The Family Practice Group

2. Quality of Treatment and Care

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Brigstock Family Practice has a standard procedure when assessing a patient's needs and suitability for treatment.

2.1 Assessment of a Patient at the Clinic

During an initial assessment the clinician will assess the referral letters and patients records. They will also consult with patient/guardian to gain a full understanding of the patients' needs

The clinician will ensure that people who use the services are at the centre of their care, treatment and support and will ensure that they are able to make decisions about their care**.** Patients/guardians will be provided with information that supports people who use services, or others acting on their behalf, to make decisions about their care, treatment and support.

Clinicians will ensure that patients/guardians understand the care, treatment and support provided.

2.1.1 For specific courses of treatment it is imperative to establish whether the condition is treatable. The correct course of treatment and is discussed in detail with the patient. The clinician must ensure that the patient is able to make an informed choice.

2.2 Information, Treatment Plans and Care Development

The Practice has a range of written material available to patients to help them make informed decisions about treatment

2.2.1 In line with NHMR Core Standard C1, any patient, or prospective patient, will be given a Patient Guide outlining the services we provide, how to make comments, suggestions and complaints and detailing the contact information of the Patient Advise and Liaisons Service. The Patient Guide is reviewed annually as a matter of course and it is the responsibility of the Registered Manager to make sure that all statements are detailed therein are not misleading, information is accurate and any claims made in respect to services are justified..

2.2.2. Once a prescribed course of treatment is suggested by the clinician, the patient is given the relevant information for that procedure.

2.2.3. After treatment, the patient must be issued with an Aftercare Leaflet outlining any post-treatment care needing to be implemented by the patient or the clinician. The aftercare leaflet details contact information for the clinic should the patient have any concerns or questions post-treatment. Emergency and out-of-hours numbers are contained within the Aftercare Leaflet.

2.2.4. All staff members must wear name badges at all times. This is in order for patients to know the name and the position held of the staff member that they are dealing with and thus the identity of the person that is providing information.

2.3 Patient Consent

2.3.1 Introduction

The purpose of this protocol is to set out the practice's approach to consent and the way in which the principles of consent will be put into practise. It is not a detailed legal or procedural resource due to the nature and complexity of the issues surrounding consent.

Consent has three main elements:

- It must be voluntary – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family
- It must be informed – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment doesn't go ahead
- The patient must have capacity – the person must be capable of giving consent, which means they understand the information given to them and they can use it to make an informed decision

Where possible, a clinician must be satisfied that a patient understands and consents to a proposed treatment, immunisation or investigation, as well as the nature, purpose, benefits and risks of the procedure. Drawings, interpreters, videos or other means may be used to help ensure that the patient understands the situation, and has enough information to give 'Informed Consent'.

As a result of case law, consent must be clarified regarding not just the available options, but also the risks. The doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks particular to them involved in proposed treatment, and of reasonable alternatives. A risk is "material" if a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it.

2.3.2 Implied Consent

Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- An explanation will be given to the patient with regards to what the

clinician is about to do, and why.
- The explanation will be sufficient for the patient to understand the procedure.
- In all cases where the patient is under 18 years of age, a verbal confirmation of consent will be obtained and entered into the medical record.
- Where there is a significant risk to the patient, “Expressed Consent” is to be obtained in all cases (see below).

In emergency situations where the patient may not be able to give consent then there is always an implied consent to save life. Once the patient is able to communicate fully, the treatment they underwent must always be explained to them.

2.3.3 Expressed Consent

Expressed consent (written or verbal) will be obtained for any procedure which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent given and the risks of the procedure. A Consent Form [*] may be used for the patient to express consent (see below) which should then be attached to the clinical record.

Expressed consent may be given over the telephone and in those cases it will be good practice that the recorded call is attached to the clinical file in the same manner as other documents.

2.3.4 Obtaining Consent

- Consent (Implied or Expressed) will be obtained prior to the procedure, and prior to any form of sedation.
- The clinician will ensure that the patient is competent to provide a consent (i.e. is 16 years old or over) or has “Gillick Competence” if under 16 years. Further information about Gillick Competence and obtaining consent for children is set out below.
- Consent will include the provision of all information relevant to the treatment.
- The clinician should explain the proposed treatment and any alternatives available to the patient, the risks and benefits of each option, and support the patient choice about which treatment best meets your needs.
- Questions posed by the patient will be answered honestly, and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.
- The person who obtains the consent will be the person who carries out the procedure (i.e. a nurse carrying out a procedure will not rely on a consent obtained by a doctor unless the nurse was present at the time of the consent).

- The person obtaining consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
- The scope of the authority provided by the patient's consent will not be exceeded unless in an emergency.
- The practice acknowledges the right of the patient to refuse consent, delay the consent, seek further information, limit the consent, or ask for a chaperone.
- Clinicians will use a Consent Form [*] where procedures carry a degree of risk or where, for other reasons, they consider it appropriate to do so (e.g. malicious patients).
- No alterations will be made to a Consent Form once it has been signed by a patient. Should consent be subsequently withdrawn, the patient should do so in writing and include in their note that withdrawal has been made after the implications have been explained to them.
- Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other present family members etc.).
- If a patient is mentally competent to give consent but is physically unable to sign the Consent Form [*], the clinician should complete the Form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

Other aspects which may be explained by the clinician include:

- Details of the diagnosis, prognosis, and implications if the condition is left untreated.
- All options for treatment, including the option not to treat.
- Details of any subsidiary treatments (e.g. pain relief).
- Patient experiences during and after the treatment, including common or potential side effects and the recovery process.
- Probability of success and the possibility of the need for further treatments.
- The option of a second opinion.

2.3.5 Immunisations

Informed consent must be obtained prior to giving an immunisation. There is no legal requirement for consent for immunisation to be in writing, and a signature on a consent form is not conclusive proof that consent has been given, but serves to record the decision and discussions that have taken place with the patient, or the person giving consent on a child's behalf.

The practice will however not assume that any relative (other than anyone with parental responsibility) bringing a child for immunisation has the authority to agree to the treatment. In such cases, the clinician administering the immunisation must be satisfied that the parent has agreed to all of the immunisations on that occasion. How that consent has been assessed must be included in the practice clinical record.

2.3.6 Consent for children

Everyone aged 16 or over is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then he/she will be judged competent to give consent for him/herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign a Consent Form [*] for themselves, but they may like a parent to countersign as well.

For children under 16 (except for those who have Gillick Competence as noted above), someone with parental responsibility should give consent on the child’s behalf by signing accordingly on the Consent Form [*].

2.3.7 Mental Capacity Act [*]

The Mental Capacity Act (MCA) 2005 became fully effective on 1st October 2007 in England & Wales and provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. ‘A person who lacks capacity’ is defined as a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. The lack of this capacity could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident and may be on either a temporary or a permanent basis.

(In Scotland the Adults with Incapacity (Scotland) Act 2000 provides similar legislation for people over the age of 16. In Northern Ireland, decision-making is governed by the common law. The Northern Ireland Assembly is working towards statutory provisions for treating adults lacking mental capacity but it is not known when this will be introduced.)

The MCA makes clear who can take decisions in which situations, and how they should go about this. Practice staff must always ensure that should any patient have made a Lasting Power of Attorney for their Health (as opposed to finance), a copy is obtained and scanned to the clinical file.

2.3.8 Deprivation of Liberty Safeguards [*]

The Deprivation of Liberty Safeguards (DoLS) can only apply to people who are in a care home or hospital. This includes where there are plans to move a person to a care home or hospital where they may be deprived of their liberty. The care home or hospital will work with the Local Authority in authorising a DoLS and the practice may be asked to contribute to the decision.

There is no valid advance decision (Living Will) to refuse treatment or support that would be overridden by any DoLS process (see Living Wills below). If a DoLS is not able to be authorised it may mean that the care home or hospital has to change its care plan so that the person can be supported in a less restrictive way.

2.3.9 Living Wills

A Living Will is a form of advance consent made by someone with capacity to do so as to how their treatment should be conducted in the future. It must be made by a patient in writing, signed by them and witnessed. It must be specific about the treatments it covers and the situations where it is to apply and in particular should it cover refusal for a life-saving treatment it must make it clear and unambiguous.

Practice staff who are made aware of a patient with a Living Will must ask the patient to provide a copy and it should be appended to their clinical record.

Resources
Consent Form (For Patient) [*]
Mental Capacity Act/DoLS Policies [*]
NHS Consent advice: https://www.nhs.uk/conditions/Consent-to-treatment/
Living Wills: https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/
BMA Consent toolkit:
https://www.bma.org.uk/advice/employment/ethics/consent/consent-tool-kit

2.4 Access to information

A patient may request to see their records at any reasonable time when their clinician is on duty in line with the Data Protection Act 1988. The only exceptions here are records made by the medical profession where specific permission from the consultant will be required.

2.4.1 If the patient feels that there is information contained within their files with which they disagree, they can request that the record be altered. Alternatively, a note may be made in the records indicating the disagreement of the patient. Such alterations will be made by the clinician with specific notes from the original statement.

2.4.2. Patients' records are kept for a minimum of eight years beginning on the date of the last entry.

2.5 Resuscitation Policy

Please refer to the clinic's Resuscitation policy no.16

2.6 Access to services

Treatment is available to the whole population who are registered with the practice, regardless of race or ability, where the therapy in question will not cause significant risk to either the Patient or the Clinician.

2.7 Patient Rights

All members of staff will treat all Patients with personal consideration and respect.

Patients have the right to choose whether or not their information is used for marketing or training purposes

Patients can expect all staff to respect their privacy, dignity and religious and cultural beliefs at all times and in all places.

Staff will ask patients whether they want to be called by their first or last name and respect their preference.

Patients who choose not to discuss health related matters with members of the opposite sex receive consultations with health care professionals of the same sex where possible.

Patients have the right to have any proposed treatment, including any risks involved in that treatment and any alternatives, clearly explained to them before they decide whether to agree to it;

Have access to their records, and to know that everyone working for the practice has a legal duty to keep your records confidential;

Have any complaint about the services investigated and to get a quick, full written reply from the Manager. Should the response be deemed to be inadequate, the Patient has the right to take the matter to the Health Care Commission.

2.8. Confidentiality

Patient confidentially is key to professional conduct. Records are subject to the standard conditions of confidentiality and comply with the NHS Care record Guarantee (Appendix 104_The Care Record Guarantee).

Confidential information concerning the patient will not be disclosed to a third party unless, in the opinion of the Manager or Clinician, there is a serious risk to the patient's health or safety. Also see the Clinic's Information Management Policy no.18.

Patient records are stored in a secure location in the clinic, accessible only by authorised personnel (see section 17 of this manual – Records Management).

2.9 Chaperones

This policy sets out guidance for the use of chaperones and procedures that should be in place for consultations, examinations, investigations and clinical interventions.

2.9.1 Introduction

The surgery is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

This policy recognises the following principles:

- That all medical consultations, examinations and investigations are potentially distressing and those involving the breasts, genitalia or rectum; or those requiring dimmed lights or the need to undress may make patients feel particularly vulnerable.
- For some people who use our services, whether because of mental health needs and/or learning disabilities, consultations, examinations or procedures may be threatening or confusing. A chaperone, particularly one trusted by the patient, may help the patient through the process with the minimum of distress.
- For most patients respect, explanation, consent and privacy take precedence over the need for a chaperone.
- The presence of a third party does not negate the need for adequate explanation and courtesy and cannot provide full assurance that the procedure or examination is conducted appropriately.
- No family member or friend of a patient should be expected to undertake any formal chaperoning role in normal circumstances unless explicitly requested by the patient.
- The presence of a chaperone during a clinical examination and treatment must always be the clearly expressed choice of a patient (however the default position should be that all intimate examinations are chaperoned)
- The patient must at all times have the right to decline any chaperone offered. This must be documented in the patient's record.
- Chaperones are most often required or requested where a male examiner is carrying out an intimate examination or procedure on a female patient.

- However, the Surgery considers it good practice to offer all patients a chaperone for any examination or procedure where the patient feels one is required, regardless of the gender of the examiner or patient.

- Reported breaches of the chaperoning policy should be formally investigated through the Surgey's risk management and clinical governance arrangements and treated, if determined as deliberate, as a disciplinary and safeguarding matter.

2.9.2 Purpose

The purpose of this policy is:

To ensure those patients' safety, privacy and dignity is protected during intimate examinations or procedures and delivery of intimate clinical care interventions.

To minimise the risk of a Health Care Practitioners (HCP's) actions being misinterpreted

To ensure the HCP's safety whilst carrying out intimate clinical examinations and interventions

To recognise that the Surgery's Consent policy and the Surgery's Respect Policy must be adhered to at all times

2.9.3 Scope

This policy applies to all healthcare professionals working within the Surgery, including Students, Doctors Medical, Nursing and Midwifery, Clinical Technicians and other Therapists working with individual patients in clinic situations. This policy also covers any non-medical personnel who may be involved in providing care. In this policy, all staff groups covered will be referred to as the "Healthcare Professional" (HCP). The use of the feminine gender equally implies the male and similarly the use of the male gender equally implies the female.

This policy applies to all clinicians directly employed on substantive or honorary contracts by the organisation and contractors whose contract specifies adherence to this policy.

All healthcare professionals have a responsibility to ensure they work in line with their own professional code of conduct.

This policy specifically applies to all intimate examinations and procedures.

These are defined as any examination or procedure involving the rectum, genitalia or breasts. It also includes examinations or interventions involving the complete removal of outer clothing down

to underwear or less. Other examinations could also be deemed intimate by some patients and HCP's need to be aware of cultural differences and what may constitute an intimate examination.

2.9.4 Definitions

A Chaperone

The designation of the chaperone will depend on the role expected and the wishes of the patient i.e. either a passive/informal role or an active/formal role. There is no clear definition of a chaperone since this role varies considerably depending on the needs of the patient, the healthcare professional and the examination or procedure being carried out. Chaperone may refer to: Chaperone (clinical), a person who acts as a witness for a patient and a medical (or HCP) practitioner during a medical examination or procedure.

Informal Chaperone

An informal chaperone would not be expected to take an active part in the examination or witness the procedure directly. An example is a family member or friend i.e. a familiar person who may be sufficient to give reassurance and emotional comfort to the patient; who may assist with undressing the patient and who may act as an interpreter if deemed appropriate.

Formal Chaperone

This implies a health professional such as a qualified Nurse, or a specifically skilled unqualified staff member e.g. health care assistant (HCA). Where appropriate they may assist in the procedure being carried out and/or hand instruments to the examiner during the procedure. Assistance may also include clinical interventions and support provided to the patient when attending to personal hygiene, toileting and undressing/dressing requirements.

A chaperone will be able to identify any unusual or unacceptable behaviour on the part of the health care professional, and should immediately report any incidence of inappropriate behaviour, which includes inappropriate sexual behaviour to their line manager or another senior manager.

A chaperone will also provide protection to healthcare professionals against unfounded allegations of improper behaviour made by the patient.

In all cases the presence of the chaperone should be confined to the physical examination part of the consultation or procedure unless the patient requests otherwise.

Confidential clinician/patient communication should take place on a one to one basis after the examination / procedures unless the patient requests otherwise. It is the responsibility of the health care professional to ensure that any concerns they have regarding the examination or procedure are reported immediately to their line manager or senior manager. It is the responsibility of the health care professional to ensure that accurate records are kept of the clinical contact, which also includes records regarding the acceptance or refusal of a chaperone.

It is the responsibility of the health care professional to access any information and training required to support their role as a chaperone which may include any of the following:

- To provide emotional comfort and reassurance to patients during sensitive and intimate examinations or treatment.
- To assist in an examination or procedure, for example handling instruments during IUCD insertion, ECG procedure.
- To offer practical support during care interventions, such as undressing the patients, and attending to intimate toileting or hygiene requirements.
- To act as an interpreter is appropriately skilled and trained to do so
- To provide protection to HCP's against unfounded allegations of improper behaviour.
- To report any unusual or unacceptable behaviour on the part of the healthcare professional.
- To act as safeguard for patients against humiliation, pain or distress whilst offering protection against verbal, physical, social or other abuse.
- To act as a safeguard for all parties (patient and practitioners) and as a witness to continuing consent of the procedure. However a chaperone cannot be a guarantee of protection for either the examiner or examinee.

2.9.5 Duties

Partners

The Partners' role is to ensure implementation of this policy and that the staff understand how the Chaperone Policy applies to them and their patients.

Managers are also responsible for ensuring that where necessary, local processes are developed and training given to planning staff rosters and skill mix to support the full implementation of this policy. Managers should review the effectiveness of the implementation, and take appropriate remedial action when they become aware of any acts or omissions that contravene it. The Partners also have a responsibility for ensuring chaperones are available within their respective areas, and that chaperones work within their scope of practice and are fully aware of this and associated policies. They also have a responsibility to

ensure accurate records are kept of the clinical contact, which also include records regarding the acceptance or refusal of a chaperone. They also have responsibility for informing the senior manager if no suitable chaperone is available. They have responsibility for ensuring all chaperones are aware of their responsibilities and that appropriate use of chaperone posters are made available within their areas if required.

Health Care Professional
The health care professional is responsible for ensuring that patients are offered a chaperone and for respecting the individual's choice to request or decline a chaperone, whether in an outpatient or inpatient setting. They are responsible for maintaining the accurate documentation including the consent given to proceed without a chaperone. They are also responsible for escalation of concerns should these emerge during this process.

Medical Students
In line with best GMC guidance, Medical students should only
• Act as a chaperone for patients examined by the relevant clinical supervisor
• Conduct non-intimate examinations on patients with their clinical partner present, or on their own during year 5 placements.

Medical student should not:
• Conduct intimate examinations on a patient without a clinically qualified chaperone being present (i.e. doctor or nurse)
• Act as chaperone to their clinical partner for intimate examinations.
• Conduct any intimate examination unsupervised even if the patient is happy for them to proceed with the examination.

When there is no Chaperone available

It is the responsibility of all staff to follow guidelines specified in Appendix 1

Where a suitable formal Chaperone cannot be provided, an incident form should be completed outlining the reasons and action taken. The immediate line manager must be notified and any adverse implications this will have on the patient's care and or treatment discussed with them. In all circumstances the patient must be notified that a chaperone is not available and noted in their notes. It is the HCP own discretion and not the Surgery's to proceed without the formal chaperone present but this decision remains with the HCP as they will be held accountable for answering any allegations made against them.

The Chaperone

If a member of the team wishes to expressly opt out of providing chaperone duties they can disclose this to their line manager by completing the following form:

Appendix 118 Opt Out Chaperone Declaration Form

The chaperone's main responsibility is to provide a safeguard for all parties (patients and practitioners), as a witness to continuing consent to the procedure/ examination. In order to protect the patient (male or female) from vulnerability and embarrassment, a chaperone should be of the same sex as the patient (unless otherwise stated by the patient). An opportunity should always be given to the patient to decline a particular person if that person is not acceptable to them for any reason. This must be recorded and escalated to the appropriate line manager. The patient will not be asked to give a reason in these cases, however their decision must be respected. The patient will be notified by the HCP that this may delay or even mean the procedure is Cancelled until another suitable Chaperone is allocated. The implications for this must be communicated and documented in the patient's notes.

Offering a Chaperone

All patients should be routinely offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted in order to ask if the patient wants a third party present. The offer of a chaperone should be made clear to the patient prior to any procedure, ideally at the time of booking the appointment. Most patients will not take up the offer of a chaperone, especially where a relationship of trust has been built up or where the examiner is the same gender as them.

If the patient is offered and does not want a chaperone it is important to record that the offer was made and declined. If a chaperone is refused a healthcare professional cannot usually insist that one is present and many will examine the patient without one.

Patients decline the offer a chaperone for a number of reasons: because they trust the HCP, think it unnecessary, require privacy, or are too embarrassed.

However, there are some cases where the (usually male) doctor may feel unhappy to proceed. This may be where a male doctor is carrying out an intimate examination, such as cervical smear or breast examination. Other situations may exist where there is a history of violent or unpredictable behaviour by the patient that is known when the patient attends to see another doctor or health professional.

For some patients, the level of embarrassment increases in proportion to the number of individuals present.

The Surgery advises that the use of a chaperone is considered particularly for all INTIMATE EXAMINATIOINS (this list is not exhaustive) which includes:

- During gynaecological/intimate examinations or procedures.
- When examining the upper torso of a female patient.
- Intimate and invasive procedures/ examinations before or after sedation
- Intimate and invasive examinations as identified by HCP
- For patients with a history of difficult or unpredictable behaviour, this may or may not be attributable to mental health illness.
- For unaccompanied children.
- For vulnerable adults who lack capacity including those with a learning disability
- Intimate nursing and clinical care interventions e.g. attending to intimate personal hygiene and toileting requirements

If the patient requests a chaperone when attending a clinic, and there is no one immediately available, they should be offered the choice of waiting until a chaperone can be found and being informed of the time this may take to locate one or rebooking for another day when arrangements for a chaperone can be put in place.
Where an intimate examination needs to be carried out in a situation which is life threatening, or where speed is essential in the care of the patient, this may be done without a chaperone. It should, however be recorded in the patient's medical/nursing record the reasons for this and full explanation provided as soon as possible after the procedure.

Where a Chaperone is needed and not available

If the patient has requested a chaperone and none is available at that time the patient must be given the opportunity to reschedule their appointment within a reasonable timeframe should he/she chooses.

If the seriousness of the condition would dictate that a delay would have a negative impact then this should be explained to the patient and recorded in their notes. All attempts must be made to locate a suitable chaperone before a decision to continue or otherwise should be jointly reached and recorded in the patient's notes. In cases where the patient is not competent to make an informed decision then the healthcare professional must use their own clinical judgment and record and be able to justify this course of action.
Similarly, male nurses are sometimes required to perform intimate tasks on female patients, such as bathing and or rectal vaginal procedures. The patients consent should be sought prior to the procedure and a female nurse sought if the patient objects to undertake these processes. In all cases of intimate examinations and procedures a formal chaperone must be sought.

Training for Chaperones

It is advisable that members of staff who undertake a formal chaperone role should have undergone local training so that they develop the relevant competencies and skills required for this role.

All staff who undertake Chaperone duties should have an understanding of the role of the chaperone and the procedures for raising concerns.

This training should be recorded in their HR record and training logs and their line managers should be made aware of their competency. Training of new clinical staff who would act as formal chaperones must include the key principles listed below:

- What is meant by the term chaperone?
- What is an “intimate examination”?
- Why chaperones need to be present
- The rights of the patient
- Their role and responsibility e.g. advocate, the appropriate conduct during intimate examinations
- Policy and mechanism for raising concerns and accurate recording

Training will be recorded in the staffs training log books in the individual staff members personal record for existing staff undertaking formal chaperone duties by the relevant line manager.

Consent

Consent is a patient’s agreement for a health professional to provide care.

Before HCP’s examine, treat or care for any person they must obtain their valid consent.

There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way. Staff must refer to the relevant consent and mental capacity policy in relation to this.

Staff need to be mindful that by attending a consultation it is assumed by implied consent that a patient is seeking treatment. However, before proceeding with an examination it is vital that the patient’s informed consent is obtained. This means that the patient must be competent to make the decision have received sufficient information to take it and not be acting under duress.

When patients are not able to consent for themselves the HCPs should make the decision in the patients best interests in line with Surgery’s Policies and this must be documented in the patinets notes.

When a patient attends a clinic, surgery or allows a health professional into their home, it is taken for granted that they are seeking or accepting treatment, and thus implies that the consent to the

recommended treatment by the health professional is given. However, informed consent should be obtained by word or gesture before any examination takes place. This must be documented in the patient's notes.

Where more explicit consent is required prior to intimate examinations or procedures, such as an individual who is a minor or has special educational needs, staff should refer to the Surgery's Consent Policy.

In the case of any victim of an alleged sexual attack, valid written consent must be obtained for the examination and collection of forensic evidence. In situations where abuse is suspected, great care and sensitivity must be used to allay fears of repeat abuse.

Issues Specific to Religion, Ethnicity or Culture
The ethnic, religious and cultural background of patients can make intimate examinations particularly difficult, for example, some patients may have strong cultural or religious beliefs that restrict being touched by others. Patients undergoing examinations should be allowed the opportunity to limit the degree of nudity by, for example, uncovering only that part of the anatomy that requires investigation or imaging. Wherever possible, particularly in these circumstances, a same sex healthcare practitioner should perform the procedure.

It would be unwise to proceed with any examination if the healthcare professional is unsure that the patient understands due to a communication barrier. If an interpreter is available they may be able to double as an informal chaperone. In life saving situations every effort should be made to communicate with the patient by whatever means available before proceeding with the examination.

Religion, Ethnicity or Culture
Health professionals should seek to reassure patients, and limit the degree of nudity and uncover only the part of the anatomy that is to be examined.
Language barriers may also be an issue if the healthcare professional is unsure of the patient's understanding. An interpreter, if available, could act as an informal chaperone. (This can also be either informal or formal chaperone that has the skills to translate accurately)

In every case the health professional should be able to demonstrate, if challenged, that they have taken all reasonable steps to protect themselves and the patient from allegations of improper behaviour.

Issues Specific to Learning Difficulties / Mental Health Problems
For patients with learning difficulties or mental health problems that affect capacity, a familiar individual such as a named family member or professional

Carer / HCP may be the best formal chaperone. This must be agreed and documented with the individual and the family member /Carer as part of the overall best interest decision making process.

A careful, simple and sensitive explanation of the technique is vital in these circumstances. These patient groups are more at risk of vulnerability and as such, will experience heightened levels of anxiety, distress and misinterpretation. This could potentially lead to a risk of concerns that may arise in initial physical examination such as “touch”, one to one “confidential” settings in line with their existing or previous treatment plans history of therapy, verbal and other “boundary-breaking” circumstances.

Adult patients with learning difficulties or mental health problems who resist any intimate examination or procedure must be interpreted as refusing to give consent and the procedure must be abandoned. In life threatening situations the healthcare professional should use professional judgment and where possible always discuss and engage with members of the relevant specialist teams within mental health and learning disabilities. In all circumstances the named mental health team members and learning disability Nurse should be contacted where ever possible in advance to provide advice and specialist input regarding the planning of intimate procedures and the support individuals will require chaperone policy

Issues specific to Children and Young People
The care of Paediatric patients often needs to be managed on an individual case basis, due to the complexities and range of issues which apply to the safe Chaperoning of children and young people. It is therefore essential to refer to the relevant polices which apply to the specific needs of the patient. Please refer to the

Mental Capacity
There is a basic assumption that every adult has the capacity to decide whether to consent to or refuse a proposed medical intervention, before proceeding with an examination it is vital that the patient’s informed consent is gained.

This means that the patient must:

- Have capacity to make the decision.
- Have received sufficient information and
- Not be acting under duress

Under the MCA 2005 there is legal protection for people who care for or treat someone who lacks capacity but any action taken must be in a patient’s best interests and the least restrictive course of action.

Staff should refer to all the relevant consent and in particular Mental Capacity Act and Deprivation of Liberties Policies in all situations relating to any adult who does not have capacity.

Lone Working
Where a healthcare professional is working in a situation away from other colleague's e.g. home visit, out-of-hours activity, the same principles for offering and use of chaperones should apply. Where it is appropriate family members/friends may take on the role of informal chaperone only. In cases where a formal chaperone would be appropriate, i.e. intimate examinations, the healthcare professional would be advised to reschedule the examination to a more convenient location. However, in cases where this is not an option, for example due to the urgency of the situation or because the practitioner is community based, then procedures should be in place to ensure that communication and record keeping are treated as paramount.

Healthcare professionals should note that they are at an increased risk of their actions being misconstrued or misrepresented if they conduct intimate examinations where no other person is present.

A Patient's First Intimate Examination
The conduct of a first intimate examination or procedure may influence a patient's confidence for future examinations and procedures and will require particular sensitivity from the examining doctor, HCP, chaperone and anyone else involved. Therefore, it is important that the HCP discusses and provides as much detail of the procedure in advance of any examinations. It is imperative that the HCP listen's to and responds to any concerns and anxieties presented by the patient, in order to offer reassurance, degree of compassion and dignity through the use of supportive written or verbal information as indicated. Each individual will be unique and as such will require different levels of support and reassurance from the HCP.

Anaesthetised or Sedated Patients
Consent to intimate examinations must be sought before the patient is anaesthetised or sedated, except where this is implicit in the procedure to be undertaken. The appropriate departmental policy for completion of procedures and seeking consent must be followed. The above priniciples apply to patients who may feel particularly vulnerable during and after the intimate examinations that require sedation.

During the Examination / Procedure
Appropriate facilities should be made available for patients to undress in a private, undisturbed area in order to maintain their dignity and privacy. There should be no undue delay prior to examination once the patient has removed any clothing. Delays due to any unforeseen circumstances must be communicated to the patient and appropriate use of blankets etc to cover up.
Intimate examination should take place in a closed room or, in ward settings, in screened bays which must not be entered without consent while the examination is in progress. Examination should not be interrupted by phone calls or messages.

Where appropriate a choice of position for the examination should be offered for example left lateral, dorsal, recumbent and semi-recumbent positions for speculum and bimanual examinations. This may reduce the sense of vulnerability and powerlessness complained of by some patients.
Once the patient is dressed following an examination or investigation the findings must be communicated to the patient. If appropriate this can be used as an educational opportunity for the patient. The professional must consider (asking the patient as necessary) if it is appropriate for the chaperone to remain at this stage.

Any requests by the patient that the examination be discontinued during the examination should be respected. The reasons must be documented and implications of this sensitively explained to the patient. Any concerns raised by the patient regarding conduct or procedures used by the HCP must be escalated immediately to the appropriate line managers.

It is advisable that during an intimate examination, the HCP should:-

- Offer reassurance
- Keep discussion relevant
- Avoid unnecessary personal comments
- Encourage relevant question and discussion regarding the process
- Remain alert to verbal and non-verbal indications of distress from the patient
- Discontinue the process if there is any severe pain or distress evident from the patient
- Allow the patient time to respond to instructions given during the procedure
- Remain compassionate, courteous and mindful of the intimacy of the procedures the patient is undergoing

Communication and Record Keeping
Poor communication between a health professional and a patient is often the root of complaints and incidents. It is therefore essential that an explanation is given to the patient on the nature of any intimate examination i.e. what examination is proposed and the reasons why it is necessary. This will enable the patient to raise any concerns or objections and give informed consent to continue with the examination.

It is therefore essential that an explanation is given to the patient on the nature of any intimate examination i.e. what examination is proposed and the reasons why it is necessary. This will enable the patient to raise any concerns or objections and give informed consent to continue with the examination.
Details of the examination (including the presence or absence of a chaperone and their details which includes full name and contact number) must be documented in the patient's medical/nursing record.

The notes should also record if a chaperone has been offered, but declined by the patient.

2.9.6 Policy statement

The relationship between a patient and a Health Care Professional is based on trust. He/she may not have any doubts about a patient they have known for a long time and feel it may not be necessary to offer a formal chaperone.

Similarly there is evidence that many patients are not concerned whether a chaperone is present or not. However this should not detract from the fact that any patient of any gender is entitled to a chaperone if they feel one is required.

This policy is also for the protection of staff and patients and as such should always be followed. The key principles of communication and record keeping will ensure that the Health care practitioner/patient relationship is maintained and will act as a safeguard against formal complaints, or in extreme cases, legal action against the Surgery or the individual staff member.

2.10 Violent Patient Policy

The NHS has a zero tolerance policy of all violence and aggression. This policy is for the protection of all NHS staff, but also for the protection of other patients, their families, visitors, etc. In order to ensure that this zero tolerance approach is adhered to, it is essential to have robust policies and procedures in place. In General Practice, this will need to cover a variety of situations in which incidents could occur.

2.10.1 Aims and Objectives

The aims and objectives of this policy are as follows:

- To ensure adequate processes are in place for the protection of staff and patients
- To ensure staff are fully aware of their responsibilities when dealing with violent or aggressive patients
- To ensure that staff are fully aware of their rights when they have to deal with such incidents

2.10.2 Aggressive Patient

What is an aggressive patient? This is a patient (or relative) who exhibits one or more of the following patterns of behaviour:

- Verbally abusive, offensive or intimidating in their behaviour towards staff
- Threatening physical violence
- Making excessive demands and/or maintaining certain expectations and failing to accept that these are unreasonable (e.g. wanting an immediate appointment and becoming aggressive when this is not possible)
- insisting that a member of staff is dismissed
- insisting that treatment is carried out on demand
- constantly requesting a different GP
- demands to see a particular member of staff/clinician

2.10.3 Dealing with an Aggressive Patient

Patients can become aggressive for a variety of reasons, and it is always advisable to try to calm down the situation as early as possible, as this may prevent an incident.

2.10.4 An Aggressive Incident

If the patient does become aggressive, then the following process should be followed:

- If they continue with their aggressive behaviour, then tell them that they will not be dealt with until they calm down.
- Remain calm and clear and keep repeating that the behaviour is unacceptable. Insist that you are trying to help, but cannot do so until they calm down.
- In the interests of safety, it is best to stay accompanied by another member of staff. Staff should never isolate themselves with a potentially violent patient.
- Get a more senior member of staff to speak to the patient, again keeping calm and stressing that you are trying to help.
- Following the incident, the main points should be recorded on a significant events form
- All incidents of violent and aggressive behaviour should be reported to the Practice Manager

2.10.5 Repeated Incidents

If there are repeated incidents from a particular patient, then the practice should write to the patient warning them that no other incidents will be tolerated, and the patient will be removed from the list if this happens again. (See app 1 for sample letter)

Note that it is important to carry out this action once it has been written down. If the patient continues with this behaviour, even after the written warning, then they should be removed from the list for the sake of staff and other patients.

2.10.6 Violent Patients

Dealing with a violent patient requires a much more immediate response. As soon as a patient turns violent, then immediate action must be taken, as follows:

- Lock the reception door
- If the aggressive behaviour continues and a panic alarm is available, then press this immediately
- If the patient is in the consulting room with a clinician, then the correct procedure should implemented (see app 2)
- Phone the police. Once violence occurs, it becomes a crime.
- If there are other patients in the vicinity, then there is a duty to protect them. If possible remove other patients in the vicinity to another part of the waiting area or another room away from the situation.
- Following an incident of violence, the practice should hold a significant event meeting to decide if the patient should be removed from the list.
- If the patient is to be removed from the list, then the practice should now follow the procedure for the removal of patients.

2.10.7 Removal of Patient from Practice List

When it becomes necessary to remove the patient from the practice list, for reasons of violent or aggressive behaviour, then a specific process should be followed. (See info 4 Policy on removing Patients from the Practice List). Under schedule 6 of the NHS (GMS Contracts) Regulations (2004), the CCG would be required to remove a patient from the GP practice list if it is informed by the practice that the patient has committed an act of violence against anyone present on the practice premises, or at any place where the services were provided to the patient, or that the patient has behaved in such a way that any person has feared for his/her safety.
Please see appendix 4 for Removal pathway.

It is essential in all cases that the incident has been reported to the police, prior to the application to the CCG to remove the patient from the list. (See appendix 4 for an extract of the GP Contract)

2.10.8 Following an Incident

Every incident of violence or aggression should be recorded in a log specifically used for this purpose. This log should contain the following information:

- Patient ID (eg NHS number)
- Time and date of incident
- Nature of incident – particularly the trigger point (eg not able to get appointment)
- Perspective of staff member dealing with the incident,
- Names and statement of any witnesses
- Record of any actions taken

2.10.9 Staff Support

The member of staff who was subjected to the violence or aggression will need support, even though they may not recognise this fact immediately. The way this support is handled can often make the difference to the way the staff member is able to deal with what has happened, with minimal adverse effects.

The following process should take place as soon as possible after the incident:

- The Practice Manager should have a one-to-one discussion with the staff member, in private and as informally as possible (if the Practice Manager is the person affected, then a GP or Practice Nurse should do this)
- The staff member should be encouraged talk about the incident from their perspective, and encouraged to write it down (this is the best time to complete the incident log)
- Ask the staff member what support they feel they need to help them deal with the situation

- If the staff member feels they need counselling, then provide this as soon as possible, either within the practice if there is a trained counsellor, or by referral to the appropriate service
- If the person affected is not employed by the practice (e.g a Health Trainer) then inform their line manager immediately after the incident

2.10.10 When a Violent Patient Joins the Practice

Because of the length of time it takes for patient notes to come from LaSCA, it is possible that a new patient could join the practice, and only after several weeks would you discover that they have been violent in a previous practice.

In the event of this happening, it is advisable to write to the patient, to notify them that you are aware of the previous incident, and that if there is any instance of violence or aggression within your own practice, then the patient would be removed from the list. (see app 3)

Appendix 1

In Confidence

To:

Dear

On your visit to the surgery on ....., you were .....

We feel we must inform you that this behaviour is unacceptable.

It is our responsibility to point out to you that we have a zero tolerance policy across the NHS for patients who are abusive and/or violent to staff. At Dr Vajpeyi & Partners we take this policy very seriously, and would not hesitate to remove patients from the list who do not abide by this policy.

We are happy for you to remain with the practice, but insist that you abide by the above mentioned policy in all your dealings with the practice.

We hope you understand that should such poor behaviour occur again, we will have no alternative other than to exercise our right to remove you from our List

Yours sincerely,

Appendix 2

Dealing with a violent or aggressive patient if the patient is in the consulting room with a clinician requires a much more immediate response. As soon as a patient turns violent, then the correct procedure should implemented and immediate action must be taken, as follows:

- If possible the Clinician should proceed to the door of the consulting room as request assistance from reception staff.
- If unable to get to the door, press the panic button immediately
- A member of staff must immediately respond to the clinic room to provide assistance
- Another member of staff should call security to aid the removal of the patient from the premises
- Phone the police. Once violence occurs, it becomes a crime.
- If there are other patients in the vicinity, then there is a duty to protect them. If possible remove other patients in the vicinity to another part of the waiting area or another room away from the situation.
- Following an incident of violence, the practice should hold a significant event meeting to decide if the patient should be removed from the list.
- If the patient is to be removed from the list, then the practice should now follow the procedure for the removal of patients.
- Following the incident, the main points should be recorded on a significant events form
- All incidents of violent and aggressive behaviour should be reported to the Practice Manager
-

appendix 3

Date ……

In Confidence

To: ……

……..

Dear

Thank you for registering with

We are now in receipt of your full medical records.

We note, from these records, that you have a history of abusive and/or violent behaviour at your previous practice.

It is my responsibility to point out to you that we have a zero tolerance policy across the NHS for patients who are abusive and/or violent to staff. At Brigstock Family practice we take this policy very seriously, and would not hesitate to remove patients from the list who do not abide by this policy.

We are happy for you to remain with the practice, but insist that you abide by the above mentioned policy in all your dealings with the practice.

If you wish to discuss this matter further, then please do not hesitate to contact me.

Yours sincerely

Appendix 4

South West London

Patient Removal Process

Patient/Doctor relationship breakdown

Has a written warning been issued in the last 12 months?

NO

Issue written warning to patient

YE

Unless to do so would:

- be harmful to patient's health
- put practice staff at risk

Patient moved out of catchment area

Give 30 days' notice to make alternative arrangements

Violent/Threatening Patient

Report incident to police and get incident number

For any 8 day or immediate removal requests, please complete the form at the following webpage - https://pcse.england.nhs.uk/services/registrations/ and email to pcse.patientremovals@nhs.net or call 0300 311 22 33 to speak to the helpdesk who will log your call.

Removal takes place 8 days after request received

Record details in patient notes

Record details in patient notes

The PCSE will notify both patient and practice that the necessary paperwork has been completed and confirm that the patient is no longer on the list

2.11 Duty of Candour

Introduction:

Patients must be dealt with in an open and transparent way in relation to care and treatment provided. There are statutory obligations which promote an open and honest way when things go wrong and this applies to BFP as a whole organisation.

Any unexpected or unintended incident that causes moderate or severe harm, death or prolonged psychological harm for a minimum of 28 days is to be reported under the statutory duty.

The organisation must inform the patient in person and a written record provided. An apology must be given to the patient and a written record of all correspondence kept. Failure to comply with this statutory requirement could lead to criminal proceedings.

BFP promotes a culture that that encourages candour, openness and honesty at all levels and will take action to tackle bullying and harassment in relation to duty of candour.

Statutory duty of candour

Extract from the NHS Constitution for England 2009: "…when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively"

Extract from CQC Regulation 20 : Duty of Candour: "The aim of this regulation is to ensure that health service bodies are open and transparent with the "relevant person" (as defined in the regulation) when certain incidents occur in relation to the care and treatment provided to people who use services in the carrying on of a regulated activity."

The Duty of Candour has been introduced as a direct result of the Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust, which recommended that a statutory "duty of candour" be imposed on all healthcare providers, which defined "Openness", "Transparency" and "Candour";

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

The intention is that there is a culture of openness and truthfulness to improving the safety of patients, staff and visitors to the Practice, as well as raising the quality of healthcare systems. If patients or employees have suffered harm as a result of using their services, a Practice should be able to confidently investigate, assess and if necessary apologise for and explain what has happened.

It is also intended to improve the levels of care, responsibility and communication between healthcare organisations and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents.

Being Open

A culture of "being open" should be fundamental in a Practice's relationships with (and between) patients, the public, Practice Staff and other healthcare organisations.

The Duty of Candour is the contractual requirement to ensure that the Being Open process is followed when an incident that affects patient safety results in moderate or severe harm, or death.

What is a Patient Safety Incident?

The National Patient Safety Agency defines a Patient Safety Incident as: "Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care".

"Being open" and "Duty of Candour"

Practices must:

• Acknowledge, apologise and explain when things go wrong;
• Carry out investigations into incidents affecting Patient Safety;
• Provide support for those involved in the incident (patients and staff) to cope with the physical and emotional impact.
• Reassure patients, families and carers that lessons learned will prevent any patient safety incidents happening in future;

Definition of "Levels of Harm"

No harm
• Impact prevented – any incident that had the potential to cause harm but was prevented and resulted in no harm to staff or patients.

• Impact not prevented - any incident that has occurred, but resulted in no harm to people receiving care.

Low

An incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care.

Moderate
An incident that resulted in a moderate increase in treatment (e.g. increase in length of hospital stay by 4-15 days) and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe
An incident that appears to have resulted in permanent harm to one or more persons receiving care.

Death
An incident that directly resulted in the death of one or more persons receiving care.

A "Sincere Apology"

The Francis Report indicated the importance of affected parties receiving a sincere apology for the impact that any incident can have on the patient, their families, next of kin and their carers, especially in incidents that cause severe harm or the loss of life. A meaningful apology for the incident or the circumstances that have led to the incident is an important part of coping with the effect that it has caused, and means that the Practice has taken these events (major or minor) seriously.

However, the Duty of Candour also states that an apology does not constitute an admission of liability. Patients and relatives will request detailed explanations of what led to the incident(s) occurring (and their adverse outcomes), and an apology and acknowledgement of the impact it has on them helps to understand that there are lessons that the Practice can learn to ensure this does not happen again in the future.

To meet the requirements of CQC Regulation 20, a Practice must be:

• Open and transparent with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.

• Tell the relevant person (in person) as soon as reasonably practicable after becoming aware
that a safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.

• Provide an account of the incident which, to the best of the Practice's knowledge, is true of all the facts the Practice knows about the incident as at the date of the notification.

• Advise the relevant person what further enquiries the Practice believes are appropriate.

• Offer an apology.

• Follow up by providing the same information in writing, and any update on the investigations.

• Keep a written record of all communication with the relevant person.

CQC Key Lines of Enquiry relevant to Being Open and Duty of Candour

Key Question KLOE Prompt

Is it Safe? S2

Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?

Is it Well Led? W3

Does the culture encourage candour, openness and honesty?

CQC Inspections will report on “Duty of Candour” under the Key Question of Safety – if the care provided does not reflect the required characteristics of “Good” (as defined in the CQC Provider Handbook), then inspections are recommended to assess whether the service “Requires Improvement” or “Inadequate”, and whether there has been a breach of the regulation.

As this is an issue that affects patient safety, any information received from a member of the public or Practice staff relating to Duty of Candour will be investigated in line with the CQC’s Safeguarding and Whistleblowing protocols where relevant.

Recognising an Incident

The relevance of the Duty of Candour begins with an acknowledgement that as the result of a safety incident, a patient has suffered moderate or major harm, or has died. As soon as an incident has occurred or been identified;

• Clinical care must be administered to prevent further harm.

• If any additional treatment is necessary, it should happen as soon as reasonably practicable after discussing with the patient (or carer if the patient is unable to participate in discussion) and with the appropriate consent.

Moderate / severe incidents, or any incidents that result in the death of a patient, must be reported to the patient or next of kin (with the appropriate consent) within a maximum of 10 working days from the incident being reported.

The initial notification of the incident must be verbal (face to face where possible), unless the patient/carer/family cannot be contacted or decline notification.

An explanation and a sincere expression of apology must be provided verbally and recorded. At the time of the incident, an initial apology and explanation must be given.

The Patient/Carer must be offered a written notification of the incident along with a sincere apology.

A step by step explanation of the incident must be offered as soon as it is practicably possible, even if this is an initial view pending investigation of the incident.

The Practice must maintain full written documentation of any letters, discussions, meetings during this investigation, including the response from any of the patients/carers. If any meetings or interviews are offered and declined, then there must be a record of this.

Once the investigation has been completed and a final report has been made, the results should be shared with patient/relatives/carers within 10 working days.

2.12 Carers

Introduction

This document establishes the procedures that the Practice has in place for identifying Carers to ensure they are appropriately referred for a Carers Assessment to Adult Care Services.

Definition of a Carer

Carers are people who, without payment, provide help and support to a family member, friend or neighbour who cannot manage on their own due to physical or mental illness, disability, substance misuse or frailty brought on by old age.

Caring roles can include administering medication, lifting and handling, personal or emotional care. Carers should not be confused with paid care workers, care assistants or with volunteer care workers.

A “Young Carer” is defined as being below 18, who carries out significant caring tasks and by so doing, shoulders a level of responsibility for another person which is inappropriate for their age.

This situation often arises when parents who have long term conditions are not offered appropriate help and support, although it is a fact that most children of disabled or sick parents do not have to take on such responsible caring roles.

The person receiving care may, or may not be registered at the Carer’s Practice. When this situation arises, because the Practice will not be always be able to ascertain that the Carer / Patient relationship has ceased, the Carer may be asked to re-confirm their Carer status.

Where the person receiving care is a registered patient at the Carer’s Practice, the Carer / Patient relationship can be verified more frequently, resulting in practice-held information being able to be modified when significant events such as death or de-registration occur.

Estimate of numbers of carers

According to Croydon Carers Support Centre, 1 in 8 adults in Croydon is a carer. From our over 18 population (3042 as at 12.01.17) we would expect to have 340 carers on our list

The Practice will facilitate this process by actively identifying, supporting and referring known Carers who are patients of the Practice or where the person receiving care is a registered patient of the Practice.

The Practice will support Carers by:

- Ensure staff are aware of who carers might be and be proactive in
- identifying them

- Providing relevant information, resources and contact points

- Providing suitable appointment flexibility and understanding

- Providing care, health checks and advice to enable them to maximise their own health and needs.

Identifying Carers

Carers can be identified by self-identification and practice identification. The following activities will increase the number of carers identified:

SELF-IDENTIFICATION

Notice Boards
The Practice displays a poster on existing notice boards requesting Carers to contact the Practice to provide details of their caring responsibilities.

New Patient Registration Forms
The Practice's new patient registration form incorporates the following two questions:

- Do you look after someone?,
- Does someone look after you?

This information is used in the new patient screening appointment, tagging the patient's notes and arranging referral to Care Services.

Practice Website
The practice provides a copy of the practice protocol and contact details on the practice website.

PRACTICE IDENTIFICATION

Health Professional Identification

All Health Professionals in the surgery READ code when they ascertain a patient is a Carer.

This is regularly discussed at multi-disciplinary team meetings to exploit personal knowledge.

Upon identification of a Carer the Practice will take the following steps:

- Insert the 'Carer' Read Code of 918G as a Significant Active Problem so that it can be easily visible to the Clinician when accessing the Medical Record of the Carer.

- Add an Alert message to the Carer's Record to alert staff to these patients.

- Add the READ code 918F (Has a carer) and cross reference the carer's details in the text box

COMPETENCY

All Carer registrations will, in the first instance, be reviewed by the patient's usual doctor who will confirm that the patient is competent to give a valid informed consent.

PROCESS FOR SUBSEQUENT REFERRAL

The following read codes are used to tag Carers notes:

Carer	918A
Has a Carer	918F
No able Carer in household	ZV604
Carer unable to cope	ZV608
Referral for social services assessment	8HkB

Resources for carers:

http://www.croydoncarers.org.uk/

http://www.ageuk.org.uk/home-and-care/advice-for-carers

2.13 Medical Emergency Policy

2.13.1 Introduction

The Practice is committed to responding appropriately to medical emergencies in the patient's home or on the surgery premises providing basic life support and administering lifesaving medication.

2.13.2 Legal, ethical and good practice guidance for basic life support

The General Medical Council (GMC) expects doctors to comply with the standards of good practice set out in their guidance – Good Medical Practice1. This highlights the doctor's duty to offer assistance in an emergency taking account of their own safety, competency and availability of other options of care. This policy should be read in conjunction with the Consent Policy that details reduced requirements for consent in life saving or prevention of serious deterioration cases.

2.13.3 Key principles to consider in respect of resuscitation

The documents cited above are clear on the following principles:
The Practice duty doctors must be able to provide basic adult life support, use an automated external defibrillator (AED) and basic paediatric life support.

The practice will provide equipment and medicines in line with the Resuscitation Council guidelines and the medical emergencies in the community listed in the current British National Formulary (BNF672)

2.13.4 Staff to support medical emergencies and resuscitation

The practice will ensure that the practice will have access to a duty doctor and a trained first aider.

2.13.5 Duty doctor responsibilities

The practice expects that before each shift all duty doctors and team members:

- Have a current resuscitation certificate for adults (including AED use) and children that is renewed annually
- Are familiar with where the equipment for basic resuscitation is stored at that location
- Are familiar with the equipment available for basic resuscitation and medical emergencies that includes:
    - Guedel airways, various sizes
    - manual suction device
    - face masks for adults and children
    - pulse oximeter
    - ambu-bag
    - automatic external defibrillator

  - oxygen (NB oxygen should only be used if oxygen saturations are less than
  - 96%)
- Are familiar with medicines for community emergencies

2.13.6 First aider responsibilities

The practice expects designated and trained first aiders to do the following:

- In the event of a medical emergency when a doctor is present
  - raise the alarm and dial 999 as appropriate
  - support the patients relatives or carers
  - support the duty doctor during resuscitation or a medical emergency
- Perform basic life support in adults only (see appendix 1) if a doctor or nurse is not available
- Monitor the equipment each month and record appropriately

2.13.7 Health and safety responsibilities

The Responsible manager is responsible for ensuring the emergency equipment is fit for purpose by completing regular health and safety audits.

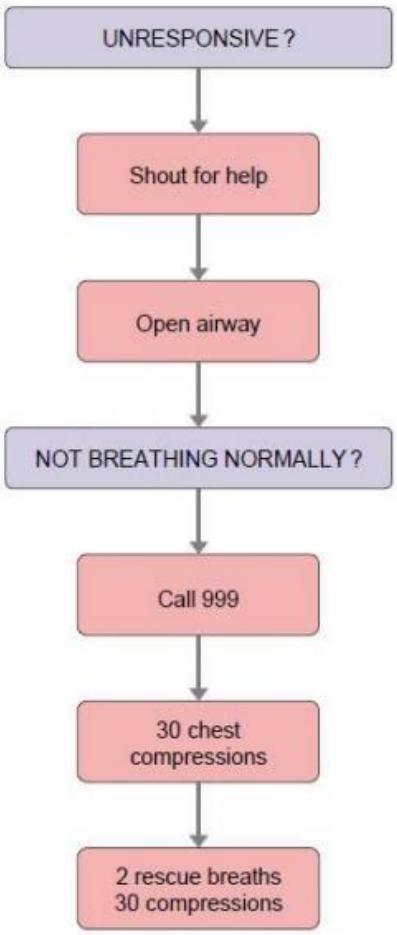
Appendix 1

Adult Basic Life Support
Resuscitation Guidelines 2010

2010 Resuscitation Guidelines

Resuscitation Council (UK)

Adult Basic Life Support



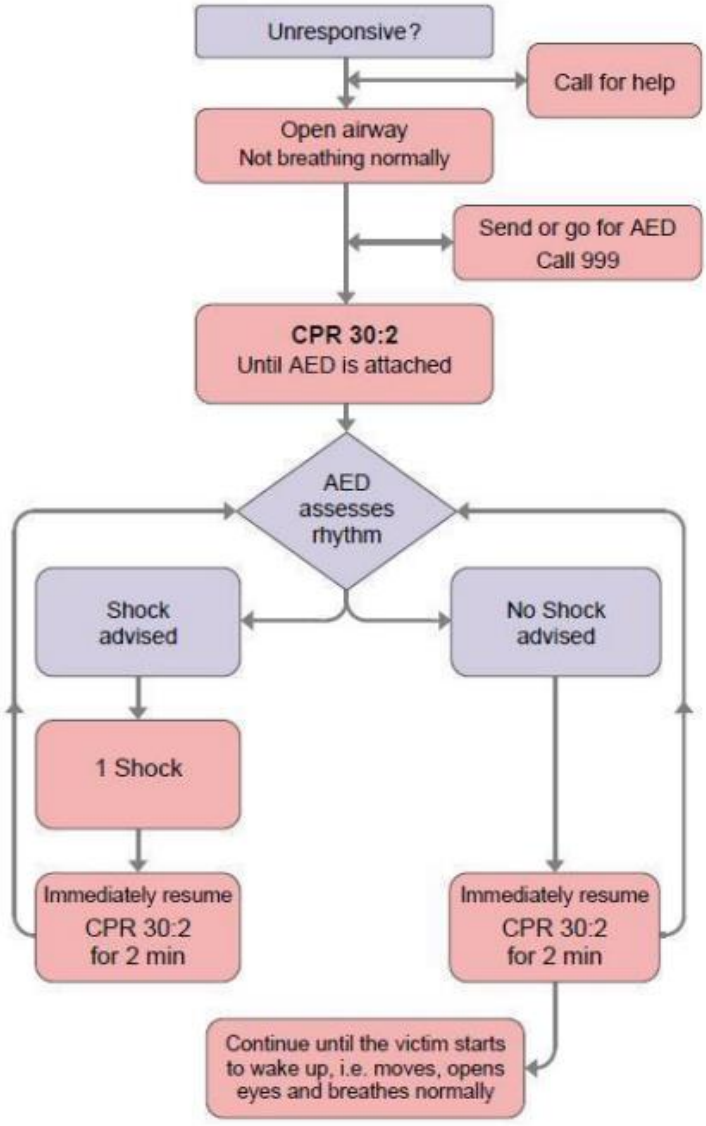
Appendix 2

Adult Basic Life Support
Resuscitation Guidelines 2010

2010 Resuscitation Guidelines

Resuscitation Council (UK)

AED Algorithm



2.14 MENTAL CAPACITY ACT POLICY (England & Wales)

2.14.1 INTRODUCTION

The **Mental Capacity Act** 2005 became fully effective in October 2007 in England & Wales and applies to those who make decisions or deal with persons who may lack mental capacity. Within primary care the provisions will apply to GPs, nurses and those to whom a referral may be made. In Scotland the Adults with Incapacity Act provides similar legislation for people over the age of 16. Similar legislation is expected in N. Ireland.

Capacity in this context is the ability to reach a decision and the lack of this capacity may be on either a temporary or a permanent basis, due to physical as well as mental causes.

The **Mental Capacity Act** (the Act) does not generally apply to young persons under the age of 16 – a parent or guardian can normally make decisions on their behalf – however under some circumstances a Court of Protection may make decisions on their behalf.

This policy is to be used in conjunction with Advance Directives [*] and Powers of Attorney [*].

2.14.2 CORE PRINCIPLES

1. A person is assumed to have capacity until it is proven otherwise.

2. A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help them do so, without success.

3. A person is not to be treated as unable to make a decision merely because they have made an unwise decision.

4. An act done for, or decision made on behalf of, a person who lacks capacity must be in that person's best interests.

5. Prior to an act or a decision under the act, due regard must be taken to whether the purpose for which the decision is needed can be effectively achieved in a way which is less restrictive of the individual’s rights or freedom of action.

2.14.3 BASIC RECORDING

In normal consultations there is the assumption of capacity unless there is evidence to suggest that this may be in doubt. This may arise from behaviour or concerns raised by others such as family members. Clinical staff will, in the

normal course of care, make decisions regarding capacity and the patient's ability to consent to the treatment proposed.

All practice clinicians will maintain a record within the clinical system of long-term or significant plans, decisions or considerations made in respect of a patient's capacity.

When making a record relating to capacity the record will include as a minimum:

- Why a particular decision has been made
- What information was used in arriving at the decision
- A record or copy of the information used
- What the decision was (or the outcome)
- What the process was in arriving at the decision - other staff involved, consultations, family involvement, referrals, etc.

The purpose of a full record and audit trail relating to both the individual decision and the full cycle of care may be required if the clinician needs in the future to justify the processes or the action taken.

2.14.4 ASSESSMENT OF CAPACITY

It is not within the scope of this policy document to provide full clinical guidance on the assessment of capacity. The following general considerations will be applied.

The Official Code of Practice (see Resources) provides for a 2 stage question test:

Q Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?

Q If so, is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

This test must be used and the records must record this and the response.

Consideration must be given to:

- Whether they are able to understand the information given to them
- Whether they are able to retain this information
- Whether they are able to assess this information whilst reaching a decision
- Whether they are able to communicate their decision using any effective means

Where the person is unable to do ***any one*** of the above they are unable to make the decision themselves.

In addition the practice will:

- Provide all necessary information, including the consequences of making or not making a decision
- Provide information on all available options
- Consult with family members
- Take into account ethnic cultural and personal preferences where known
- Select location carefully, with consideration for the patient, to ensure that the patient is at ease and comfortable in the surroundings.
- Pitch the consultation to the needs and level which suit the patient best
- Assess the patient at their best level of functioning.

The practice will also consider:

- Intellectual ability
- Memory
- Attention / concentration
- Reasoning
- Understanding
- Ability to communicate

The Code of Practice also provides a further 6 questions to aid in the assessment process:

1. Does the person have a general understanding of what decision they need to make and why they need to make it?
2. Do they understand the consequences of making or not making the decision, or of deciding one way or the other?
3. Are they able to understand the information relevant to the decision?
4. Can they weigh up the relative importance of the information?
5. Can they use and retain the information as part of the decision making process?
6. Can they communicate the decision?

See Appendix B for a checklist.

2.14.5 PRINCIPLES OF BEST INTEREST

"Best interest" is not defined. Avoid making assumptions of best interest based on age, appearance, behaviour etc. and consider their wishes and feelings. It is also important to take into account any written instructions which exist already (Advance Directives).

Take the views of family and carers and involve the person where possible. Assess whether the decision can be deferred if the person is likely to regain capacity.

Document your assessment processes and reasons. Consider taking the least restrictive alternative.

2.14.6 ADVANCE DIRECTIVES

These enable an adult with capacity to make provision for a time when they may loose capacity. An Advance Directive properly drawn up is as valid as a current decision. If an Advance Directive involves the refusal of life-sustaining treatment it must be made in writing and be signed and witnessed, however in other circumstances directives may be verbal and recorded / written down.
See also Advance Directives [*].

A Lasting Power of Attorney will overrule an Advance Directive if made after and gives an attorney the right to consent or refuse treatment. An Advance Directive decision will also be withdrawn if the person subsequently did something inconsistent with it.
See also Powers of Attorney [*].

2.14.7 INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA)

The IMCA is an independent service which provides safeguards for those people who lack capacity but have no-one else to make decisions for them or support them (other than paid persons).

An IMCA must be instructed and consulted, for people lacking capacity who have no-one else to support them whenever:

- an NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home and

- the person will stay in hospital longer than 28 days, or
- they will stay in the care home for more than eight weeks.

An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved

See Appendix A

The IMCA service is available in England and Wales.

In England the service is delivered through local authorities, who work in partnership with NHS organisations. In Wales the National Assembly for Wales delivers the service through local health boards.

Local authorities or NHS organisations are responsible for instructing an IMCA to represent a person who lacks capacity. In these circumstances they are called the 'responsible body'.

For decisions about serious medical treatment, the responsible body will be the NHS organisation providing the person's healthcare or treatment. Examples of serious treatment (amongst others) may be:

- chemotherapy and surgery for cancer
- electro-convulsive therapy
- therapeutic sterilisation
- major surgery (such as open-heart surgery or brain/neuro-surgery)
- major amputations (for example, loss of an arm or leg)
- treatments which will result in permanent loss of hearing or sight
- withholding or stopping artificial nutrition and hydration and
- termination of pregnancy.

For decisions about admission to accommodation in hospital for 28 days or more, the responsible body will be the NHS body that manages the hospital.

Staff in the NHS, for example doctors or consultants (the "decision makers") all have a duty, under the Mental Capacity Act, to instruct an IMCA where the eligibility criteria are met. This duty started, in England, on 1st April 2007 and in Wales on 1st October 2007.

The "decision-maker" is the person who is proposing to take an action in relation to the care or treatment of an adult who lacks capacity, or who is contemplating making a decision on behalf of that person. Who the decision maker is will depend on the person's circumstances and the type of decision. For example, the decision-maker may be a care manager or a hospital consultant. Staff working in statutory organisations, in the local authority or NHS, who are involved in making best interests decisions should know when a person has a right to IMCA and when they have a duty to instruct an IMCA. This duty may fall on GPs from time to time.

Practices are recommended to research the local method of referral to IMCA through the Patient Advice and Liaison Service (PALS) operating within their PCT area.

2.14.8 RESOURCES

DoH Primary Care Training Pack

Mental Capacity Act 2005 Code of Practice

IMCA England

Making decisions: the IMC service: Department of Health - Publications and statistics

Powers of Attorney [*]
Advance Directives [*]

2.15 Increasing awareness of Sepsis Policy

2.15.1 Introduction

This policy outlines how FPG will increase the awareness of Sepsis amongst staff in order to reduce the number of avoidable deaths in adults and children from this treatable condition. UK mortality rate for patients admitted with sepsis is 30% - approximately 5 times higher than for ST elevation myocardial infarction and stroke - and is responsible for approximately 44,000 deaths and 150,000 hospital admissions in the United Kingdom (UK) per year.

It is expected that the practice may deal with approximately 1-2 cases of sepsis per year directly.

Sepsis is a time-critical condition. In the most severe cases, septic shock, for every hour that appropriate antibiotic administration is delayed, there is an 8% increase in mortality.

Reliable delivery of excellent sepsis care depends on early recognition and timely treatment , together with excellent communication during handover with health professionals.

Sepsis is currently poorly recognized and treated within the NHS. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report 'Just say Sepsis' attempted for the first time to
describe the quality of care delivered in General Practice and found room for improvement in almost 39% of cases. Expert reviewers found that 80% of infections giving rise to sepsis originated in the community.

BFP will ensure that:

1. All non clinical staff will receive training in how to spot the deteriorating patient annually
2. All clinical staff will receive training on how to access Sick patient Assessments and NEWS2 scoring on EMIS
3. All clinical staff with be required to complete e-lfh or other appropriate training in sepsis
4. Emergency equipment will be adequate for the prehospital admission of patients with presumed sepsis.

2.15.2 What is Sepsis

Sepsis is characterized by a dysregulated host response to infection mediated by the immune system and resulting in organ dysfunction, potentially multi-organ failure, shock and death.

Septic shock is defined as a subset of sepsis where particularly profound circulatory, cellular and metabolic abnormalities substantially increase mortality.
No recognition pathway is a substitute for clinical acumen and clinicians should think 'could this be sepsis?' if a person presents with signs or symptoms that indicate possible infection.

At risk groups for Sepsis

In patients who have one or more of the risk factors below, the clinician should give particular consideration as to whether face-to-face assessment (as opposed to telephone consultation) in the context of a potential infection is appropriate.

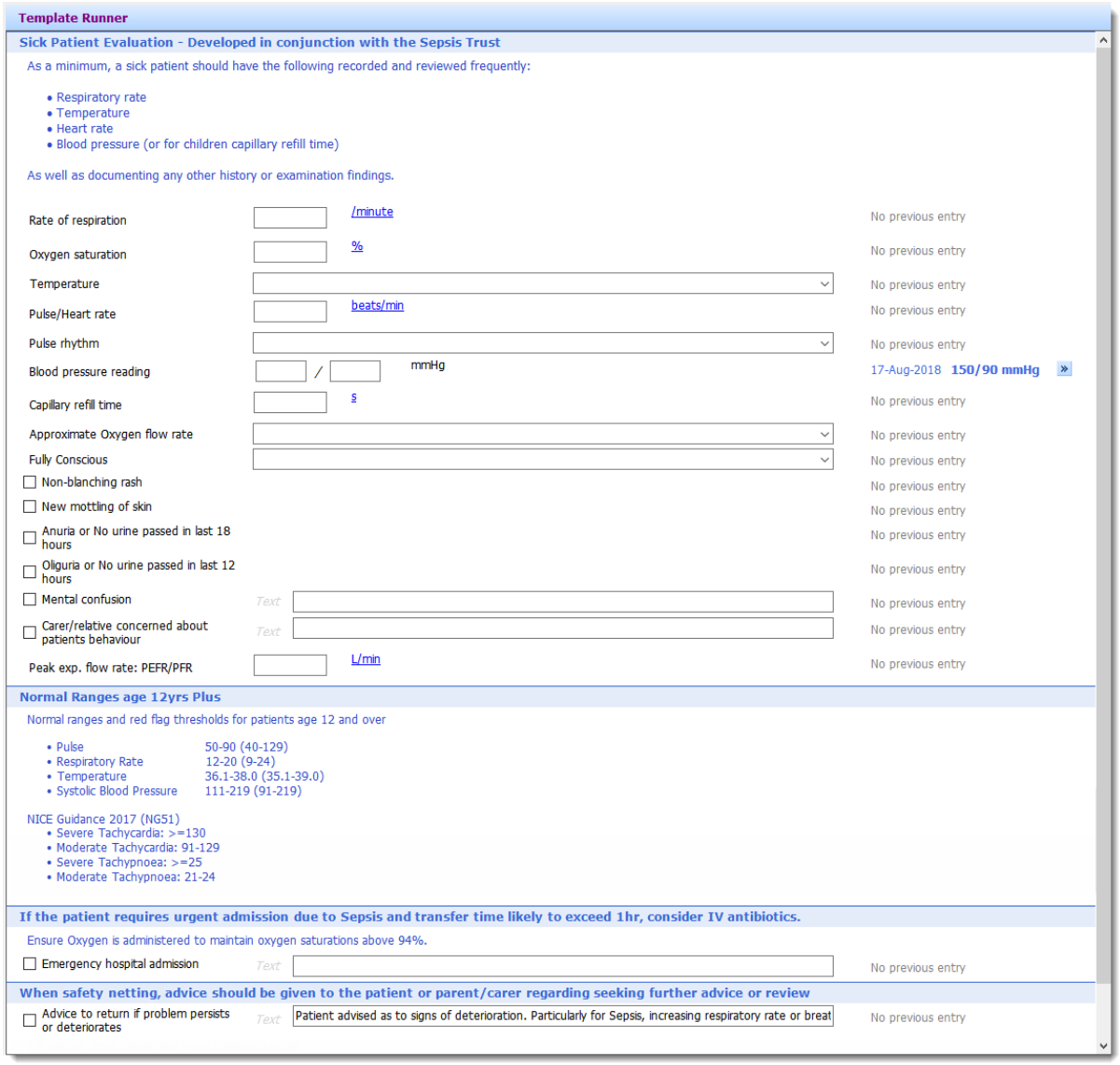
Pregnant or who have recently been pregnant
Immunocompromised patients**
Children under 1

The elderly, defined by NICE as age over 75 years or patients over 65 years with complex illness or frailty
Recent trauma, invasive procedure or surgery (within the last six weeks)
Patients with indwelling devices or known breach of skin integrity
Intravenous drug abusers

2.15.3 The use of EMIS support to support recognition of Sepsis

A patient presenting with severe sepsis may not always display obvious signs of critical illness so EMIS have added new protocols and templates to the EMIS Web Library to alert clinicians to the possibility of sepsis, and help assess if there is a need for urgent admission to hospital.

The EMIS sick patient assessment template alert pops up if e.g. a GP prescribes antibiotics for a patient and prompts clinicians to add more information to the records in order to ensure a comprehensive assessment of the patient has been completed.



When you have recorded your observations using the data capture template, select Save Template on the ribbon to save the information and close the template. Once saved, there are three possible levels of outcome alerting that are generated by the Sepsis alert protocol:

1. Clear case of sepsis – Medical Emergency. The Red Flag Sepsis alert and outcome protocol will also run if an Emergency Hospital Admission has not been recorded in the template.
2. Possible case of sepsis – action/safety netting needed.
3. Amber flag sepsis – needs further assessment/follow up.
4. If the observations are all within normal limits, no alerts are generated.

2.15.4 Communication with Ambulance Service and secondary care:

i) Communication in cases of Red Flag Sepsis

For patients identified with Red Flag Sepsis, immediate arrangement should be made for urgent transfer for hospital assessment. This should be by 'blue light' ambulance, with a Paramedic crew if immediately available. The call should include direct reference to the term 'Red Flag Sepsis'.

It is reasonable to check that a Red 2 dispatch code has been applied.

A brief, clear handover should accompany the patient to include observations, any relevant medical history and antibiotic history including allergies. Where possible, a telephone referral to the receiving clinical team should be made, using the term 'Red Flag Sepsis'

ii) Communication in cases of Amber Flag Sepsis

Where there are one or more Amber Flags in the absence of any Red Flag, clinical judgment will determine appropriate action.

Patients with as yet 'minor' sepsis can deteriorate rapidly. Patients with Amber Flags who have one or more risk factors described should receive particularly careful consideration as to whether hospital assessment is required, as should patients who live alone with poor access to communication and transport.

Where clinical assessment is unable to identify a suspected source of infection, hospital assessment should also be carefully considered.

The urgency of hospital transfer is not as clear-cut as with Red Flag Sepsis, and clinical judgment will inform disposition. The call to the Ambulance Service should include direct reference to the acuity of the condition, using the terms 'Amber Flag Sepsis'.

The key immediate interventions that increase survival are described in a bundle termed the Sepsis Six (Box 1). This bundle has been shown to be associated with significant mortality reductions when applied within the first hour.

Box 1: The Sepsis Six (Source: http://sepsistrust.org)
1. Administer oxygen to maintain saturations >94%
2. Take blood cultures and consider infective source
3. Administer intravenous antibiotics
4. Consider intravenous fluid resuscitation
5. Check serial lactates
6. Commence hourly urine output measurement

While few General Practitioners will have the resources to provide the entirety of this bundle of care, it is included to illustrate the time-critical nature of Red Flag Sepsis and the need for collaborative care pathways.

Where resources permit, General Practitioners should initiate oxygen therapy to maintain target saturations of 94% or higher. Patients with sepsis are exempt from British Thoracic Society guidelines for the administration of oxygen to acutely ill adults as the pathophysiology of sepsis is such that organs become critically hypoxic. Hypoxia will kill before hypercapnia.

Therefore where patients are known to have moderate to severe pulmonary disease (and where available), we still recommend that oxygen be administered but to maintain a lower target oxygen saturations above 88%.

Antimicrobials – n/a at BFP as transit time << 1 hour
Blood cultures – n/a at BFP as antibiotics would not be administered

2.16 Clinical Supervision Policy

2.16.1 Introduction

The core principle of clinical work is that the treatment depends on the nature and quality of interaction between patient and clinician. Supervision of such work is therefore integral to all clinical work undertaken by the Practice. The Practice uses supervision to ensure standards of care for patients are met and to support the development of the skills of our staff.

2.16.2 Purpose

The purpose of this procedure is to maintain standards for clinical and professional practice within the Practice.

2.16.3 Scope

This procedure applies to the clinical supervision of all clinical staff, whether in training or qualified, and whether in role of clinical supervisor or supervisee. The relationship between the clinical supervisor and supervisee will vary depending on whether the supervisee is undertaking post qualification training or peer supervision.

Other areas of activity including management, teaching and research may also require and benefit from supervision. Although many of the principles outlined in this document will apply equally well, they are not covered by this procedure.

The principles within this procedure are to be followed in all clinical supervisory situations.

2.16.4 Definitions

Clinical supervision is a formal collaborative process intended to help maintain ethical and professional standards of practice and to enhance creativity and competence. Clinical supervisors must be recognised as qualified to supervise either through a formal qualification or through having sufficient experience as is recognised by custom and practice within their own profession.

It is essential that supervisees and supervisors are able to work together constructively and that clinical supervision can include elements of safe challenge for all participants.

The frequency of supervision will vary according to the volume of clinical work, training requirements and the experience of supervisees and the work setting.

Clinical supervision is a mutually agreed arrangement for trainees and/or qualified staff to discuss their work regularly with someone who is an experienced and competent clinician and with the process of supervision.

Clinical supervision provides supervisees with the opportunity on a regular basis to discuss, reflect on, and monitor their work with patients. It should take account of the setting in which supervisees practice. Supervision is intended to ensure that the needs of the patients are being addressed, that clinical risks are appropriately assessed and managed and to monitor the effectiveness of the therapeutic intervention and the impact of the work on the supervisee.

Supervision may contain elements of training, personal development or line management, but clinical supervision is not primarily intended for these purposes and appropriate management of these issues should be observed.

Process Notes summarise the reflections of the clinician in exploring their response to their experience with a patient. They are not rough notes on a clinical session for later processing into formal clinical notes. They must never contain any information which could identify a patient.

2.16.5 Duties and responsibilities

Responsibilities of the lead GP

The lead GP has a responsibility for ensuring that members of staff within the practice are supported to fulfil the professional responsibilities of that discipline regarding supervision for the purposes of sustaining the safety and quality of clinical work and in order to retain eligibility for registration with the appropriate organisations.

The lead GP is responsible for ensuring that all clinical staff are appraised annually and the results are recorded in the practice HR files.

Responsibility for clinical trainees

For those clinical trainees who undertake clinical practice in the Practice, the Head of Discipline will be responsible for arranging and confirming that each trainee has a suitably competent service supervisor and that supervisory arrangements are maintained throughout the training period. “Service” refers to the service or team in which the trainee is based, and this can change during the course of longer, major professional trainings within the Practice.

Clinical staff and trainee responsibilities

Are responsible for ensuring that they maintain contact with their supervisor and follow advice received.

2.16.6 Addressing Difference and Diversity in Clinical Supervision

Equality and respect for all patients practice underpins the basic values of clinical work and supervision.

Supervisors have a responsibility to be aware of their own issues of prejudice and stereotyping, and particularly to consider ways in which this may be

affecting the supervision relationship. Discussion of this is part of the supervision process.

Supervisors need to be alert to any prejudices and assumptions that clinicians reveal in their work with patients and to raise awareness of these so that the needs of patients may be met with more sensitivity. One purpose of clinical supervision is to enable supervisees to recognise and value difference. Supervisors have a responsibility to challenge the appropriateness of the work of a supervisee whose own belief system interferes with the acceptance of patients.

Attitudes, assumptions and prejudices can be identified by the language used, and by paying attention to the selectivity of material brought to supervision.

2.16.7 Modes of Supervision

Equality and respect for all patients practice underpins the basic values of clinic work and supervision

The Practice recognises a range of different modes of supervision, and it is for the supervisor of each situation to determine the most effective mode to be adopted in each clinical situation. It may be that a range of modes are most effective in some areas of practice. It needs to be negotiated between those with responsibility for the management of the supervision what form is most appropriate

One-to-One, Supervisor-Supervisee

This involves a supervisor providing clinical supervision on an individual basis for an individual clinician who is usually less experienced than the supervisor.

Group Clinical Supervision

The supervisor acts as the leader, takes responsibility for organising the time equally among all the supervisees, and attention is usually concentrated on the work of each individual in turn.

One-to-One Peer Clinical Supervision

This involves two participants providing clinical supervision for each other by alternating the roles of supervisor and supervisee. Typically, the time available for clinical supervision is divided equally between them. This model would typically be suitable for qualified senior clinicians.

Peer Group Clinical Supervision

This takes place when three or more clinicians share responsibility for providing each other’s clinical supervision within the group. Typically, they will

consider themselves to be broadly of equal status, training and/or experience. This mode on its own is unsuitable for inexperienced clinicians.

Live Supervision in Teams

This takes place via video link and one way screen in teams of 2 or more clinical trainees with specially trained supervisors. The supervisor holds accountability for the work undertaken with families and is responsible for the different levels of interaction between therapist/family and team/therapist/family.

2.16.8 Clinical Trainees: Fostering Professional Development through supervision

Clinical trainees undertaking clinical work as part of their training with in the Practice's clinical services will be provided with a form and frequency of supervision that ensures safe and effective practice. The type and level of supervision offered will vary according to the specific demands of the training.

Supervision of Clinical Work

Supervision of direct clinical work with patients is a central element of clinical training undertaken in the Practice. It may be undertaken by the trainees' tutor, or, it may be delegated to other staff, in different disciplines to that of the trainee depending on the kind of therapy being undertaken in the case in question, and the particular interests and skills of the supervisor. Interdisciplinary contacts of this and other kinds are an essential feature of the Practice's multi-disciplinary training. Different clinical models such as psychoanalytical or systemic psychotherapy deliver supervision through methods appropriate to their model, for example:

- Supervision of psychoanalytical work is usually indirect. Selected sessions are written up in detail as process notes and reported to the supervisor later. This can be in a group or individually, weekly or less often.
- Direct supervision via a video link or through a one way screen is often done in teams, with two or more colleagues (some trainees and some staff) viewing, while one or two therapists work in the room with a family group.

Record keeping

Both the supervisor and supervisee are responsible for ensuring that the patient's clinical records are up to date in line with the Health Care Records Procedure, and that patient data is handled in accordance with the respective information governance procedures.

Process notes are an aid to the clinical supervision process. They summarise the reflections of the therapist in exploring their response to their experience

with a patient. They are not rough notes on a clinical session for later processing into formal clinical notes. They must never contain any information which could identify a patient. Process notes must be destroyed after a supervision session, or exceptionally after a case is closed, except for trainees where notes can be kept until the completion of the programme. If process notes are to be used for any purpose relating to treatment (eg audit or research) then the patient must give permission before the notes are made and would be treated as for clinical notes for the purposes of the Data Protection Act.

Both the supervisor and supervisee should also ensure that any relevant discussion within the supervision regarding the clinical care of the patient should also be recorded in the patient's clinical records. Supervisors should keep records of all supervisory discussions which should be shared and agreed by the supervisee.

2.16.9 Clinical Supervision of Qualified Staff

The Practice aims to ensure that staff are appropriately qualified and trained for their clinical and other responsibilities. This is achieved in a number of ways.

- All clinical staff regularly participate in team meetings, case discussion groups and other forums where case work is discussed and this is fundamental to the ongoing arrangements for peer support and supervision in the Practice's work.

- Trainers need to be trained, and this requirement will be confirmed at and before appointment to a supervisory role. For some disciplines, e.g. medicine, clinical and educational supervisors must be formally trained, accredited and registered by their regulatory body (in this case the General Medical Council).Continuing professional development (CPD) is a professional requirement for all disciplines. Staff are required to update their learning and skills at conferences, workshops, in research and in private study. The Practice supports this process. This will include supervisors participating in CPD that is directly relevant to their supervisory role.

- Senior clinical staff in the Practice are expected to take responsibility for the clinical progress of a certain number of patients, regardless of who provides supervision for these cases. The responsibilities of this 'consultant' role include knowing when to ask other senior colleagues for advice and help.

2.17 CLINICAL GOVERNANCE POLICY

2.17.1 INTRODUCTION

This policy sets out the Practice's approach to clinical governance.

The implementation of the practise of clinical governance is designed to improve the service to patients and ensure their safety and well-being. It applies to all members of the clinical team, supported by administration staff, reception staff and attached staff.

We recognise that clinical governance is a critical activity for both us as an organisation and our clinicians to support their ongoing development and validation.

We want to be a sustainable practice that thrives on innovation and we want to extend that reputation as a centre of excellence for training to all professional groups. Clinical governance is an important component of continuous learning and development, as well as a vital check and balance for quality.

2.17.2 POLICY – CLINICAL GOVERNANCE TOOLS

Patient involvement

We will seek patient participation and provide patients with the mechanism to feedback and make suggestions. These will include patient surveys, complaints and compliments and our patient participation groups. We will discuss feedback received from patients and publicise both suggestions and the practice response. Where individuals are identified, they will receive a personal response. We will view the practice from the patient perspective, (in particular from formal patient survey results) and actively seek to implement feasible and beneficial ideas.

Clinical Audit

We will undertake regular clinical audits, record the results and plan improvements to patient benefit. We will also undertake audit of administrative procedures to ensure that they are working effectively.

Shared clinics / case discussion

For some members of the team, in particular those who are in training or in roles that we are developing such as the paramedic practitioner or pharmacist, we will operate regular shared clinics. This provides opportunity for feedback and further development and sharing of clinical knowledge and consultation skills. We will also hold regular supervision sessions to review selected patients and consultation outcomes.

Evidence-based medical treatment

We will maintain an up to date knowledge of current developments and research and assess these against established and proven methods of working. We will share expertise and opinion within the practice and between clinicians to promote learning and discussion. This will happen through a range of informal and formal opportunities.

Information and its use

We will make full use of information both electronic and paper-based in clinical and nonclinical decision making. We will share best practices with others both inside and outside the practice. We will seek to improve data quality and encourage patients to participate in their own clinical treatment, their records, and decisions which affect them.

Risk control

We will operate a free system of Significant Event Reporting to encourage review, feedback and learning from incidents in an open and no-blame culture. All significant events will be discussed and documented within the forum of a clinical review/policy meeting.

2.17.3 POLICY – CREATING A LEARNING ENVIRONMENT

Staff and staff management
We will encourage team working across the practice, establish a “no-blame” learning culture, see Blame Free Culture policy, and provide an open and equal working relationship with colleagues.

Continuing Professional Development (CPD)

We will ensure CPD via full participation in appraisal, revalidation, attendance at training events, and the organisation of regular in-house clinical seminars from specialist consultants. All development activity will be documented as part of individual learning portfolios. Non-clinical staff will be encouraged to attend events related to their own specialism or professional development needs, and it is not intended that this will be cash-limited.

Strategic capacity
We will operate a 3 year strategic plan based on projected patient needs and gear activity towards creating resources to achieve both immediate and longer term patient clinical needs.

2.17.4 IMPLEMENTATION

See Appendix 136 for detail of the practice Clinical Governance lead. This person will be responsible for;

- Promotion of quality care within the practice.
- Provide clinical governance leadership and advice.
- Keeping up to date with research and governance recommendations, and communicating these accordingly.

- To act as an expert resource and advisor in the examination and review of significant events.
- To initiate and review clinical audits.
- To oversee the management of the key policy provisions above.

2.18 QUALITY ASSURANCE & MANAGEMENT POLICY

2.18.1 Statement

Brigstock Family Practice aims to provide care of a consistent quality for all patients; we strive to meet the high standards expected in any clinical setting. We expect all members of our practice team to work to these standards to help us achieve our aim of providing a quality service. Our management systems define each practice member's responsibilities when looking after you.

The policies, systems and processes in place in our practice reflect our professional and legal responsibilities and follow recognised standards of good practice.

2.18.2 Policy

Our aim is to achieve the best outcomes for our patients by providing good care and transparent management of our practice. We use the most appropriate policies and systems and employ appropriately trained and competent team members. We evaluate our practice and staff on a regular basis through audit, peer review, performance development and patient feedback to help us monitor the effectiveness of our quality assurance procedures.

We work with NHS organisations, such as BSol (Clinical Commissioning Group) as well as external organisations such as the British Medical Association (BMA, the trade union and professional association for doctors and medical students in the UK), the Nursing Medical Council (NMC, the regulator for nursing and midwifery professions in the UK) and other regulatory bodies, as well as local medical councils and external suppliers.

Brigstock Family Practice has effective procedures for assuring and enhancing the quality of the services we provide for our patients, and we aim to;

- Provide a safe and welcoming practice
- Ensure all members of the practice team are appropriately trained
- Provide information for patients about the practice and the care available
- Ensure patients understand the terms on which care is offered
- Explain all treatment options and agree clinical decisions with the patient, explaining the possible risks involved with each option
- Provide treatment plans based on the agreed treatment
- Obtain valid consent for all treatment, written or verbal
- Refer to specialists for investigation or treatment as appropriate and without undue delay
- Maintain contemporaneous clinical records with an up-to-date medical history for all patients
- Provide secure storage of patient records to maintain patient confidentiality
- Explain the procedure to follow for raising a complaint or concern

Our practice teams are the specialists that work to deliver a quality service for patients, and we support them and their development by;

- Providing a working environment that is safe and without hazards or risks
- Providing appropriate induction training for all new members of staff
- Providing job descriptions and contracts of employment to all staff, which are reviewed and updated to accurately reflect the current duties and responsibilities
- Provide ongoing training and identify opportunities for development for all employees
- Keeping and updating staff records to ensure the following information is up to date:
    - criminal records checks are accurate and up to date
    - emergency contact details
    - relevant medical history information
    - in-house and external training
    - absence through holiday and sickness
    - performance reviews
- Having agreements in place for any 3rd party/external contractors working at the practice which include confidentiality and safety
- Ensure that all staff are kept up to date with all practice policies and procedures.

2.18.3 Practice Regulators

The Practice is regulated by the Care Quality Commission, who monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. They publish results of their regulatory inspections, giving performance ratings to help people understand the standards of care provided by healthcare providers in England.

NHS England is the body that commissions GP practices to provide a service under contract to the NHS, and they monitor and manage GP contracts and commission other primary care services.

NHS England and Clinical Commissioning Groups (CCGs) are now responsible for commissioning the vast majority of NHS services, with local authorities taking on new public health commissioning responsibilities. All GP Practices have to be members of a CCG, who have a legal and we are a member of BSol

2.18.4 Practice Teams – Clinical and non-clinical staff

Our practice staff will adhere to practice policies and procedures. We expect everyone working at the practice to do the following;

- Understand our aims and objectives

- Have an understanding of the skills and competencies required to deliver the services
- successfully
- Understand and participate in our quality assurance activities.
- Dealing with emergencies, including a collapsed patient.
-

All clinical staff are registered with their relevant body and their registration must be kept up to date. They must meet their continuing professional development requirements and maintain records of their individual CPD activity. In addition, the practice maintains records of all training provided by the practice as well as any training provided for individual members.

2.18.5 Policies and Procedures

The Practice has policies and procedures in place to protect and support the staff and patients – these are reviewed on an annual basis to ensure their accuracy and relevance. These policies include;

- Registration & Information for Patients
- Quality of Treatment and Care
- Management of Patient Conditions
- Patient Views
- Policies and Procedures
- Role and Responsibilities of the Registered Manager
- Human Resources
- Locums & Practising Privileges
- Policy & Procedures Management of Sharps Injuries and post exposure to blood and other body fluids
- Complaints and Staff Concerns
- Premises, Facilities and Equipment
- Risk Management
- Health and Safety Measures
- Infection Control
- Resuscitation
- Records Management
- Information Management
- Research
- Safeguarding Children and Adults Policy
- Medicines Policy
- Quarterly Immunisations
- Repeat prescribing
- Good prescribing policy

This list is not exhaustive, but representative of the subject matter covered by the policies in place at the practice.

The practice manager manages, collates, analyses and evaluates all information:
a) About the quality and safety of the care, treatment, support and regulatory compliance achieved by the Practice;
b) Provided by external guidance and reviews issued by national organisations;
c) About the risk(s) to people's health, welfare and safety.

She then reviews this with the Practice Partners, who agree relevant changes which are subsequently implemented.

2.18.6 Practice Audit processes

Brigstock Family Practice carries out regular checks and audits of our procedures to monitor the quality of our service to patients. We manage, collate, analyse and evaluate all information:

a) About the quality and safety of the care, treatment, support and regulatory compliance achieved by the Practice;
b) Provided by external guidance and reviews issued by national organisations;
c) About the risk(s) to people's health, welfare and safety.

Clinical audit is a way that doctors, nurses and other healthcare professionals can measure the quality of the care they provide. They can compare their performance to see how they are doing and identify opportunities for improvement. Changes can then be made and monitored by further audits to see if these changes have been successful. On a regular basis we will monitor and collect data on;

- Number of patients seen
- Number of patients treated
- Number of patients who did not attend appointments (DNA)
- Patient wait times and patient demand
- Patient Satisfaction levels
- Referrals to other healthcare professionals
- Safety incidents (patient or staff) and outcome of investigations
- Prescriptions issued and drug management
- Clinical and non-clinical activities

2.18.7 Clinical Governance

The Practice follows clinical governance to ensure we deliver a consistent standard of care to our patients. Clinical governance is a systematic approach to managing risk, as well as maintaining and improving the quality of patient care. It pulls together the different strands of quality improvement which includes clinical audit, clinical leadership, evidence-based practice and the dissemination of good practice, ideas and innovation and addressing poor clinical performance. In relation to clinical governance, our teams will;

- Understand their individual and Practice responsibilities
- Understand their role in delivering a safe service

- Review and monitor our policies and procedures on a regular basis to stay up to date
- Take part in our internal audit processes
- Take responsibility for their actions, and raise any issues
- Take responsibility for their training and development, and actively carry out their Continuous Professional Development responsibilities

The Practice will also regularly audit and monitor their performance and ability to deliver on the following;

- Infection Control measures
- Child/vulnerable patients protection
- Prevention and public health
- Clinical Records, patient privacy and confidentiality
- Clinical staff training requirements and development
- Clinical Audit and Peer Review

2.18.8 Patient Feedback

We care about how patients feel about the service we provide, and encourage them to let us know how we are doing by providing feedback, as well as listening and acting upon views and opinions discussed with members of our Practice Team.
We have a patient comments and complaints procedure and aim to respond promptly – we discuss positive feedback and we want to learn from any shortcomings in the service we provide.