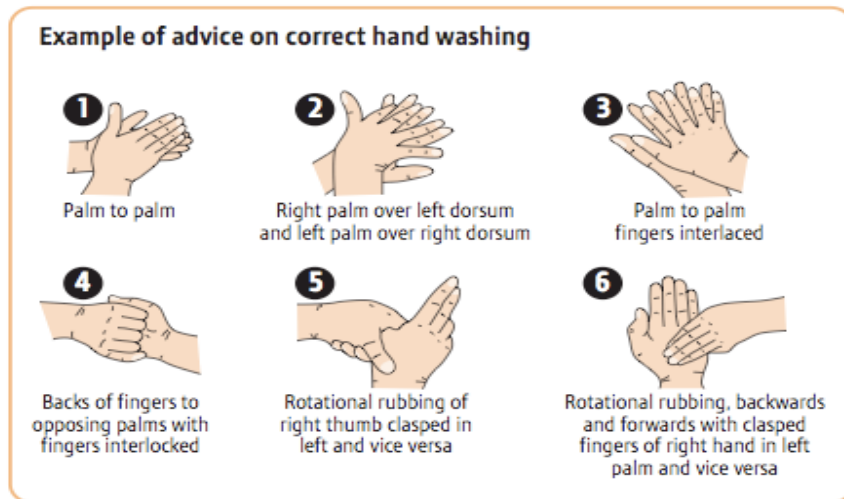
For further information speak to a member of the equality and diversity team based at the Trust Headquarters.

## 9. Infection Prevention and Control

All staff are required to comply with infection control policies to break the links in the chain of infection and reduce risk. Micro-organisms that cause infection include viruses, bacteria, fungi, protozoa. Micro Organisms can be found in and on people in blood, secretions, faeces, and in the environment; in dust, soil, water, food. Infections can be passed endogenously from one part of the body to another, or exogenously from one person to another or the environment including equipment. Portal entry into the body can be by inhalation, ingestion, genital, vertical, skin breaks/mucous membranes, cannulae, catheters, wounds. Infection can be passed indirectly by food, water, inanimate objects, medical device, clothing, environment, dust, and directly from person to person via physical contact – hands, body fluid, e.g. glandular fever, STI, and by vertical transmission. Susceptible hosts include those that are immunocompromised, the elderly, persons with physically / psychologically ill health, persons with underlying disease, persons under going Medical / Surgical intervention and antibiotics.

In order to break the chain of spreading infection, things that need to be considered are;

- hand hygiene,
- personal protective equipment,
- safe handling of sharps, waste, linen, and specimens,
- decontamination of equipments,
- aseptic technique invasive devices,
- staff health,
- spillage management,
- environmental hygiene,
- isolation protocols,
- outbreak notification and management,
- adherence to policies,
- SICP must be applied in all aspect of care to minimise the risk of infection.



### **Bare Below the Elbow**

This applies to all staff having contact with service users. Sleeves must be rolled up to above the elbow and no wrist watches worn. This can reduce the risk of cross infection.

### **Hand Hygiene**

Use the FIVE steps for hand hygiene which includes:

1. Before patient contact
2. Before aseptic tasks
3. After exposure to body substances
4. After patient contact
5. After contact with patient surroundings
  - Use alcohol gel on entering a ward or department
  - You can use alcohol gel on visibly clean hands or soap and water on visibly dirty hands
  - Use soap and water following contact with anyone with diarrhoea. If in doubt, wash your hands with soap and water.

### **All this washing. I'm worried about my hands.**

Regular moisturising will help to look after your skin. If you develop a skin condition, contact your Agency's Occupational Health Service for advice.

### **What is the Trust doing to reduce risk of health care associated infections?**

Clinicians are trained to ensure they have the necessary skills and

competence to provide clean safe care.

Monitoring teams check the inpatient environment daily to ensure service users receive care in environments that are clean and fit for purpose.

Our rapid response teams attend to cleaning issues in all areas.

There is a restricted antibiotic prescribing policy.

We nurse service users separately if they have known or suspected infections that can be transmitted to patients or staff.

We use environmental disinfection products which are active against bacteria, viruses and spores.

### **What do I do in the case of a needle stick injury?**

If you do not work in a clinical role, you should not come into contact with any sharps as clinical staff who use them are responsible for disposing of them appropriately at the point of use.

If you or a patient does sustain an injury:

- Bleed it under running water with soap for 3 minutes, put on a plaster and cover with a waterproof dressing.
- Take name of patient (if injured)
- Report it to a person in charge/line manager and contact Occupational Health department without delay, within one hour.
- Complete an incident report.

You may contact the 24 hour Sharps line number for advice: **0845 371 0572**

### **What if I see a blood or body fluid spillage?**

These spillages should be dealt with as soon as possible with a chlorine disinfectant and paper towels. If you see it in a clinical area – report it to the person in charge. If you see it anywhere else, immediately report it to Domestic Services.

### **Do I need to wear protective clothing?**

You will only need to wear personal protective clothing such as gloves and aprons if you are in contact with any body fluids or as part of isolation procedures.

### **Basic Principles of waste management**

Waste is classified according to the risk it poses. Waste must be segregated at source.

Foot operated lidded bins are required. Traceability: clinical waste must be labelled at source i.e. Ties / Tags. Waste must be stored in a locked facility.

### **Diarrhoea Management**

Observe for: A different smell/consistency, increased frequency, patient becomes unwell, non-infective causes? / alternative cause, side room isolation. Take a stool specimen, start a stool chart and inform infection control team & the doctor in charge of Patient's care.

### **Post Exposure Prophylaxis (PEP)**

A combination of drugs can be given to reduce the risk of acquiring HIV which should be commenced within 1 hour but can be commenced up to 72 hours after exposure.

A risk assessment should be taken by OH or A&E will determine the need for PEP.

Prompt reporting of injury is essential.

### **MRSA control management**

In patient Units:

Screen all patients on admission. If MRSA is identified: continue to isolate, ICN advice needed if no side room, use correct decolonisation protocol, careful management of invasive devices – ANTT. For Bacteraemia infections, a doctor will need to consult microbiologist for antibiotic advice.

Community patients:

No routine screen / swab required. Only as required.

### **WASH HANDS OR USE ALCOHOL GEL BETWEEN ALL PATIENTS**

### **Outbreak management**

An outbreak is considered when two or more people with the same infection are connected at the time and space. What to look out for;

Organisms - *Clostridium difficile*, MRSA, Infectious gastroenteritis, Influenza, Clusters of patients with the same organism.

If an outbreak is suspected, contact the Infection Control Team immediately and make a note of the patients involved, patients' clinical history, where they are situated in the ward, where there now / moved to, when their symptoms started, what symptoms they had.

### **What do I need to know about isolation precautions?**

Isolation precautions are when someone is cared for separately from other service users. If someone's care requires additional precautions, these will be indicated by a sign on the door of the ward.

You must get advice from clinical staff in that area prior to entering or having patient contact.

### **When to isolate:**

Isolate patients with diarrhoea and/or vomiting, pyrexia of unknown origin (PUO), open pulmonary tuberculosis, Meticillin Resistant *Staphylococcus aureus* (MRSA), patients with shedding skin conditions and with other resistant organisms. Put isolation sign on side room door.

### Classification of Decontamination:

Risk	Level of decontamination	Recommendation
<b>High</b>	Items which penetrate the skin or mucous membrane or enter sterile body areas. e.g. catheters, prosthetic devices	Sterilization (Autoclave) or single use items
<b>Intermediate (Medium)</b>	Items in contact with intact mucous membranes, body	Sterilize or chemical disinfection in some situations.
<b>Low</b>	Items used on intact skin, e.g. wash bowls. Items not in direct contact with patients. e.g. sphygmomanometer cuffs	Clean with detergent & water and drying

### Classification to Decontamination Hand:

Method	solution	Task
<b>Social</b>	Liquid Soap. Soap Bars not recommended.  <b>Alcohol gel</b> Apply on physically clean hands,  <b>DO NOT USE</b> when caring for a patient with diarrhoea	<ul style="list-style-type: none"> <li>• For all routine task</li> <li>• Before and after patient / environment contact, handling food, making bed.</li> <li>• After handling body fluids and items contaminated with body fluids</li> </ul>
<b>Aseptic hand disinfection</b>	Antiseptic e.g. chlorhexidine povidone-iodine or alcohol hand rub after social clean.	In high risk areas, Before aseptic procedure

<b>Surgical Hand Scrub (2mins)</b>	Antiseptic, e.g. Chlorhexidine, thorough and careful. Dry with sterile towels	Prior to surgical and other invasive procedures
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All the Trust's infection control policies can be found on the Trust intranet. The Infection Control page contains useful information about the service and practices. We all have a responsibility to reduce the risk of infection. If you think you have an infectious illness, like diarrhoea or chicken pox, check with your manager before coming to work. Ensure your immunisations are up to date if you have contact with patients.

**Infection Prevention and Control Team: 07940 237 087**

## 10. Manual Handling Safety Essentials

Muscular Skeletal Disorder (MSD) is the most common occupational injury in Great Britain effecting one million people each year. The vast majority of injuries are as a result of poor lifting and manual handling.

Musculoskeletal Disorders include problems such as back pain, joint injuries and repetitive strain injuries of various sorts. With a little bit of knowledge, these injuries can be totally avoidable. This section aims to help raise your awareness of the risks.

**Manual handling** is any task which involves a person moving an object or a load from one position to another using some kind of physical effort. For example, carrying a box between rooms, loading supplies from the back of a van or even moving a table to clean behind it. Manual handling injuries can occur wherever people work. Injuries are not just a result of heavy manual labour; even light loads can cause injury too or postures, repetitive handling of materials, and previous or existing injury all increase the risk of developing an injury. Most people perform some sort of manual handling task every day at work or at home. Within the UK, it is estimated that 70% of the population have suffered or are suffering from back problems by the time they retire.



The spine's role is to provide strength and to protect the spinal cord. It is made up of 33 bones called vertebrae. In between each of these bones is a disk which acts as a shock absorber and stops the vertebrae from rubbing together. The areas of the back with the most movement are the neck area and the lower back as these areas are the most flexible. These two areas of the back are where most of the injuries occur as a result of poor manual handling.

Common back injuries are;

**Strains:** due to muscles becoming overstretched and overtired due to excessive use.

**Sprains:** due to sudden sharp movements or tearing ligaments or tendons.

**Slipped discs:** generally caused by moving uneven or awkward loads which can result in the gel pad between the vertebrae coming displaced or deformed.

Other injuries that can occur as a result of poor manual handling are crush injuries, cuts, abrasions and burns. Some injuries can occur whilst doing a seemingly harmless task like picking up a pencil. In this case it is not often the result of the lifting itself that has caused the damage but the result of poor lifting techniques over the years gradually damaging the back and a final small action performed in the wrong way results in the final injury. Injury can be very painful and can effect daily life. Some people achieve complete recovery. However, in many cases the damage is permanent and can leave you with pain and misery for years.

## **The Technique**

Let's see how we can avoid injury:

Every time we lift or move an object we should plan ahead. In a work environment where tasks are carried out on a regular basis, the task should form part of a formal documented assessment. But even when tasks are documented, hazards can change on a daily basis. This can effect how a task is performed. E.g. obstructions on the route, storage positions may change and even the weather can alter the circumstances.

It's good to practice and to undertake your own informal assessment before undertaking any lifting or transporting tasks, even if it is an occasional task. E.g. are there any trip hazards that were not there earlier or diversions and so on. By following a simple assessment process we can help reduce manual handling risks.

**Things to consider are;**

- **The load**
- **The task**
- **The individual**
- **The environment**

**LITE** – identifies each of the steps we need to take when performing a manual handling assessment to help us carry out our tasks safely.

- **L – Load – is the load heavy?** - the size of the load doesn't often indicate how heavy the load is. Check whether it is marked up with its weight. Before lifting, always check how heavy it is by gently rocking it or gently moving it. **Is the load bulky?**- the way we hold a bulky object can put strain on muscles and stretch them. **Is the load stable?** - ask the question **is there anything I can do to make this move safer?** Assess whether the load can be split in to smaller or several lighter loads. This may take longer but will lower the risk of injury. Gloves or overalls may need to be worn if an object has sharp corners or edges. In the case of hot liquids, consider if they can be moved before they become hot liquids or once they are cooled down. You may need help moving it if you can't change the load.
  
- **I – Individual** – consider everyone is different and their ability to carry out manual handling tasks vary from person to person due to factors like age, sex, or physical fitness. There might also be physical fitness or medical conditions which can limit what a person can do. Consider the following when assessing if someone is fit to carry out a task safely; **does the person have back or limb problems, pregnancy, hernias, heart problems and other medical problems. Does the handler need to twist or turn their body? How frequent or repetitive is the lifting?** - the guidelines suggest that if a person has to twist or turn more than 45 degrees than the weight should be 10% lower. When twisting more than 90 degrees the weight should be 20% lower. If lifting twice a minute, it should be 30% lower. If 12 times a minute, 80% lower.
  
- **T – Task** – **can the task be avoided? Can the task be performed safely where the item already is? can it be transported another way other than lifting?** If the object has to be lifted think about the start and finish points of the move, the further it goes the heavier it will seem as the muscles become tired and increase the risk of accidents. **Can you make the load lighter? Where can you put the load down to have a rest?** – it should try to be a place where you avoid lowering the object so have to lift again. Correctly store the load- heavier objects should be stored at waist height to avoid later lifting and consider if there is lots of lifting, can you have a rest and do other things in between.
  
- **E – Environment** – the environment can have a significant impact on what we can do safely. Dry, large spaces are different to confined damp, environments. Obstructions on route should be removed. Liquid spillages, low cables and untidy storage can create slip or trip hazards. Take extra care if the route is uneven. Try to find the safest route. Steps and ramps can increase risk. Other risks that can increase or decrease risk is lighting, temperature, humidity. Poor lighting makes it harder to spot hazards on route. Dramatic changes in temperature or humidity can affect a person's ability to carry out a task. Cold muscles are prone to injury and humid muscles can cause floors to be wet and slippery. Clothing should try to be non restrictive and allow free movement. Good appropriate footwear is also important. The risk assessment carried out may require you to wear safety equipment and clothing such as gloves, hat, goggles or a mask.

It is wise to walk the route before moving heavy goods to check for hazardous conditions. Stairs, narrow doorways make it difficult to navigate with a load. Use the lift or a trolley if possible.

### The Lift

- Firstly, check how heavy the load is by rocking it.
- Position over the load with feet apart. Stand as close to the load, so the load is close to the body as possible. Position feet on side of the load if you can.
- Lower yourself to the load keeping your back straight and bend knees. Make sure you are balanced and take a firm grip on the load. Keep the load as close to the body as possible keeping your back straight and head up.
- Use your legs to lift yourself up to a standing position as legs and buttocks are the largest muscles in the body.
- Keep your back straight and head up. Use your feet to change direction rather than twisting and turning your body.
- Shoulders should remain level and face the same direction as your hips.
- To lower the load, reverse the lifting action.

If the load is heavy, mechanical aid can be used by a trained person. Talk through what you're going to do. Work as a team. Someone should take the lead. If using a trolley, make sure not to stack so high you can not see the route. It's best to push the load than pull the trolley. When pushing, keep back straight and elbows in and lean in the direction you are pushing. Always travel at a walking pace, don't run. Please bear in mind that weight will change if there is a slope so get assistance if required. Report trolley's that are not in a safe condition.

**Avoiding injury is in our hands. Make sure you report any injuries on an incident form.**

## 11. Fire Safety at Work

Even in the best run establishments, fires can occur when you least expect them. Even though you may have experienced many false alarms the real thing can be terrifying and extremely dangerous. Any member of staff that does not know what to do in a fire emergency is not only a danger to themselves; they are also a potential danger to guests and other members of staff. Therefore, when a fire alarm is sounded, it is essential that you are aware of which action to take. This action might be relatively simple like no matter where you are in the building, you know the way to the nearest escape route and you are able to guide any visitors to the nearest assembly point quickly and safely. Remember, **lifts should not be used**. Your duties may be more involved; checking an area, confirming the source and the severity of the fire, informing the local fire service, or grounding and locking lifts.

When a fire is detected there are four key actions to be taken;

- **Raise the Alarm**
- **Evacuate the building**
- **Call the fire service**
- **Tackle the fire if it is safe to do so and you are competent to do so.**

### **Raise the alarm**

No matter how small the fire is, the first thing you should do is raise the alarm. Depending on the circumstances, and your local procedures, this might mean ringing reception, the switchboard or operating the alarm. Once an alarm sounds, the building should be evacuated. If your duties include calling the fire service, it is vital to let them know where the fire is, how big it is and whether anyone is in danger. Once they have this information, the fire crew when they are on their way to you, will already be printing out the layer of your building, its construction and any known hazards. It always makes sense to tackle the fire whilst it is small, but always raise the alarm first and always make sure someone knows what you are doing. Leave immediately if the fire continues to grow. Remember company policy may be that you don't tackle any fires. This may be the case when there may be other dangers such as fuels, gas, or flammable chemicals. **If you suspect the presence of a fire, never open a door until you have tested the temperature of the door first.** Do this by running your hand along the door seam and touching the door in a number of positions with the back of your hand. If you see smoke around a door and if a door is hot, do not open it as this may feed the fire with oxygen and could well cause a back draught. A back draught is a situation which can occur when a fire is starved of oxygen because the doors and windows are shut. Consequently combustion ceases but the fuel gases and smoke remain at a high temperature. If oxygen is re introduced to the fire by opening the door, combustion can restart and this often results in an explosion as the gases heat and expand. Back draughts are very dangerous situations.

If you can see the fire and feel confident to tackle the fire yourself, before it gets any bigger, you must always keep checking that you have an escape route. Remember, a room fire can reach a temperature hot enough to melt glass and some metals in minutes.

### **If possible always turn off gas and electrics before tackling fires.**

Do not tackle the fire if you do not feel confident that you are using the right fire extinguisher for the type of fire, as you can seriously injure yourself and even spread the fire. This is especially important if your fires are electrical, oil, spirit or petrol based. Also, **do not tackle the fire if there is a gas leak, compressed gas cylinders or aerosol cans in the vicinity.** Do not tackle the fire until the alarm has been raised, someone knows what you are doing, and always make sure you have an escape route so that you can not be trapped. Finally, do not be a hero – if you do not feel confident to tackle it, or it looks dangerous-get out, close any doors behind you to contain the fire for as long as possible. Fire doors are designed to prevent fires and smoke spreading. They can contain fires for up to 1 hour. All businesses have a procedure of what to do once an alarm has been raised. Depending on the size of

the business and the number of staff available different duties may be allocated. E.g. fire wardens may attend key areas, guide people from the building. Staff duties may also include switching off appliances, operating emergency gas cut offs and ensure designated areas are clear of staff and guests. While performing these duties it is essential that all staff remain vigilant and do not put themselves or anyone else in danger. If you do not have an allocated duty then you should leave immediately via the nearest fire exit ensuring that you take any visitors in your area with you. You should then make your way to the safest nearest assembly point. Once you are out of the building you must not return until the fire service says that it is safe.

**It is your duty to look out for any potential fire risks as you go about your day to day job.** If you identify a risk, you should either report it or remove it if able to. **Remember, a fire needs three things to burn effectively – heat, oxygen and combustible substance.** If we prevent the three coming together, we prevent fires.

Fire escapes and exit routes should be clearly marked. Damaged Signs and lights that are not working should be reported immediately. Any obstructions to fire doors or escape routes should be cleared. If an alarm sounds, staff should ensure that trolleys are pushed in to the nearest empty room to make sure corridors are kept clear. Ensure wedged doors are closed. Regular fire assessments of the building are undertaken to identify hazards. Report any missing or used extinguishers. Never leave doors open. Most fire casualties are as a result of smoke inhalation often far away from the fire source. If an electrical item is not working properly report it. **In an office environment what to look out for is faulty electrical equipment and flammable materials located near a heat source.**

45% of all serious fires are due to Arson. Ensure doors and windows are secure especially at night and where possible no combustible materials are kept there that can be a danger. Report or challenge any suspicious behaviour straight away.

### **Fire Extinguishers**

**Fire blanket** – the fire blanket is a piece of heat resistant material that can be used to either cover a fire or it can be wrapped around someone whose clothes may be on fire. It should only be used on small contained fires. As you need to get particularly close to the fire to cover it, your hands are particularly vulnerable. You need to cover the fire fully for it to be effective.

There are different types of fire extinguishers used for different types of fire, as using the wrong type of extinguisher can be potentially dangerous. You do need to know what you are doing before you use one.

The most popular are **Water, powder, foam, carbon dioxide and wet chemical**

They are all relatively easy to use, but can be heavy so care needs to be taken when lifting and carrying them. They all work by pulling a pin aiming a jet at the base of the fire, squeezing a trigger and sweeping the jet from side to side.

**Remember: “PASS”:**

- **PIN**
- **AIM**
- **SQUEEZE**
- **SWEEP**

**Any extinguisher** can be used for **solids** such as wood, paper, linen. However, water and foam extinguishers are the most effective.

**NEVER use water on electrical fires or burning fat or oil.**

**Electrical appliances** – remove the electrical supply first if possible, then tackle the flames with a **carbon dioxide extinguisher** which starves the flames of oxygen. If not available, a **powder extinguisher** works nearly as well. **Never use water or foam on electrical fires**







**Flammable liquids** such as oil, spirits, and petrol - foam, powder or carbon dioxide can be used. **Do not use water.**

**Wet chemical extinguishers** are the most effective for **oil fires** in kitchens. If the oil has only just ignited, a foam extinguisher can be used but if the oil is very hot it can be dangerous. Carbon Dioxide would be powerless. Powder can reduce flames but can not cool the oil. To use a wet chemical extinguisher, hold the pipe above and around one meter away from the fire.

Ensure you know what your alarm sounds like and know your role during a fire alarm. If you do not know -ask. There are two types of smoke alarms. One is a detector and the other is an alarm which a member of staff or visitor would press. The majority of fire alarms will be automatic and will usually be displayed on the fire board which is often located in reception areas. Many things can trigger false alarms – you never know when the real thing is, so every alarm must be checked. Once an alarm has been raised your fire coordinator should ensure the Trusts’ policy is followed quickly and safely and that any fire wardens should

move to their designated positions if it is safe to do so. If an automatic call to the fire service has not already been made, the designated person must contact the fire service. The duty fire coordinator should refer to a fire card or a fire file that defines action and duties to be undertaken in the event of a fire alarm.

When a fire alarm is sounded most staff must leave the premises by the quickest route and help any visitors to safety. Staff with specific roles to play should refer to the evacuation checklist. If you are a coordinator, make sure the rooms adjacent and above from the fire are evacuated first.

	<p>CLASS A extinguishers for solid materials: wood, textiles, paper, furniture, plastics</p>		<p>CLASS B extinguishers for flammable liquids and solids: petrol, oils, solvents, paints, alcohol</p>		<p>CLASS E extinguisher for Electrical Fires: When it is not possible to isolate the electrical supply</p>
	<p>CLASS C extinguishers for fires involving gases: mains gas, butane and propane etc</p>		<p>CLASS D extinguishers for fires involving metals: alkali metals such as Sodium and Potassium</p>		<p>CLASS F extinguishers for high temperature cooking oils</p>

## 12. Medicine Safety (for Qualified Clinicians only)

The use of medication forms part of the treatment plan for the vast majority of our service users. When used in the correct manner, medication has the potential to have a beneficial effect on the wellbeing of those entrusted to our care. However, if medication is used in an incorrect or unsafe manner, it can have severe negative consequences ranging from an increase in unwanted effects to permanent injury or even death.

The estimated rate of potentially serious medication errors is 3-5 per month for the average mental health Trust. Over 60% of all reported errors are administration errors. Three incident types account for more than 70% of medication administration errors, namely; medication given at the wrong dose or frequency, the wrong medication being given, or doses of medication being omitted or delayed.

You may find it helpful to consider the correct administration of medication under the following five headings - the “Five Rs” of medication administration:

Right medication

Right dose

Right patient

Right route

Right time

With regards the administration of medication, the [Nursing and Midwifery Council's Standards for Medicines Management](#) states that as a registrant, in exercising your professional accountability in the best interests of your patients:

- You must be certain of the identity of the patient to whom the medicine is to be administered.
- You must check that the patient is not allergic to the medicine before administering it.
- You must know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.
- You must be aware of the patient's plan of care (care plan or pathway).
- You must check that the prescription or the label on medicine dispensed is clearly written and unambiguous.
- You must check the expiry date (where it exists) of the medicine to be administered.



- You must have considered the dosage, method of administration, route and timing.
- You must administer or withhold in the context of the patient's condition, (for example, Digoxin not usually to be given if pulse below 60) and co-existing therapies, for example, physiotherapy.
- You must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable.
- You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible. Where medication is not given, the reason for not doing so must be recorded.

## **Rapid Tranquillisation**

Please refer to the full Rapid Tranquillisation Protocol on the Trust Intranet under Medicines Policies ([http://elftintranet/our\\_library/medicine\\_policies.asp](http://elftintranet/our_library/medicine_policies.asp)).

### **What is rapid tranquillisation (RT)?**

RT is the term applied to the use of medication with the objective of quickly calming a severely agitated patient. RT is used when a patient is an immediate risk to themselves or others. The goal of RT is to calm the patient, not to induce sleep or unconsciousness.

### **When is RT used?**

Patients should be administered RT only after a thorough risk assessment has established that the benefits of doing so outweigh the potential risks posed by the use of the medication.

### **What steps need to be taken before RT is administered?**

If a patient is acutely disturbed, then the patient's doctor or the duty psychiatrist must be called to attend immediately. The opportunity to make a diagnosis may be lost if the patient is sedated before an understanding of their mental state is reached.

Non-pharmacological interventions should be considered before the decision to use medication is taken. The legal basis of treatment should also be considered. For instance, informal patients cannot be given any medication against their will, and patients who are sectioned under the Mental Health Act may have a limited list of medication that they can be legally administered.

If the decision is taken to use medication, the patient must first be informed and given the opportunity to accept oral medication voluntarily. If oral medication is repeatedly refused, the decision to forcibly medicate a patient (IM) will be taken jointly by medical and nursing staff. Once the decision has been made to forcibly medicate, the patient must be isolated from other patients on the ward and placed in a side room.

### **Which medications are used for RT?**

The three main groups of drugs used for RT are:

- **Anitpsychotics** e.g. haloperidol (oral/IM), olanzapine (oral/IM), quetiapine (oral), risperidone (oral)  
Generally these should not be administered to a patient who has never received an antipsychotic drug before. If the patient is already taking antipsychotic medication, this should be taken into account when deciding what dose to administer. Note: IM benzodiazepines cannot be given within 1 hour of giving IM olanzapine. 5mg IM Haloperidol = 10mg oral.
- **Benzodiazepines** e.g. lorazepam (oral), midazolam (IM).  
If a patient is already taking a benzodiazepine regularly this should be taken into consideration when administering RT. Benzodiazepines should be avoided in patients who are substance misusers or who are acutely intoxicated with alcohol. Respiratory depression caused by benzodiazepines can be readily reversed by administering flumazenil, a specific benzodiazepine antagonist that is kept as stock on all the wards.
- **Sedating antihistamines** e.g. Promethazine (oral/IM)

General rules when using medication for RT:

- In all cases the minimum effective dose of medication should be used. BNF maximum doses should only be exceeded in extreme circumstances and with guidance and permission from senior medical staff.
- Polypharmacy within a class of medication (e.g. antipsychotics) should, where possible, be avoided.
- Consideration should be given to any co-existing medical illnesses

More information about the medication used in RT (e.g. doses, duration of action, side effects) can be found in the Rapid Tranquillisation Policy on the Trust Intranet.

### **What should happen after a person is given RT?**

A patient who is administered RT should be monitored afterwards according to the stipulations set out in the Rapid Tranquillisation Policy. Monitoring undertaken should be recorded on the Rapid Tranquillisation Monitoring Chart that can also be found in the RT policy. The nurse administering the medication for rapid tranquillisation is responsible for subsequent monitoring arrangements.

The patient should be monitored for signs of CNS depression e.g. drowsiness, disorientation. Other parameters that need to be monitored for an ambulatory patient include; pulse rate, blood pressure, and respiratory rate. In addition to these, if the patient is not ambulatory, their temperature and oxygen saturation should be monitored. If the patient refuses observations, then their level of consciousness and respiratory rate should still be monitored remotely and recorded on the monitoring chart.

The frequency of monitoring required depends upon the individual patient circumstances. Ambulatory patients should be monitored at least every 30 minutes for an hour. Non-ambulatory patients should be monitored at least every 15 minutes for an hour. Monitoring should continue until the MDT feel it is safe to stop.

Patients who are given RT should be offered a feedback session to discuss their feelings about the intervention, and should be offered the opportunity to write their account in the medical notes.

## **High dose antipsychotic therapy**

### **What is high dose antipsychotic therapy (HDAT)?**

HDAT is the term used to describe a patient's antipsychotic therapy if they are taking:

- A single antipsychotic in a dose that is above the BNF recommended maximum, **or**:
- Two or more antipsychotics that, when expressed as a percentage of their respective maximum recommended doses and added together, result in a cumulative dose of > 100%

For example:

Zuclopenthixol depot 300mg weekly (50% BNF max) and Olanzapine 15mg daily (75% BNF max) = 50% + 75% = 125% (>100%, therefore 'high dose')

### **Why is HDAT used?**

The use of HDAT should be an exceptional clinical practice and is only employed when standard treatments, including clozapine, have failed. It may also be necessary to use HDAT as a temporary measure during an acute exacerbation of a patient's illness, when switching from one antipsychotic to another, or for rapid tranquilisation. The decision to raise the total dose of antipsychotics above the recommended upper limit must only be taken by a Consultant Psychiatrist.

### **What are the risks of HDAT?**

Most antipsychotic adverse effects are dose-related, so HDAT may increase the incidence and severity of these adverse effects. The effects may include:

- Extrapyramidal side effects (EPSE)
- Sedation
- Postural hypotension
- Anticholinergic effects (dry mouth, constipation, blurred vision, urinary retention)
- QTc prolongation and sudden cardiac death

### **What can be done to minimise the risks from HDAT?**

Patients on HDAT should be closely monitored for adverse effects. To help with this monitoring the pharmacist will start a “High-dose monitoring form” which contains spaces for a doctor to fill in the results from the regular monitoring that needs to take place. Things that need to be monitored include ECG, U&Es, LFTs, hydration status, temperature, and blood pressure.

### **What are the responsibilities of nursing staff with regards HDAT?**

- Monitor patients for adverse effects
- Weekly temperature check
- Weekly blood pressure check
- Document “high dose” status in the nursing care plan and daily progress notes.
- Check that monitoring sheet is being completed
- Ensure that high-dose status is discussed at review

## **13. Observation policy (for Nursing staff only)**

The Trusts Observation Policy seeks to address the mental health needs for service users who are considered to be vulnerable or at risk of suicide, self harm or harm to others. In addition the policy sets out the responsibilities of Trust employees who may be required to observe patients and sets out the process and procedures for guiding practitioners in making decisions to ensure a safe and therapeutic environment, to facilitate the assessment and management of inpatient’s level of observation and the rationale for supporting those decisions.

The purpose of the policy is to provide direction and guidance for the planning and implementation of high-quality supportive observation procedures for the Trust. This would provide a safe environment for service users thereby maximising the opportunity for successful therapeutic interventions. The policy aims to secure therapeutic observation between Trust staff and service users.

## **Levels of Supportive Observations**

There are four levels of supportive observation within the policy:

- 1) General supportive observation**
- 2) Intermittent supportive observation**
- 3) Continuous supportive observation – within eyesight**
- 4) Close supportive observation – within arm's length**

## **Competency:**

It is the responsibility of the Modern Matron in each of the localities to ensure that every member of nursing staff (permanent and bank) on their ward is assessed as competent to undertake supportive observations on the ward(s). The modern matron or PIN must deem permanent band 5 nurses competent to assess any bank nurse out of hours.

On arrival to a new clinical setting, the bank member is required to undergo a local induction, which will include the completion of the Supportive Observations Competency Checklist. This will then be kept on record for that setting and competency will be deemed to last for 12 months from the date of signing unless questions of competency are raised, whereupon a further assessment may be required. The member of staff should not undertake any observations until they are deemed competent to do so.

Subjects covered in the competency form are:

- Observation and/or Seclusion Policy read and understood including responsibilities and documentation.
- Understanding the rationale for enhanced supportive observations i.e. self-harming, suicidal, physical health concern etc.
- Understanding specific service user details relating to this episode of enhanced supportive observations i.e. mood, mental state, behaviour, Physical health etc.).
- Understanding when and how to summon assistance if required

- Understanding of the importance of the patients care plan and receipt of formal hand over from the shift coordinator and being introduced to the patient prior to commencement of any period of observation
- Understanding their responsibilities in the event of an emergency on the ward (i.e. fire, serious incident etc.).

### **Observation level**

Assessing levels of observation is an integral part of the admission process; all patients should be allocated a level of observation as soon as they arrive on the ward by the shift coordinator and in response to any subsequent assessment of risk. On admission the shift coordinator must initiate at least intermittent supportive observations of a new service user as soon as they arrive on the ward. The level of observation is based on the services users' reason for admission, clinical presentation and known history.

### **Staff Allocation**

Once observations have been prescribed the shift coordinators will draw up a rota at the commencement of every shift to ensure that the observations are distributed fairly and according to competence. No period of observation by a member of staff will be longer than 1 hour. At the end of each observation period, the member of staff will have a break from each observation of at least 30 minutes

**General Supportive Observation** is the minimum acceptable level of supportive observation for all in-patient units. Each service user's whereabouts and well-being will be checked visually and (if necessary) verbally by an allocated member of staff on an hourly basis.

**Intermittent Supportive Observation** is appropriate when service users are potentially but not immediately at risk of seriously harming themselves or others or there are concerns about their physical health which requires them to be checked at specific times. The interval between observations must be clearly identified by the person who has prescribed the observations. This may vary according to the MDT's assessment of need, but will usually be between 10–30 minutes.

**Continuous Supportive Observation – within Eyesight** is required when the service user could potentially attempt suicide or there are serious concerns about the service user's physical health. The service user will be kept within sight at all times, by day and by night, by an allocated member of staff. The supportive observation prescription must state if the service user does not require observation whilst using the toilet/taking a bath. Gender issues are to be considered regardless of whether the service user is observed or not when using the bathroom/toilet.

**Close Supportive Observation – within Arm’s Length** will be used when a service user is considered to be in need of the very highest level of observation i.e. the service user is considered to be at an immediate or high level of risk of suicide or there are serious concerns regarding their physical health. The service user will therefore be nursed in close physical proximity of an allocated member of staff, with due regard to safety, privacy, dignity, gender and environmental dangers.

### **Documentation**

All levels of observations have specific documents that have to be completed. Records of all decision making, progress and review of enhanced levels of supportive observation should be documented in detail in the service user’s progress notes. The undertaking of general supportive observation should be recorded hourly and the whereabouts of the service users recorded using codes. During intermittent supportive observation a record of the service user’s behaviour and whereabouts must be recorded at the time the supportive observation is undertaken, i.e. if the supportive observation is prescribed as every 10 minutes then there should be a record of progress every 10 minutes.

## **14. Mental Health Act**

### **Compulsory Powers under the Mental Health Act 1983**

The Mental Health Act 1983 provides the legal framework to regulate the circumstances in which the liberty of persons who are mentally disordered may be restricted and, where there is conflict, to balance their interests against those of public policy. The simple guide below should be read in accordance with the Mental Health Act 1983, related statutory Regulations, the Code of Practice and any other relevant guidance, including that from the Care Quality Commission. This and other information can be found on the Trust’s intranet at:

[http://elftintranet/our\\_organisation/mental\\_health\\_law.asp](http://elftintranet/our_organisation/mental_health_law.asp)





<b>Compulsory Detention/ Power</b>	<b>Purpose</b>	<b>Time Limits</b>	<b>Patient Appeal Rights</b>	<b>Discharge</b>
<b>Section 2</b> Admission to Hospital for Assessment	To detain people who are suffering from a mental disorder, for assessment.	For up to 28 Days	Appeal to Tribunal and Managers.	RC, Tribunal, Managers and Nearest Relative can order discharge.
<b>Section 3</b> Admission to Hospital for Treatment	To detain people who are suffering from a mental disorder where appropriate treatment is available.	For up to 6 months, then can be renewed for 6 months, then every 12 months	Appeal to Tribunal and Managers.	RC, Tribunal, Managers and Nearest Relative can order discharge.
<b>Section 4</b> Emergency Admission to Hospital	For people in crisis who need emergency admission.	For up to 72 Hours	Appeal to Tribunal and Managers.	RC, Tribunal, Managers and Nearest Relative can order discharge.
<b>Section 5(2)</b> Doctor's Holding Power	To hold an in-patient for further assessment for detention (not CTO pts)	For up to 72 Hours	No Right of Appeal.	Ends upon completion of formal assessment for detention under section 2 or 3.
<b>Section 5(4)</b> Nurses Holding Power	To hold an in-patient for further assessment for detention (not CTO pts)	For up to 6 Hours	No Right of Appeal.	Ends upon arrival of doctor.
<b>Section 17A</b> Community Treatment Order	To allow discharge from hospital subject to conditions, with power to recall to hospital for up to 72 hours.	For up to 6 months, then can be renewed for 6 months, then every 12 months	Appeal to Tribunal and Managers.	RC, Tribunal, Managers and Nearest Relative (when suspended authority is section 3) can order discharge.
<b>Section 135(1)</b> Place of Safety	Police power to enter premises and remove a person who is	For up to 72 hours	No Right of Appeal	Either if assessed as not suffering from a mental disorder, or other

	believed to be suffering from mental disorder.			arrangements have been made.
<b>Section 136</b> Place of Safety	Police power to remove a person who appears to be suffering from mental disorder, from a public place.	For up to 72 hours	No Right of Appeal	Either if assessed as not suffering from a mental disorder, or other arrangements have been made.

<b>Compulsory Detention</b>	<b>Purpose</b>	<b>Time Limits</b>	<b>Patients Appeal Rights</b>	<b>Discharge</b>
<b>Section 35</b>	Remand to hospital for a report on the mental condition of the accused.	28 days at a time up to maximum of 12 weeks.	Application to court for termination of the remand.	Court
<b>Section 36</b>	Remand of accused to hospital for treatment.	28 days at a time up to maximum of 12 weeks.	Application to court for termination of the remand.	Court
<b>Section 37</b>	Hospital Order	For up to 6 months, then can be renewed for 6 months, then every 12 months	Appeal against conviction or sentence. After 6 months, right to appeal Tribunal. Appeal to Managers anytime.	RC, Tribunal and Managers can order discharge.
<b>Section 37/41</b>	To protect the public from serious harm by restricting the application of the Act to a patient made the subject of a hospital order.	Without limit of time	Appeal against conviction or sentence. After 6 months, right to appeal Tribunal.  Appeal to Managers anytime.	RC and Managers can order discharge with consent from Secretary of State. Tribunal can discharge.
<b>Section 38</b>	Admission to hospital to	Initially 12 weeks, then	Appeal against conviction or	Court

	determine whether a hospital order is an appropriate disposal.	28 day periods up to maximum of 12 months.	sentence. Court may terminate order.	
<b>Section 44</b>	Committal to Hospital where there is committal to Crown Court by Magistrates for possible Restriction Order. Has same effect as section 37/41.	Until case is disposed of by the Crown Court.	Appeal against conviction or sentence.  After 6 months, right to appeal Tribunal.  Appeal to Managers anytime.	RC and Managers can order discharge with consent from Secretary of State. Tribunal can discharge.
<b>Section 45A</b>	Upon sentencing to imprisonment, Crown Court can direct immediate admission of the patient to hospital. Has same effect as section 37/41.	Restriction element lasts until sentence expiry.	Appeal against conviction or sentence.  After 6 months, right to appeal Tribunal.  Appeal to Managers anytime.	RC and Managers can order discharge with consent from Secretary of State. Tribunal can discharge.
<b>Section 47</b>	Transfer to hospital of a sentenced prisoner in need of treatment (see 49 below).	As section 37 above	Immediate right to appeal to Tribunal	RC, Managers, Secretary of State and Tribunal.
<b>Section 48</b>	Transfer to hospital of a non-sentenced prisoner in urgent need of treatment (see 49 below).	As section 37 above or upon disposal of case.	Immediate right to appeal to Tribunal	RC, Managers, Secretary of State and Tribunal.
<b>Section 49</b>	Additional restriction on discharge of prisoners detained under	Without limit of time or upon sentence expiry.	See sections 47 and 48 above	Secretary of State and Tribunal.

	sections 47 or 48.			
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**Section 17** – Authorisation of Leave **Section 18** – Retaking of Patients Absent Without Leave  
**Section 19** – Transfer of Authority to Detain **RC** – Responsible Clinician **Managers** –The Trust

## 15. Conflict Resolution

All Staff should be aware of potential causes and early warning signs of violence in health care and have knowledge of conflict resolution and de escalation techniques.

It has been suggested that 85% of people who are likely to act in an aggressive way will display behaviours that generally fall into;

**POSTURE** – Observe a person’s posture to identify if it is likely to convey calmness or otherwise.

**PROXIMITY** – Assess the use of personal space and lack of awareness or respect for the space of others.

**SPEECH** – Speed, Pitch, Tone, Volume & Content

**MOTOR** – Look for increased movements that may be large or small to indicate that the person is not calm.

### Understanding the Reasons for Behaviour

People's behaviours are consistent with their beliefs, culture & interpretation of situations.

Every behaviour has a function, which may be:

**Demands (I want)**

**Negation ( I don't want)**

**Sensory Stimulation**

**Communication & Interaction**

We need to understand the individual's interpretation of situations in order to Care/Support them effectively.

### **Triggers & Recognition of Anger**

Possible causes of Anger include:

- Age, Religious, Cultural, Gender, Sexuality & Disability
- Stress (Service User & Staff)
- Communication
- Staff Attitude
- Restrictions
- False Promises
- Drugs & Alcohol
- Environment
- Physical Health
- Learnt Response
- Family
- Mental Health Issue
- Insufficient Knowledge

**De-escalation** is an interactive process of helping someone to reduce their level of distress, which may include going to a quiet place and collaborative problem solving.

### **Non-verbal De-escalation skills**

Proxemics – Position, Proximity & Posture

Eye contact

Respect touch boundaries

Facial expression

Environment

Consider influence & risks of your appearance

Think about your hand movements

### **Verbal De-escalation skills**

- Ask for facts of the problem
- Acknowledge and check feelings
- Consider Agreement and/or Apologising
- Diversion
- Keep language simple and avoid provocative phrases
- Start negotiations when more rational
- Mind the conflict resolution style you adopt;
  - Competing (I must win/be in charge)
  - Avoiding & Accommodation (I must be liked/conflict is bad)
  - Collaborating & Safe Compromising (Solutions call for flexibility)
- Management of situations involving weapons

### **Managing your own emotions**

- Plan and chose what you are going to do
- Recognize and acknowledge own signs of anxiety
- Positive mind set – but acknowledge own limitations.
- Recognize danger signals of your own & colleagues.
- Avoid a defend-attack spiral
- Focus on active listening (Verbal & Non-verbal)
- Manage own breathing

### **Use of Force**

**Employers, Law & Professional Bodies regulate use of force**

The Law: Criminal Law Act (1967)

- Provides defence for use of force, provided the force used is:
  - (a) Unavoidable (necessity)
  - (b) Reasonable in the circumstances
  - (c) Proportionate the harm likely to occur

### **Key Points that may affect staff responses**

- The person's behaviour
- Specific circumstances surrounding the event

### **Assessing Reasonableness**

(Perception of Threat: Intent & Potential)

- Gender, Age & Size

- Relative strength & special skills level (yours & theirs)
- Substances involved
- Some mental illness symptoms
- Weapons involved
- Numbers involved
- Location
- Previous history

### **Post Incident work (for Staff & SU's)**

→Support Defusing & Reassure eye witnesses →Psychological support →Counselling

→Documentation & Reporting (ABC Model)

→Crime committed? Police Involvement?

→Learning lessons (ABC Model) →Trigger factors → Behaviour of the person →staff response: did it work? →learn, share, change approach →involve Service User.

### **Local NHS Protect (Security Management Specialist - LSMS)**

**Richard Harwin** [richard.harwin@eastlondon.nhs.uk](mailto:richard.harwin@eastlondon.nhs.uk) Mob: 07870683993 Tel:020 7655 4222

**Health & Safety Lead**

**Glenis Roberts** Email: [glenis.roberts@eastlondon.nhs.uk](mailto:glenis.roberts@eastlondon.nhs.uk) Mob: 07507 605 769 Tel: 020 7655 4054



## 16. Contact List

Department	Contact Name	Contact Details
Complaints and Legal Affairs	Jane Quinn	0207 655 4064
Fraud	Parkhill	0207 953 8432
Information Governance	Chris Kitchener	0207 655 4110
Health, Safety & Security	Launa Rolf	0207 655 4222
Healthcare Governance and Risk Management	Andy Acquaye	0207 655 4133
Safeguarding Children	Jan Pearson	0207 655 4136
Domestic Abuse & Safeguarding Adults	Janet Boorman	0207 655 4240
Equality & Diversity	Clementine Femiola	0207 655 4147
Child Protection Helpline	(Freephone)	0800 800 5000 <a href="mailto:help@nspcc.org.uk">help@nspcc.org.uk</a>
Domestic Abuse 24 hour Helpline	(Freephone)	0808 2000 247
Infection Prevention & Control Team	Carol Shannon	07940 237 087
Medicine Safety	Shameem Mir	0207 655 4038
Mental Health Law	Guy Davis	0207 655 4046
Security Management Specialist	Richard Harwin	0207 655 4222

<b>Health &amp; Safety Lead</b>	<b>Glenis Roberts</b>	<b>0207 655 4054</b>
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**Appendix 1**



**Local Induction Checklist for Temporary Bank/Agency Staff**

All Temporary Bank/Agency staff when working on a ward/in a department for the first time or following a gap of three months or more need to be locally inducted. The checklist should be completed with your supervising manager on the first day of you working in order that you are

trained in information locally where you will be working. 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 tempstaff[induction@eastlondon.nhs.uk](mailto:induction@eastlondon.nhs.uk) or

fax it to 0207 655 4141 within 1 week of your start date.

I confirm that I have received the Temporary 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);

<sup>1-14</sup> refer to overleaf

Area Covered	Clinical Staff	Admin Staff
Identity Check		
Confirmation of mandatory training completed		
Hours of work/shift pattern/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 phone numbers		
On call and bleep system – Doctors, emergency		

<b>Alarm system- Fire, ward alarms, personal alarms</b>		
<b>Observations<sup>1</sup></b>		
<b>Fire<sup>2</sup></b>		
<b>First Aid<sup>3</sup></b>		
<b>Codes/keys/security pass/badge<sup>4</sup></b>		
<b>Ward environment safety<sup>5</sup></b>		
<b>Infection control<sup>6</sup></b>		
<b>Patient care<sup>7</sup></b>		
<b>Social Therapist<sup>8</sup></b>		
<b>Medicines safety procedures – Sops, protocols</b>		
<b>Incident reporting procedures/forms</b>		
<b>Standards of behaviour<sup>9</sup></b>		
<b>Manual Handling<sup>10</sup></b>		
<b>Confidentiality/record- keeping<sup>11</sup></b>		
<b>Resuscitation</b>		

<b>procedures/equipment</b>		
<b>Reporting to and contact details</b>		
<b>Specific Duties and responsibilities<sup>12</sup></b>		
<b>Local Lone Working Procedure<sup>13</sup></b>		
<b>All other matters<sup>14</sup></b>		

TEMPORARY STAFF NAME: \_\_\_\_\_ SIGNED: \_\_\_\_\_

POST TITLE: \_\_\_\_\_ NAME OF AGENCY EMPLOYED UNDER: \_\_\_\_\_

DEPARTMENT/LOCALITY: \_\_\_\_\_ START DATE: \_\_\_\_\_

NAME (Trust member of staff delivering induction): \_\_\_\_\_

SIGNED: \_\_\_\_\_ 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.**

<sup>1</sup>**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.

<sup>2</sup>**Fire:** where the exits are, the fire procedure, equipment, alarms, telephone numbers and assembly points.

<sup>3</sup>**First Aid:** First aider and location of box

<sup>4</sup>**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.

<sup>5</sup>**Ward environment safety:** for example ensuring that no sharp or potential ligatures to be left around, trip and fall hazards.

<sup>6</sup>**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.

<sup>7</sup>**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.

<sup>8</sup>**Social Therapist:** To report ANY concerns regarding patients to the Nurse in Charge. Not to administer or dispense any medication.

<sup>9</sup>**Standards of behaviour:** no back to back shifts, dress code, no alcohol, no smoking, no illicit drugs, no violent or abusive behaviour, gross negligence, inappropriate relationship with client.

<sup>10</sup>**Manual Handling:** Moving and handling procedures/equipment. Be careful when lifting heavy goods and handling clients.

<sup>11</sup>**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.

<sup>12</sup>**Specific duties and responsibilities:** Please indicate other post specific information given.

<sup>13</sup>**Local Lone Working Procedure:** Discuss potential hazards of working alone and assess the risks involved and put measures in place to avoid or control the risks.

<sup>14</sup>**All other matters:** If you are not sure about something then ask Nurse in Charge/Supervisor (if you are the Nurse in Charge, you will be told how to contact the Clinical Co-ordinator).