Mandatory Training Workbook
Introduction

This workbook has been designed to offer a flexible way in which to access and meet the necessary levels of mandatory training required by Blackpool Teaching Hospitals NHS Foundation Trust.

This workbook gives managers and staff an opportunity to ensure that the key principles, along with individual responsibilities of are fully understood. The sections contained within the book are up to date, relevant and important and serve to safeguard the health, safety and wellbeing of our patients, staff and visitors, to ensure we deliver a first class service.

This workbook currently applies to all temporary & permanent staff. It is not a requirement for locums, who are subject to separate arrangements.

Each member of staff will need to complete the relevant sections, this is dependant on their individual staff group and role. Please refer to the contents page or the Trusts Mandatory Training Matrix within Corp/Pol/045 for guidance.

The Aim of the Workbook

This workbook is to provide you with up-to-date information on Risk Management, Health and Safety issues and other current topics relevant to your role, which the Trust deems Mandatory.

Objectives

1. To raise your awareness of the key elements of Mandatory Training

2. To enable you to apply this awareness to your job role and workplace

3. By completing the workbook and questions, you will be able to use the knowledge gained to prevent incidents and accidents and improve the safety of the environment for patients, staff and visitors

4. To enable you to provide evidence in preparation for your appraisal and, where appropriate, for your Knowledge and Skills Framework (KSF) Portfolio.
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UNIT 14 & 15 ARE NOT REQUIRED BY COMMUNITY HEALTH SERVICES EMPLOYEES
PLEASE COMPLETE UNITS APPLICABLE TO YOUR STAFF GROUP
LEARNING OBJECTIVES
When you have completed this unit you should:

1) know what the term Information Governance means
2) understand the importance of providing a confidential and secure healthcare service
3) be able to handle information safely and securely
4) know how to comply with data protection and freedom of information legislation
5) have accessed, and completed, the appropriate annual mandatory Information Governance e learning module

WHAT IS INFORMATION GOVERNANCE?
Information Governance is a term which describes the way we ‘process’ or handle information. It covers personal information (that is, relating to patients/service users and employees) and also corporate information (for example, financial and accounting records).

INTRODUCTION
All staff, both clinical and non clinical, must complete and pass a prescribed Information Governance training module every year. The training module, which includes a short multiple-choice assessment test, is accessible through a national on-line e-learning tool. The topics covered include:

• Confidentiality
• Data Protection
• Freedom of Information Act (2000)
• Good record keeping
• Information security

The instructions for accessing the learning tool can be found on the Trust intranet IG pages at: http://blackpoolhr3.multi2.sitekit.net/learning_and_development/elearning-page.htm

CONFIDENTIALITY
Patients expect that information about them will be treated as confidential and this is set out as one of the core principles of the NHS. All staff working for Blackpool Teaching Hospitals NHS Foundation Trust have a duty to protect and maintain the confidentiality of patients and other personal information.

You must read the Trust’s Confidentiality Code of Conduct policy and guidelines which are available on the Document Library pages of the intranet.

Make sure that you completely understand your responsibilities. If you do not understand you must speak to your line manager. You are asked to ‘sign up’ to the Confidentiality Code of Conduct at induction and again, each year, through the appraisal process.

The duty of confidentiality is written into employment contracts. Any breach of confidentiality of information gained, whether directly or indirectly, in the course of work is a disciplinary offence that could result in dismissal.
INFORMATION SECURITY

Please note that SMART CARDS are issued to you for access to the systems you have permission to use. They must not be shared with your colleagues. Remember to remove your SMART card from the PC when you have finished.

Choose a secure PASSWORD that is memorable only to you - and keep it private. It is a breach of Trust policy to share your password with colleagues. Your password is for you and you alone. DO NOT write your password down anywhere.

USB STICKS (or memory sticks) may only be used if you need one as part of your role. Please make sure that you are using at ‘Trust’ issued encrypted USB stick. If you need to obtain one, the application form can be found on the Trust intranet. The form must be authorised by your line manager. For further information contact the Information Governance Helpdesk.

Take care when using SOCIAL NETWORKING sites. The importance of this cannot be over-emphasized.

The Nursing and Midwifery Council (NMC) has issued advice on the use of social networking sites which is relevant to all professionals at:
www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Social-networking-sites/

The BMA have also issued practical and ethical guidance on using social networking:

Take special care with all MOBILE DEVICES. Make sure all mobile devices, including laptops and Blackberry’s, are locked away securely when not in use. Do not leave devices in your car overnight.

You must not use iPhones or Blackberry’s to take clinical photographs. The Department of Medical Photography and Illustration is the first point of contact for any imaging needed throughout the Trust. Please refer to the Trust procedure: Photography and Video Recordings of Patients: Confidentiality and Consent, Storage and Copyright (CORP/PROC/002) for further information.

INFORMATION GOVERNANCE/INFORMATION SECURITY INCIDENTS

Any breach or near miss must be reported. Tell your line manager as soon as possible what has gone wrong. You will need to make a report using the on-line untoward incident reporting system. Look out for the Information Governance newsletters which contain important updates including lessons learned.

INFORMATION GOVERNANCE ADVICE AND SUPPORT

Your Information Governance team can provide advice and support on:

- Corporate or health records management
- Data protection and confidentiality
- Information security
- Freedom of Information
- Data access enquires

It is especially important to seek Information Governance advice at the outset of any new project or when you plan changes to systems.

You can contact the Information Governance Helpdesk (01253) 30 3959/3057 or email information.governance@bfwhospitals.nhs.uk
Never share sensitive information on Social Networks

It’s amazing what details can be picked up from what seem like harmless tweets!

Possible Passwords
Gollum or Tina Tequila

Possible Security Questions & Answers
Pets name: Gollum/Tina
Best Friend: Rob
Works for: NHS
Occupation: Nurse

Address
From Google Earth link previously tweeted

Breach
Discussing Patients
Unauthorised access to records

Other useful Information provided
Date of birth: 25th March 1964
Maiden name: Minted
Divorced: Lives alone
Works for NHS-can find out sensitive medical information

Useful Information for Boss
Provided real reason for late start
Thinks he is stupid

For further information on BMA Guidance, please go to this link:
Social Networks

7 things you should never do

It’s amazing what details can be picked up from what seem like harmless tweets!

Never make friends with people you are unsure of

Never reveal any of your personal information

Never be rude or complain about your employer, colleagues, patients or suppliers

Never discuss sensitive information

Never discuss work related issues

Never upload compromising photos

Never advertise the fact that your house is empty
Unit 2
Clinical Governance & Risk Management Awareness
including investigation of accidents, complaints & claims

INTRODUCTION

The Trust aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff and assets. A primary concern is the provision of safer, risk-free environments together with working policies and practices, which take into account assessed risks.

Key areas of Risk Management in which staff must be involved are:

• To identify hazards and risks by regularly assessing all aspects of service delivery, patients and the care environment
• To report and investigate incidents (including non-clinical and clinical incidents; accidents; health and safety incidents; security incidents and any other untoward event)

Worldwide surveys identify errors in at least 10% of hospital episodes which lead to harm. UK studies identified that between 1/3 and ½ of these errors could have been avoided.

The NHS Litigation Authority (NHSLA), under-write many of the Trust’s clinical risks. They require the Trust to achieve a high standard of risk management in order to provide and demonstrate that we are a safe organisation.

Risk management is the responsibility of everyone in the organisation. The experience from other sectors, such as the aviation industry, shows clearly that as reporting levels rise the number of serious incidents begins to decline. Completion of all the elements in this workbook will assist all staff to effectively address many of the everyday risk situations they will encounter.

RISK ASSESSMENT

The Trust is required under the Management of Health and Safety at Work Regulations 1999 to undertake “suitable and sufficient risk assessments to identify significant risks to the health, safety and welfare of employees and anyone that may be Affected by their activities.”

Risk assessments should be easily accessible and all staff should be aware of their contents in relation to the job they do.

Risk assessments need to be kept up to date and relevant and should be reviewed either:

• When there has been a significant change, e.g. introduction of new machinery or processes
• There has been a major accident or near miss
• It has been 12 months since the last review

There are 5 steps to risk assessment:

1. Identify the hazards
   This should be done with some input from the persons undertaking the task

2. Decide who can be harmed and how
   Again consultation should be made with staff to ensure that everyone at risk has been identified
3. Identify what controls are already in place and what further controls are required to make the task safer. There should be some input from the persons undertaking the task as they understand what works and what doesn't work.

4. All significant findings need to be written down using the Trust’s Risk Assessment Form.

5. Review your risk assessment and update if necessary.

The Trust has a Corporate Procedure Carrying Out A Risk Assessment And Developing A Risk Register And Board Assurance Framework CORP/PROC/006 that should be read alongside this workbook.

INCIDENT REPORTING:

The Trust is committed to the establishment of a supportive, open and learning culture that encourages staff to report incidents and near misses through the appropriate channels. The aim is not to apportion blame but rather to learn from incidents and near misses and improve practice accordingly. All staff within the Trust have a responsibility to ensure that they report any incident or near misses they have been involved in or witnessed.

Why Do We Report Incidents?

• To check system failures.
• To establish the facts of each incident.
• To improve patient care and services.
• To establish controls to prevent recurrence.
• To identify underlying trends and their causes.
• It is a legal requirement.
• To develop mode is of good practice.

How and What Do We Report?

An untoward incident can be:

• an event that results in or had the potential to result in any level of injury or ill health
• an event that results in an unexpected outcome
• an event that interrupts normal procedure
• an event that damages the Trusts’ reputation.

Some examples of the most commonly reported incidents are:

• Medication Errors
• Hospital Acquired Infections
• Delayed, Missed or Wrong Diagnosis
• Skin Tissue Damage/Pressure Ulcers
• Patient Accidents, such as Slips, Trips, Falls
• Incorrect Use or Failure of Medical Devices
• Staff Health & Safety Incidents
• Information Security Incidents

Each Directorate has specific triggers and these will be found within the Divisional Risk Management Strategy. Whereby the untoward incident involved faulty drug products or medical devices/equipment, these should be withdrawn from used and retained for investigation.
When Do We Report?

All untoward incidents should be reported via the Electronic Incident Reporting System (Found on the Trust Intranet Home Page) within 24 hours of the incident occurrence. Serious incidents whereby severe/major harm has been caused must also be reported immediately to the relevant Assistant Director of Nursing/Divisional Director and the Risk Management Department.

Further Guidance can be found in the Trust’s Corporate Procedure - Untoward Incident and Serious Incident Reporting http://bfwnet/departments/policies_procedures/documents/Procedure/Corp_Proc_101.pdf which should be read alongside this workbook.

This procedure should be read in conjunction with the Trust’s Risk Management Strategy and the Divisional Risk Management Strategy.

NATIONAL PATIENT SAFETY AGENCY

The NPSA has published a guide for staff and Trusts for improving patient safety called ‘Seven Steps to Patient Safety’:

Step 1: Build a Safety Culture – create a culture that is open and fair
Step 2: Lead and Support your Staff – establish a clear and strong focus on patient safety throughout your organisation
Step 3: Integrate your Risk Management Activity – develop systems and processes to manage your risks and identify and assess things that could go wrong
Step 4: Promote Reporting – ensure your staff can easily report incidents locally and nationally
Step 5: Involve and Communicate with Patients and the Public – develop ways to communicate openly with and listen to patients
Step 6: Learn and Share Safety Lessons – encourage staff to use root cause analysis to learn how and why incidents happen
Step 7: Implement Solutions to Prevent Harm – embed lessons through changes to practice, processes or systems.

Patient safety is not just for doctors, nurses and other clinical staff. Patient safety is affected by systems and processes as well as specific clinical care, for example

- An incorrectly typed or addressed referral letter may mean a delay in diagnosis or treatment
- A poorly handled telephone call may result in a patient not seeking help when they need it
- A box, trolley or piece of equipment left unattended in an inappropriate place could result in someone falling over it

THE WAY FORWARD

The Trust aims to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff and assets. A primary concern is the provision of safer, risk-free environments together with working policies and practices, which take into account assessed risks. The Trust aims to offer the best in NHS Care.
When things are identified as not safe and pose a risk to our patients, they need to be raised in an open and honest way.

**Barriers to Reporting**

It is crucially important that staff report all incidents near misses. However, it is recognised that people can be reluctant to report events for several reasons:

- Fear of reprisals; lack of trust
- Additional burden of work - too busy
- Fear of exposure of weakness; lack of competence; suspension; litigation
- Loss of reputation; income or job
- Lack of action to stop things happening again.

**The Trust Policy is to promote a fair blame culture and that only under specific circumstances would disciplinary action be considered following a reported event.**

**WE NEED YOUR HELP TO MAKE PATIENT SAFETY HAPPEN**

**CLAIMS INVESTIGATIONS**

A claim is defined as an allegation of clinical negligence and/or demand for compensation made following an adverse clinical incident or adverse incident resulting in personal injury or any clinical incident which carries a significant risk of litigation for the Trust. Claims are handled in accordance with the Civil Procedure Rules, which are the court rules by which civil litigation (including negligence and personal injury claims) are governed.

A claimant has to prove both breach of duty and causation before they are eligible to receive compensation. Compensation is split into two categories – general damages and special damages. A Letter of Claim is a summary of the facts on which a claim is based, including the allegation of negligence (breach of duty), the alleged adverse outcome (causation), injuries, condition and prognosis and financial losses incurred. A Letter of Response is a reasoned answer to the Letter of Claim either admitting or denying all or part of the claim.

Court Proceedings include a Claim Form, Particulars of Claim (setting out allegations of breach of duty and causation), medical evidence in support of the claim and a Schedule of Loss. The Defence is the response to the Particulars of Claim.

**Electronic Records**

- The patient’s name, NHS number, date of birth (and Hospital Number in the Acute Health Record) must be recorded on every page in the health record.
- Every entry in the health record is to be made in real time (dated and timed using 24 hour clock) and in chronological order to reflect the continuum of patient care.
- All free text entries must be legible.
- Entries must be clear, relevant and unambiguous when inputting in the free text fields. An incorrect entry must be “Greyed Out” (highlighted with a grey block to signify an error) or by an equivalent method.
- Attention/Alerts, Allergies, Advance Directives etc must be recorded in the fields provided.
  - Advance Directives
  - Adverse Reactions
  - Anti-Thrombotic Treatment
  - Blood Group Warnings
  - Disability and Communication Awareness
• Drug Allergies
• Drug Trials
• Infection Risk
• Research
• Separate Health Records
• Significant Events

Author:
• Electronically created documentation i.e. ALERT and Euroking facilitate the capture of the author’s information as an electronic signature. A valid electronic signature can only be created as a result of the author of the record logging in with a valid user identification i.e. user name and password.

Abbreviations:
• All entries must be written in full. Abbreviations must not be used unless they have first been written in full on the first entry in the content of the document when inputting in the free text fields.

Process For Ensuring A Contemporaneous Complete Record Of Care is Completed
• The Healthcare Professional must ensure a chronological record of care is recorded within the patient’s health record.
• Information must be recorded as soon as possible after the episode of care or event and no later than the end of the shift.
• Records must be an accurate record of what took place. The time and date that the entry is being made must be clearly documented. The time and date that the event occurred must be clearly documented in the content of the entry, so that there is no doubt exactly when the event being documented occurred.

Please refer to Procedure link - http://fcsharepoint/trustdocuments/Documents/corp-proc-567.doc
Unit 2 assessment: Clinical Governance & Risk Management Awareness

1. Who is responsible for the Trust’s risk management?
   (a) Everyone
   (b) Clinical Governance
   (c) The Board

2. Why do we report incidents?
   (a) To check system failures
   (b) To identify underlying trends and their causes
   (c) To develop models of good practice
   (d) All of the above

3. What are the barriers to reporting incidents?
   (a) Lack of trust
   (d) Fear of reprisals
   (c) Being too busy
   (d) All of the above

4. What are the 5 steps to a risk assessment?
   (a) Survey staff, identify the hazards, decide who can be harmed and how, identify controls, and complete the Trust’s Risk Assessment Form.
   (b) Identify the hazards, decide who can be harmed and how, identify controls, complete the Trust’s Risk Assessment Form, review your assessment and update if necessary.
   (c) Identify the hazards, decide who can be harmed and how, identify controls, complete the Trust’s Risk Assessment Form, inform staff.

5. Under what rules are claims handled?
   (a) Criminal Procedure Rules
   (b) Civil Procedure Rules
   (c) Both

6. What compensation is available?
   (a) General damages
   (b) Special damages
   (c) Both

7. Does a claimant have to prove both ‘breach of duty’ and ‘causation’ to make a claim?
   (a) Yes (b) No

8. What do court proceeds include?
   (a) Claim Form, Particulars of Claim, and medical evidence
   (b) Claim Form, Particulars of Claim, and a Schedule of Loss
   (c) Claim Form, Particulars of Claim, medical evidence and a Schedule of Loss

9. Should a Letter of Response admit or deny a claim?
   (a) Yes
   (b) No - never!
   (c) It depends on the circumstances
Unit 2: Clinical Governance & Risk Management Awareness Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

Forename: (Block Capitals)

Job Title: ..............................................................

Department/Ward: ..............................................................

Division/Directorate: ..............................................................

Date Completed: (This must be within 12 weeks of receipt) ..............................................................

Staff Signature: ..............................................................

Manager: (Printname) ..............................................................

Manager: (Signature) ..............................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: ..............................................................
FOR FIRE SAFETY TRAINING FACE TO FACE LECTURES ARE REQUIRED ON ALTERNATE YEARS

The Legislation
The Regulatory Reform (Fire Safety) Order 2005 (FSO) came into effect in October 2006. The law applies to all staff and contractors. Under the FSO, the responsible person must carry out a fire safety risk assessment and implement and maintain a fire management plan. The fire management plan will include:
- Means of detection and giving warning in case of fire;
- The provision of means of escape;
- Means of fighting fire; and
- The training of staff in fire safety.

Other issues falling within the scope of the FSO include the storage of flammable materials, the control of flammable vapours, standards of housekeeping, safe systems of work, the control of sources of ignition and the provision of appropriate training. The FSO is enforced by the Lancashire Fire and Rescue Service. To carry out a fire risk assessment of the workplace we must consider all employees and all other people who may be affected by a fire in the workplace and we are required to make adequate provision for any disabled people with special needs who use or may be present at the premises.

We must also:
- Identify the significant findings of the risk assessment and the details of anyone who might be especially at risk in case of fire (these must be recorded);
- Provide and maintain such fire precautions as are necessary to safeguard those who the workplace; and
- Provide information, instruction and training to all employees about the fire precautions in the workplace. The law also requires employees to co-operate with safety measures and to ensure the workplace is safe from fire and its effects, and not to do anything which will place themselves or other people at risk.

In Health Care Premises the main causes of fire are:
- Smoking
- Electrical
- Cooking Appliance
- Arson

Identify the hazards
For a fire to start, three things are needed: A source of heat / ignition; Fuel; and Oxygen. If any one of these is missing, a fire cannot start. Taking steps to avoid the three coming together will therefore reduce the chances of a fire occurring.

FUEL
Flammable gases Flammable solids / Furniture

OXYGEN IGNITION SOURCE
Always present in the air.
Once a fire starts it can grow very quickly and spread from one source of fuel to another. As it grows, the amount of heat it gives off will increase and this can cause other fuels to self-ignite. The following identifies potential ignition sources, the materials that might fuel a fire and the oxygen supplies which will help it to burn.

IDENTIFYING SOURCES OF IGNITION
We can identify the potential ignition sources in the workplace by looking for possible sources of heat which could get hot enough to ignite the material in the workplace. These sources of heat could include:

- Smokers materials
- Naked flames
- Cooking
- Electrical sparks / Faulty electrical appliances

Indications of ‘near misses’, such as scorch marks on furniture or fittings, discoloured or charred electrical plugs and sockets, cigarette burns etc, can help you identify hazards which you may not otherwise notice.

IDENTIFYING SOURCES OF FUEL
Anything that burns is fuel for a fire. So you need to look for the things that will burn reasonably easily and are in sufficient quantity to provide fuel for a fire or cause it to spread to another fuel source. Some of the most common ‘fuels’ found in our workplace are:

- paper and card;
- plastics, rubber and foam such as polystyrene, e.g. the foam used in upholstered furniture and mattresses
- flammable gases such as liquefied petroleum gas (LPG) and acetylene;
- textiles;
- loose packaging material

IDENTIFYING SOURCES OF OXYGEN
The main source of oxygen for a fire is in the air around us. In an enclosed building this is provided by the ventilation system in use. This generally falls into one of two categories: natural airflow through doors, windows and other openings; or mechanical air conditioning systems and air handling systems. In many buildings there will be a combination of systems, which will be capable of introducing/extracting air to and from the building.

Additional sources of oxygen can sometimes be found in materials used or stored in a workplace such as:

- Some chemicals (oxidising materials), which can provide a fire with additional oxygen and so assist it to burn. These chemicals should be identified on their container by the manufacturer or supplier who can advise as to their safe use and storage; or
- Oxygen supplies from cylinder storage and piped systems, eg oxygen used for health care purposes

REDUCING SOURCES OF IGNITION
We can reduce the hazards caused by potential sources of heat by:

- ensuring that heat-producing equipment is used in accordance with the manufacturer’s instructions and is properly maintained;
- ensuring that sources of heat do not arise from faulty or overloaded electrical equipment, and reporting defective equipment
- keeping ducts and flues clean;
- prohibiting smoking
- ensuring that all equipment that could provide a source of ignition, even when not in use, is left in a safe condition;
- taking precautions to avoid the risk of arson.
MINIMISING THE POTENTIAL FUEL FOR A FIRE
There are various ways we can reduce the risks caused by materials and substances which burn. These include:
• removing flammable materials and substances, or reducing them to the minimum required for the operation of the business;
• ensuring flammable materials, liquids (and vapours) and gases are handled, transported, stored and used properly;

Safe storage of small quantities of highly flammable substances in fire-resisting cabinets

• replacing damaged upholstery where the foam filling is exposed;
• ensuring that flammable waste materials and rubbish are not allowed to build up and are carefully stored until properly disposed of;
• taking action to avoid storage areas being vulnerable to arson or vandalism;
• ensuring good housekeeping, especially on all corridors

REDUCING SOURCES OF OXYGEN
We can reduce the potential source of oxygen supply to a fire by:
• closing all doors, windows and other openings not required for ventilation
• not storing oxidising materials near or with any heat source or flammable materials; and
• controlling the use and storage of oxygen cylinders, ensuring that they are not leaking, are not used to ‘sweeten’ the atmosphere.

REDUCING THE RISK OF ARSON
Deliberately started fires pose very significant risks to all types of workplace. A study conducted by the Home Office has suggested that the cost of arson to society as a whole has now reached over £1.3 billion a year. The same study suggests that, in an average week, arson results in:
3500 deliberately started fires; 50 injuries; two deaths; at a cost of at least £25 million.
The possibility of arson should be considered and it is one that you can do much to control. The majority of deliberately started fires occur in areas with a known history of vandalism or fire-setting. Typically, local youths light the fires outside the premises as an act of vandalism, using flammable materials found nearby. Appropriate security measures, including the protection of stored materials and the efficient and prompt removal of rubbish, can therefore do much to alleviate this particular problem.
Occasionally, arson attacks in the workplace are committed by employees or ex-employees. We must be aware of this potential threat, and take precautions to reduce it: Controlling the way we store waste combustibles is essential in minimising the risk, reducing the opportunity reduces the risk.

**FIRE DETECTION AND FIRE WARNING**

A fire alarm and detection system with manually operated call points and automatic fire detection is installed in the premises; essentially this will act as an early warning system, and should give adequate time for all occupants including patients to evacuate from the area affected.

It is essential that you know where the manual call points are in your work area

**TYPICAL MANUAL CALL POINT**

The red manual call point should be activated whenever you discover a fire or smoke. The fire alarm sounder will activate immediately the call point is activated or immediately the detectors recognise smoke, fire or heat.

In the activated area the alarm sounder will be a continuous tone.

**MEANS OF ESCAPE**

Once a fire has been detected and a warning given, everyone in the work area must be able to evacuate to a safe area without being placed at risk. This is why it is essential to keep all evacuation routes clear. In buildings, most deaths from fire are due to the inhalation of smoke. Also, where smoke is present, people are often unwilling to travel more than a few metres through it to make their escape. It is therefore important to make sure that, in the event of a fire in one area, people in other areas of the building can use escape routes to get out safely without being exposed to the smoke or gases from the fire.

**COMPROMISED ESCAPE ROUTE**

In our premises, where travel distances are often quite lengthy and where it is possible for a single route to be affected, an alternative means of escape will always be available.
ARRANGEMENTS FOR EVACUATING THE WORKPLACE

We have considered how to evacuate the workplace. Never use a lift to evacuate the premises.

**Non Patient Areas**
Upon hearing the fire alarm all employees will evacuate from the building, regardless of the tone, to an area of ultimate safety, this will be an assembly point within the hospital grounds. All visitors must be escorted from the area to the assembly point. This is known as a 'simultaneous' evacuation. Staff should remain at their assembly point until stand down has been given by the Fire and Rescue Service or Fire Marshall.

**Clinical Areas**
Be aware that patients may not be able to make their own escape, and may need assistance.

**Continuous Ringing Bell**
This indicates that the fire alarm has been sounded in the immediate zone. Staff should prepare patients and should evacuate to the assembly point.

**Staff Assembly Point**
All staff reporting to an Assembly Point should remain there until given instructions by the fire Marshall or Lancashire Fire and rescue Service.

**Operating Theatres (for those acute based)**
Where an operating list is in progress, one nurse (in Theatre uniform), should attend the Assembly Point and liaise between the Senior Nurse attending the fire alert and the Theatre staff remaining on duty. This nurse will not be expected to assist with any evacuation from within an adjacent zone.

**Fire alarm testing**
This takes place weekly.
Means of fighting fire
There is sufficient fire-fighting equipment in place for employees to use, to extinguish a fire in its early stages. The equipment is suitable to the risks and appropriate staff will be trained in its proper use.

<table>
<thead>
<tr>
<th>Extinguisher</th>
<th>Type of Fire</th>
<th>Special Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colour</td>
<td>Solids (wood, paper, cloth, etc)</td>
<td>Tolerant of liquid fires</td>
</tr>
<tr>
<td>Water</td>
<td>Yes</td>
<td>Dangerous if used on liquid fires.</td>
</tr>
<tr>
<td>Foam</td>
<td>Yes</td>
<td>Not practical for home use.</td>
</tr>
<tr>
<td>Dry Powder</td>
<td>Yes</td>
<td>Safe use up to 1000V.</td>
</tr>
<tr>
<td>Carbon Dioxide (CO₂)</td>
<td>No</td>
<td>Safe on high and low voltages.</td>
</tr>
</tbody>
</table>

Extinguishers can only be used to extinguisher certain types of fires

Good housekeeping reduces the possibility of a fire occurring. Carelessness and neglect not only make the outbreak of a fire more likely but will inevitably create conditions which may allow a fire to spread more rapidly.

**NEVER STORE MATERIALS ON A FIRE ESCAPE ROUTE. IT IS A CRIMINAL OFFENCE AND COULD INCUR A TWO YEAR PRISON SENTENCE AND AN UNLIMITED FINE**
MAINTENANCE OF PLANT AND EQUIPMENT

Plant and equipment which is not properly maintained can cause fires. The following circumstances often contribute to fires:

Poor housekeeping, such as allowing ventilation points on machinery to become clogged with dust or other materials - causing overheating;

Flammable materials used in contact with hot surfaces;

Static sparks (perhaps due to inadequate electrical earthing).

You should visually inspect all electrical items before you use them for signs of wear and tear, any which are damaged, should be removed from service immediately.

Toasters are a major cause of unwanted fire alarm activations, this is usually because the browning setting is too high, the crumb tray requires emptying, the user has left the toaster in toasting mode whilst attending to another task. Toasters must always be monitored, when in use, set to a low browning setting and cleaned regularly.

DAMAGED ELECTRICAL CABLE
STORAGE AND USE OF FLAMMABLE MATERIALS
Wherever possible:
Quantities of flammable materials should be reduced to the smallest amount necessary for running the business and kept away from escape routes;
Remaining stocks of flammable materials should be properly stored in a fire-resisting construction;
Stocks of office stationery and supplies and flammable cleaners' materials should be kept in separate cupboards or stores with a lockable or self-closing fire door.

FLAMMABLE LIQUIDS
Flammable liquids can present a significant risk of fire. Vapours evolved are usually heavier than air and can travel long distances, so are more likely to reach a source of ignition. Liquid leaks and evolution of vapours can be caused by faulty storage (bulk and containers), plant and process - design, installation, maintenance or use.
Ignition of the vapours from flammable liquids remains a possibility.

The quantity of flammable liquids in workrooms should be kept to a minimum, normally no more than a half-day's or half a shift's supply.

Rags and cloths which have been used to mop up or apply flammable liquids should be disposed of in metal containers with well fitting lids and removed from the workplace at the end of each shift or working day.

There should be no potential ignition sources in areas where flammable liquids are used or stored and flammable concentrations of vapour may be present at any time.

ITEMS PROHIBITED ON AN ESCAPE ROUTE
The following items should not be located in protected routes, or in a corridor and stairwell which serves as the sole means of escape from the workplace, or part of it: Portable heaters of any type; Upholstered furniture; Coat racks; Temporarily stored items including items in transit, e.g. furniture, beds, laundry, waste bins etc;
Vending machines; and Electrical equipment (other than normal lighting, emergency escape lighting, fire alarm systems, or equipment associated with a security system), e.g. photocopiers.
**ESCAPE DOORS**
Doors people have to pass through in order to escape from the workplace should open in the direction of travel where:
- More than 60 people may have to use the door;
- The door is at or near the foot of a stairway;
You should make sure that people escaping can open any door on an escape route easily and immediately, without the use of a key. All outward opening doors used for means of escape, which have to be kept fastened while people are in the building, should be fitted with a single form of release device such as a panic latch, a panic bolt, or a push pad.

**FIRE DOORS**
Where fire doors are provided they should be fitted with effective self-closing devices and labelled ‘Fire Door - Keep Shut’. Fire doors to cupboards and service ducts need not be self-closing, provided they are kept locked and labelled ‘Fire Door - Keep Locked Shut’.
Self-closing fire doors may be held open by automatic door release mechanisms which are either:
- Connected into a manually operated electrical fire alarm system or Actuated by independent smoke detectors Where such mechanisms are provided, it should be possible to release them manually. The doors should be automatically closed by: The actuation of a smoke-sensitive device on either side of the door;
- Never wedge open a fire door - it is a criminal offence and may incur a two year prison sentence and an unlimited fine.
Unit 3 assessment:
Fire Safety

1. Name 3 types of fire on which you would use a carbon dioxide fire extinguisher
   (a) Flammable liquid fires, cooking oil fires, electrical fires
   (b) Solids (wood, paper etc), electrical fires, and flammable gas fires

2. After an evacuation when can you re-enter the building?
   (a) After 30 minutes
   (b) When the flames have died down
   (c) When the Fire Brigade says it’s safe to do so

3. Where should highly flammable substances be safely stored?
   (a) Out of reach
   (b) In sluice rooms
   (c) In fire-resisting cabinets

4. What is the weekly financial cost of arson?
   (a) £10m  (b) £25m  (c) £40m

5. What colour is a manual call-point?
   (a) Green  (b) Red

6. How often is the fire alarm tested?
   (a) Twice-weekly
   (b) Weekly
   (c) Monthly

7. Name the fire safety legislation which came into effect in 2006:
   (a) Fire Safety in the Workplace Regulations 2004
   (b) Regulatory Reform Fire Safety Order 2005

8. Name the 3 elements required for a fire to start:
   (a) Flame, hydrogen, oxygen
   (b) Heat, fuel, oxygen

9. What does the fire alarm signify when it is sounding with a continuous tone in a clinical area?
   (a) Engineers are performing their regular checks on the alarm.
   (b) There is a fire or smoke hazard in the immediate area and all persons should be prepared to evacuate when instructed.
   (c) The fire alarm has sounded for an adjacent zone and all staff should report to an Assembly Point.
Unit 3: Fire Safety Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

……………………………………………………………………………………………………………………

Forename: (Block Capitals)

……………………………………………………………………………………………………………………

Job Title: ....................................................................................................................................

Department/Ward: ........................................................................................................................

Division/Directorate: .....................................................................................................................

Date Completed: (This must be within 12 weeks of receipt) ..........................................................

Staff Signature: ............................................................................................................................

Manager: (Printname) .....................................................................................................................

Manager: (Signature) ....................................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: ..............................................................

VERSION 4 - JUNE 2014
As part of the requirements of Clinical Governance, new staff must receive information about Infection Prevention and Control (IPC) during their induction. Thereafter, all staff must receive an annual update. This section of the workbook has been designed by the IPC team to enable staff to undertake mandatory annual IPC update training on a self-directed learning basis. The focus of this training is on Standard Infection Prevention and Control Precautions. It is designed to enhance and develop your knowledge of Standard Precautions in order to facilitate safe, effective, Infection Prevention and Control practice.

The following topics are covered in this section:
- The Chain of Infection
- Standard Precautions (Hand hygiene and sharps safety)
- Staphylococcus Aureus/Meticillin Resistant Staphylococcus Aureus (MRSA)
- Clostridium difficile
- ESBL producing bacteria
- Norovirus

In addition, references will be made to Blackpool, Teaching Hospitals IPC policies and procedures to guide your learning and practice.

THE CHAIN OF INFECTION

Transmission of infection is considered to be a cycle, commonly referred to as ‘The chain of infection’. In order to prevent the transmission of infection it is necessary to break the chain.
**Infectious agent (Pathogen)**
This is any micro-organism that causes infection such as MRSA, Clostridium difficile or influenza.

**Reservoirs**
This could be a colonised or infected person, or contaminated equipment or environment.

**Portal of exit**
This is how the micro-organisms leave the reservoir. For example body fluids and respiratory secretions.

**Mode of transmission**
Contaminated hands are the most common way in which microorganisms are spread but there are other modes such as coughing, sneezing and diarrhoea.

**Portal of entry**
These infectious agents need a way to enter the body such as ingestion, inhalation and inoculation. Any indwelling device such as a urinary catheter or cannula also allows pathogens to enter the body.

**Susceptible host**
Reduced immunity through chemotherapy or antibiotics can make some patients more vulnerable to infection. The elderly and the very young are also particularly susceptible.

**How do you break the chain?**
**Standard Precautions** apply to all patients and clients at all times. You are personally responsible for implementing standard precautions in your personal practice to reduce the risk of infection to yourself, your colleagues and your patients and clients.

**Standard Precautions**
Standard Precautions are the basic principles of Infection Prevention and Control that should underpin safe practice, in order to protect both staff and patients/clients from infection. They include:

- Hand Hygiene
- The wearing of Personal Protective Equipment (PPE)
- Safe use and disposal of sharps
- Decontamination of equipment and maintaining a clean environment
- Waste management

**HAND HYGIENE**
Effective hand hygiene is the single most effective method of preventing the spread of infection.

Hand hygiene includes:
- Hand washing with soap and water;
  
  *After dealing with body fluids or after being in contact with patients with Clostridium Difficile or diarrhoea and vomiting*
- Use of alcohol hand rubs and gels;
  
  *When hands are free of dirt or organic material*
- A trust approved wipe when the above is unavailable or inappropriate
Micro-organisms are commonly found on the skin and can be described as:

**Resident flora**
Normal flora or 'commensal organisms', form part of the body's, normal defence mechanisms, and protect the skin from invasion by more harmful micro-organisms. They rarely cause disease and are of minor significance in routine clinical situations.

**Transient flora**
Those acquired by touch from the environment through contact with patients, equipment and patient furniture. They are located superficially on the skin, readily transmitted to the next thing being touched. They are responsible for the majority of healthcare associated infections but are easily removed by hand washing.

**Hands should be decontaminated:**
- Before commencing work/after leaving clinical area
- Before and after direct contact with patients or clients
- After touching patient’s or client’s surroundings
- Before and after wearing gloves
- Before performing aseptic procedures, e.g. catheterisation, wound dressings
- After risk of exposure to body fluids (and after aseptic procedures)
- Before and after handling invasive devices
- Before and after handling food
- After using the toilet
- After leaving patient or client’s environment e.g. domestic setting

Studies show that health care staff frequently use poor hand washing techniques and the most commonly neglected areas are the tips of the fingers, palm of the hand, and the thumb. It is important that hand washing is carried out correctly to prevent the spread of infection. The Trust endorses the World Health Organisation 5 Moments for hand hygiene and a 'bare below the elbows' rule for all staff that are in contact with patients or equipment within the patient zone.

**Areas of hands most frequently missed during hand washing**

The Trust endorses the World Health Organisation 5 Moments for hand hygiene and a 'bare below the elbows' rule for all staff that are in contact with patients or equipment within the patient zone.
The patient zone; My 5 Moments for Hand Hygiene;

For the Trust’s Hand Hygiene Policy and Procedure follow http://fcsharepoint/trustdocuments/Pages/default.aspx CORP-PROC-418 CORP-POL-056

Personal Protective Equipment

ALL PPE IS SINGLE USE ONLY
The selection of PPE must be based on a risk assessment of the risk of transmission of microorganisms to the patient, and the risk of contamination of the healthcare worker’s clothing and skin by patients’ blood, body secretions, or excretions.

The aim of wearing PPE is:
• To protect the Health Care Worker from occupational exposure to blood and body fluids.
• To protect patients/clients from infection

Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions or to sharp or contaminated instruments.

For Guidance on which gloves to wear, please refer to corporate guideline 052

Gowns and Plastic Aprons
The aim of wearing either a fluid repellent apron or gown is to protect the healthcare workers’ clothing/uniform from contamination with micro organisms, blood and body fluids, secretions and excretions, and protect the patient from micro organisms.

Eye Protection (Visors and Goggles)
The aim of wearing eye protection is to prevent contamination or potential exposure to blood, body fluids, secretions and excretions, and chemicals.

Face Masks
Surgical face masks protect the wearers’ nose and mouth from exposure to blood, body fluids, secretions and excretions.

Respiratory protective equipment e.g. a particulate mask (FFP3) must be used when clinically indicated (to protect the wearer from inhaling airborne pathogens such as TB or influenza). (NB FFP 3 masks must only be used after a risk assessment has been undertaken and the user has been ‘fit tested’ and trained in their use).

Please refer to corporate policy 116 for more information.
The following protective clothing must be available to clinical staff, or easily accessed when required:
• Sterile and non-sterile gloves
• Plastic aprons
• Eye protection (goggles)
• Masks/ Respirators
• Impervious gowns

(NB FFP 3 masks must only be used after a risk assessment has been undertaken and the user has been ‘fit tested’) For information on PPE follow

Health care waste Management
Community healthcare can take many forms and occurs in various environments. It includes activities undertaken by all healthcare workers who provide services outside of hospitals to patients and client’s in their own homes, residents in care homes (without nursing care) and clinics.
Community health care waste may be;
Infectious waste
Offensive/hygiene waste
Cytotoxic/cytostatic medicinal products.

• Health care workers working in the community and the household environment need to assess the waste they are producing for the hazardous properties it may contain. This should be based on, professional assessment, clinical signs and any prior knowledge of the patient/client.
• Which colour bag should I use?
Which colour bin should I use?

- Orange – Sharps for incineration or alternative treatment. Marked “Fully Discharged Sharps” for use with fully discharged sharps not contaminated with prescription only medicines (POMs).
- Yellow – Sharps including infectious sharps for incineration only. Marked with “Medicinal Sharps” For use with sharps waste, including those contaminated with medicines other than those which are cytotoxic/cytostatic.
- Purple – sharps which are contaminated with cytotoxic and cytostatic medicines. Marked “Cyto sharps”.
- Blue Lid - “Solid Pharmaceutical Waste”.

The CHS Health Care Waste policy can be accessed here:


Safe use and disposal of sharps
Sharps injuries occur following a cut or puncture wound to the skin, most often from a needle or other medical sharp. If the sharp is contaminated with blood there is a risk of transmitting infectious agents such as hepatitis B or C and human immunodeficiency virus (HIV)

- Risk assessment
  - Use safety devices where there are clear indications that they are safer to use
  - Do not re-sheath needles
  - Take a sharps bin to the point of use
  - Keep sharps handling to a minimum
  - Never pass sharps directly from hand to hand
  - Used sharps must be discarded into a BS 7320 standard sharps container

- Sharp’s bins;
  - must not be used for any other purpose than the disposal of sharps
  - must not be filled above the fill line
  - must be disposed of when the fill line is reached
  - should be temporarily closed when not in use
  - should be disposed of every 3 months even if not full, by the licensed route in accordance with local policy

For Immediate Guidance on action to take following a needle stick or contamination incident
Follow http://fcsharepoint/trustdocuments/Pages/default.aspx
Needle stick Injuries and Accidents Involving Exposure to Blood and Body Fluids in Staff CORP/PROC/100

Decontamination
Decontamination is the combination of processes, including cleaning, disinfection and sterilisation used to render a reusable item safe for use on patients or handled by staff. Decontamination of reusable medical devices and equipment is an essential procedure and must always be done in accordance with manufacturer’s instructions and current guidelines.
Cleaning is defined as the physical removal of accumulated deposits by washing with a general-purpose detergent (GPD), followed by thorough drying. This process will reduce the numbers of micro-organisms and remove dirt, grease and organic matter.

Disinfection is a process that kills or inactivates organisms but not all bacterial spores.

Sterilisation is the complete removal of all organisms including spores.

This concept is absolute, that is an item of equipment is either sterile or not sterile.

Trust approved wipes (clinell universal sanitising wipes) may be used for most patient equipment as they clean and disinfect.

Alcohol wipes fix organic matter to surfaces and must not be used for routine cleaning of equipment unless specifically recommended by the manufacturers

Decontamination and reprocessing of equipment

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Cleaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Items in contact with intact skin</td>
<td>• Removal of accumulated deposits, by washing with a cleaning solution or Trust approved wipe. This reduces the number of organisms and removes dirt, grease and organic matter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium Risk</th>
<th>Disinfection</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Items that do not penetrate the skin but are in contact with mucous membranes or non-intact skin</td>
<td>• Partial removal or destruction of organisms, except spores. This reduces the number of organisms present.</td>
</tr>
<tr>
<td>• Low risk items contaminated with virulent organisms</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Sterilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Items that are in contact with broken skin/mucous membranes or introduced into sterile body sites</td>
<td>1. Complete removal or destruction of all organisms including spores.</td>
</tr>
</tbody>
</table>

Re-usable equipment

• It is vital that re-usable equipment is effectively decontaminated between each patient, (barrier nursed or not), to prevent the transmission of infection.

• Alcohol wipes fix organic matter to surfaces and are not to be used for cleaning patient equipment unless specifically recommended by the manufacturers.

• Clinell universal wipes may be used for cleaning smaller pieces of patient equipment, as they clean and disinfect. This includes equipment used for barrier nursed patients. For larger surface areas, equipment should be cleaned with neutral detergent and warm water then dried. If the patient is barrier nursed, the detergent clean should then be followed by a clean with a 1000ppm chlorine based product. For example Haz tabs.

• Commodes should be cleaned with Clinell universal wipes unless the patient has suspected or confirmed Clostridium difficile in which case Clinell sporicidal wipes should be used.
Waste Management

Waste from healthcare settings may be toxic, hazardous or infectious and therefore needs to be properly segregated, handled, transported and disposed of to ensure that it does not harm staff, patients, the public or the environment.

All staff have a duty of care to ensure that waste is segregated and disposed of correctly.

Staff can facilitate the correct segregation of waste by placing the correct bin in the correct place. For example, place black domestic waste bins next to hand wash sinks for the paper towels. Please also note that yellow clinical waste bins should be used for all waste in barrier rooms.

Types of waste:

- Clinical Waste - Any item contaminated with blood or body fluids including sharps.
- Hazardous Waste - Such as cytotoxic products.
- Domestic Waste - All other items of waste e.g. paper towels, wrapping from dressing packs, newspapers and flowers etc.

LINEN

Used hospital linen may be contaminated with micro-organisms that cause infections. The most important measures to prevent the transfer of these organisms are:

- Careful handling of linen i.e. remove with care/wear protective clothing.
- Decontaminate hands after handling used linen.
- Dispose of linen into a skip at the point of removal.
- Ensure that linen is appropriately segregated and stored prior to collection.
- Ensure linen is laundered in an appropriate facility.
- Staff uniforms can be sent to the laundry in orange canvas bags. Uniforms laundered at home must be washed at 60°.

Role of the Estates department in preventing infections

The Estates department are responsible for the maintenance & surveillance of the healthcare environment including that of the water supply for pathogenic bacteria. They work closely with Infection Prevention team and together they have established a Water Safety Group to help prevent the transmission of infection to vulnerable patients such as neonates, haematology and critical (augmented) care patients.

To support this work staff in all clinical areas have a responsibility to ensure that all water outlets are run and that this is recorded in the appropriate water flushing log book. This crucially important yet simple task will prevent infections such as Legionella and Pseudomonas. Please refer to your local log book for instructions on how to do this as the flushing regime may differ from area to area.

Isolation Precautions

‘Isolation precautions’ is another term for barrier nursing. It is considered best practice to isolate patients with infections in a single side room with the door closed to form a barrier, (hence the term barrier nursing). Where this poses the risk of physical or emotional harm to a patient, a risk assessment must be carried out and any deviation from best practice must be documented in the patient’s case notes.

Isolation precautions are additional precautions and are recommended for infections or micro organisms transmitted by the following routes:
Airborne
Infections transmitted by the inhalation of micro-organisms on droplet nuclei. These particles are expelled from the respiratory tract and may remain suspended in air for a long time. Isolate patients in single side rooms with the door closed. Limit patient movement. Masks recommended for some procedures. Gloves and aprons should to be worn when handling respiratory secretions.

Respiratory droplets
Infections transmitted by contact with respiratory secretions, including particles produced during coughing and sneezing. These particles do not travel far or remain airborne. Many of these infections are also spread by direct contact with infective material. Isolate in a single room with the door closed. Limit patient movement. Wear gloves and aprons. Masks may also be required.

Contact transmission
Infections transmitted by direct contact with patients (e.g. by touching their skin, lesions or nasal secretions). Some micro-organisms may also be able to survive in the immediate environment and be transferred by contact with surfaces or equipment. Isolate in single side rooms preferably or cohort. Limit patient movement. Use gloves and aprons for all contact with the patient and their immediate environment.

Faecal oral route
Some microbes, when ingested, cause gastrointestinal infection which is excreted in faeces. Transmission to another person occurs when these micro-organisms contaminate hands or surfaces, through inadequate hand hygiene, which in turn contaminate the next person’s hands and are then ingested.

Staphylococcus Aureus

The Trust has a comprehensive screening strategy for Staphylococcus aureus and all patients who are MRSA positive, and certain high risk patients that are MSSA positive must be commenced on the Staph aureus Integrated Care Pathway.

Staphylococcus Aureus lives harmlessly on the skin and the nose of about one third of people. Staph aureus can be sensitive (MSSA) or resistant (MRSA) to Meticillin which is an antibiotic used for testing purposes. MRSA is resistant to some of the commonly used antibiotics eg. Flucloxacillin and is therefore often more difficult to treat.

Staph aureus tends to live in the nose, arm pit, groin and wounds of people. It can also be found in the environment in dust and has been found in the community as well as hospitals.

Staph aureus usually spreads from person to person by direct skin contact or by contaminated equipment or surfaces. It can ‘hitch a ride’ to the next patient on the hands of health care workers that have not been effectively decontaminated.

People carrying Staph aureus on their skin are said to be colonised, but not infected. If this bacterium is allowed to enter body tissues, it can cause abscesses, boils and local infections. If Staph aureus is allowed to enter the blood steam it can cause septicaemia (blood poisoning). Presence of MRSA in blood cultures is known as MRSA bacteraemia.

CLOSTRIDIUM DIFFICILE

Clostridium difficile is a spore-forming anaerobic toxin-producing bacillus. These spores survive in the environment and are resistant to heat and disinfectants. Clostridium difficile causes a spectrum of clinical syndromes from asymptomatic carriage, to the development of, in severe cases, pseudo membranous
colitis. 3% of the general population and 15% of hospital patients are thought to be colonised.

Normal gut flora help limit C. difficile growth. However, when antibiotics disturb the balance of bacteria in the gut, C. difficile can multiply rapidly producing toxins which cause diarrhoea and colitis.

C. difficile has a significant morbidity and mortality rate. It predominantly affects older people and is rare in people under 45.

The following factors increase the risk of developing CDI:

- Elderly patients (>65 years of age)
- Long length of stay in healthcare settings
- Recent use of high risk antibiotics (Co-amoxiclav, Quinolones and 2nd/3rd generation Cephalosporins)
- Recent major surgery (especially gastrointestinal)
- Serious underlying disease or illness
- Immuno-compromising conditions

Symptoms of C. difficile infection (CDI) include mild to severe offensive watery diarrhoea, abdominal pain/tenderness, fever and dehydration.

CDI is spread through direct patient-patient contact via healthcare staff e.g. contaminated hands and through the use of contaminated equipment such as commodes.

Thorough hand washing with soap and water is essential when caring for patients with C. difficile as alcohol hand rub does not effectively kill spores.

Please see Corporate Guideline 092 for more information

ESBL (Extended Spectrum Beta Lactamase)

Some types of bacteria have developed the ability to be resistant to many commonly used antibiotics by producing an enzyme called ESBL. This enzyme blocks the effect of some antibiotics making the bacteria resistant. Not only are they resistant, but ESBL producing bacteria can also pass on this resistance to other species of bacteria.

The types of bacteria that most commonly develop this ability include:

- E. Coli
- Klebsiella
- Proteus
- Pseudomonas
- Enterobacter
- Acinetobacter

These bacteria are known as Gram-negative bacilli. If these bacteria cause an infection, for example, urinary tract infection, pneumonia or surgical wound infection, they can be very difficult to treat as they are resistant to many antibiotics.

Source isolation, environmental cleaning and strict hand hygiene are necessary to prevent the spread of ESBL producing bacteria.

Please see Corporate Guideline 542 for more information
**Carbapenem-sae-producing Enterobacteriaceae (CPE)**

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. They include species such as Escherichia coli, Klebsiella spp. and Enterobacter spp. Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). They include meropenem, ertapenem and imipenem. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. They are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common.

In the UK, over the last five years, there has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria. Unless we act now, learning from experiences elsewhere across the globe, rapid spread of carbapenem-resistant bacteria has great potential to pose an increasing threat to public health and modern medicine as we know it in the UK.

Therefore patients who have been hospitalised here or abroad in the past 12 months require screening for CPE.

**Please refer to Corporate Policy 359 for more information regarding patient screening**

**NOROVIRUS**

Norovirus is also referred to as gastroenteritis, Norwalk and winter vomiting disease. It is a community acquired infection that rapidly spreads through healthcare settings once introduced.

It is highly infectious and the main symptoms are sudden onset of projectile vomiting and diarrhoea.

Alert the IPC team if any patients develop symptoms of unexplained projectile vomiting or if two or more patients and/or staff develop symptoms of D&V.

Wards and/or bays may be closed to admissions and patient movement will be kept to a minimum. Strict isolation, hand hygiene and the use of PPE is necessary to limit the spread.
Unit 4A assessment:
Infection Prevention & Control (Clinical staff only)

Q1. Which of the following is NOT a link in the chain of infection?
(a) Infectious agent
(b) Reservoir
(c) Portal of exit
(d) Antibiotics

Q2. Which of the following is NOT a component of Standard Precautions?
(a) Hand hygiene
(b) Use of personal protective equipment
(c) Audits
(d) Decontamination of equipment

Q3. Which of the following is NOT one of the 5 moments of Hand Hygiene but is still considered good practice?
(a) Before touching patient surroundings
(b) Before patient contact
(c) Before clean or aseptic procedure
(d) After body fluid exposure risk

Q4. “Hands do not need to be decontaminated after removal of gloves.”
(a) True
(b) False

Q5. Which area of the hands is most commonly missed during hand washing?
(a) Palms
(b) Thumbs
(c) Fingers
(d) all of the above

Q6. “Staff are required to wear surgical face masks only when performing aerosol generating procedures on patients who have flu.”
(a) True
(b) False

Q7. When should sharps bins be disposed of, even if not full?
(a) After 3 months
(b) After 6 months
(c) After 12 months
(d) There is no requirement on the amount of time bins are left open for use if they have not reached their fill-line.
Q8. Which is the correct sharps bin/container for the disposal of medicinally-contaminated sharps that are NOT cytotoxic/cytostatic?
(a) Orange-lidded
(b) Yellow-lidded
(c) Blue-lidded
(d) Purple-lidded

Q9. What would your immediate response NOT be to a needle stick injury to a finger?
(a) Wash it under running water
(b) Encourage it to bleed
(c) Suck it.
(d) Carry out a risk assessment of the injury.

Q10. MRSA is most commonly spread through which mode of transmission?
(a) Airborne
(b) Direct contact
(c) Respiratory droplets
(d) Faecal/Oral route

Q11. How is Clostridium difficile most commonly acquired in a healthcare setting?
(a) Inhalation
(b) Inoculation (sharps injury)
(c) Ingestion of spores
(d) Contact with skin

Q12. Name the main risk factor that contributes towards patients developing diarrhoea associated with Clostridium difficile?
(a) Antibiotics
(b) High Waterlow score
(c) Poor dietary intake
(d) Enemas

Q13. Approximately how long can Clostridium difficile spores survive in the environment?
(a) 5 hours
(b) 5 days
(c) 5 weeks
(d) 5 months

Q14. Extended Spectrum Beta Lactamase (ESBL) and Carbapenemase are enzymes that can be produced by certain bacteria to block the effect of some antibiotics?
(a) True
(b) False

Q15. What are the main classic symptoms of Norovirus?
(a) Diarrhoea & vomiting.
(b) Headache & vomiting
(c) Joint pain & diarrhoea
(d) Vomiting & nausea
Unit 4a: Infection Prevention & Control (Clinical staff only) Completion Statement

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A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

Forename: (Block Capitals)

Job Title: ..........................................................................................................................

Department/Ward:...........................................................................................................

Division/Directorate: ......................................................................................................

Date Completed: (This must be within 12 weeks of receipt) ........................................

Staff Signature: ..............................................................................................................

Manager: (Printname) ......................................................................................................

Manager: (Signature) ......................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: .....................................................

VERSION 4 - JUNE 2014
Unit 4B assessment:
Infection Prevention & Control (Non-clinical only)

Q1. Which of the following is NOT a link in the chain of infection?
(a) Infectious agent
(b) Reservoir
(c) Portal of exit
(d) Antibiotics

Q2. What is the single most-effective method of preventing infections from spreading?
(a) Wearing gloves
(b) Good hand hygiene
(c) A clean environment
(d) Waste management

Q3. Which is the preferred method for cleaning your hands after visiting the toilet?
(a) Soap & water
(b) Alcohol hand-gel

Q4. Which area of the hands is most commonly missed during hand washing?
(a) Palms
(b) Thumbs
(c) Fingertips
(d) Backs of hands

Q5. Which of the following is NOT one of the 5 moments of hand hygiene but is still considered good practice?
(a) Before touching patient surroundings
(b) Before patient contact
(c) Before clean or aseptic procedure
(d) After body fluid exposure risk

Q6. What are the main, classic, symptoms of Norovirus?
(a) Diarrhoea & vomiting.
(b) Headache & vomiting
(c) Joint pain & diarrhoea
(d) Vomiting & nausea
Unit 4b: Infection Prevention & Control (Non-clinical only)
Completion Statement

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Date Sent: ..........................................................
INTRODUCTION

The Mental Capacity Act 2005 covering England and Wales provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.

Added to the Act in 2009 was The Deprivation of Liberty Safeguards (DOLS). This is for people who lack the capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving vulnerable people of their liberty in either hospital or a care home, extra safeguards have been introduced in law to protect their rights and ensure that the care or treatment they receive is in their best interests.

Deprivation of Liberty Safeguards (DOLS)

The hospital known as ‘the managing authority’ has to make a DOLS application to ‘the supervisory body’ (PCT or local authority) to seek approval to put a patient on a DOLS authorisation. The clinical team can apply for a Urgent Authorisation which gives immediate authorisation to detain the patient in hospital for up to 7 days. Also at the same time the clinical team have to make a Standard Authorisation to allow further detention of the patient after 7 days as this may be required for the patient. Two independent assessors are sent out by the supervisory body to assess the patient to see if a standard DOLS authorisation is required and is to be approved by the supervisory body.

Lasting Powers of Attorneys (LPAs)

These enable people to appoint someone they know and trust to make decisions for them, usually family members. There are two types of LPA:

- Property and Affairs, which helps the person to manage their financial affairs;
- Personal Welfare, which is a new way to appoint someone to make health and welfare decisions and can only be used when the person lacks capacity.

Anyone making the LPA must be over 18 and have capacity, and the LPAs MUST be registered with the Office of Public Guardian (OPG) for them to be legal and lawful to implement. Chosen attorneys can only make decisions in the person’s best interests.

Advance Decisions to Refuse Treatment (ADRTs)

These allow the person concerned to refuse specified medical treatment in advance, providing the person is over 18 and has capacity at the time the ADRT is made.

The ADRT must clearly specify the treatment it applies to and in what circumstance. It MUST be in writing, signed and witnessed if it applies to life-sustaining treatment, clearly stating the decision applies ‘even if life is at risk’. An ADRT does not have to go through a legal process: the person concerned can just write it down like doing a letter. ADRTs are legally-binding as long as they are valid and applicable: medics can treat if there is any doubt that the ADRT is valid and applicable.
Independent Mental Capacity Advocate (IMCA)
This is a new role created within the MCA 2005 as an extra safeguard for particularly vulnerable people in specific situations – for when someone has been assessed, lacks capacity, and has no-one to consult with (ie: no family, friends, or carers) and a decision needs to be made in their best interest.

In such cases it is a statutory duty to refer the person concerned to an IMCA, especially if the decision is about serious medical treatment, long-stay hospital care (ie: 4 weeks or more) and or accommodation in a care home (ie: 8 weeks or more).

The IMCA has statutory right to see the patient in private; have access to medical/nursing records; and speak to clinical staff about the patient’s condition regarding the best interest decision to be made. However, IMCAs do not make the best interest decision but work with the medic in charge of that patient’s treatment.

MENTAL CAPACITY ACT 2005
(From the Guidance Card in the Trust’s Documents Library)

1. Remember the Five Principles of the Act:

   • Assume the person has ‘capacity’ unless you have a reasonable belief capacity may be impaired.
   • Do not treat the person as unable to make a decision unless all possible steps to help them have been taken.
   • An unwise decision does not mean the person is unable to make a decision.
   • An act or decision on behalf of a person who lacks capacity must be in their best interests.
   • An act or decision on behalf of a person who lacks capacity must aim to be least restrictive.

2. Help the person decide for themselves (ie: enable capacity)

   • Define clearly the specific decision that needs to be made and the time it needs to be made. Remember! People may be able to make some decisions but not others.
   • Be person-centred - eg: meet at a time and place that’s best for person, to help them feel at ease.
   • Provide information relevant to the decision, including information about any choices or alternatives. (Take care that the information threshold is appropriate.)
   • Use a method of communication or language that is most suited to the person - not just the written or spoken word - such as accessible language, pictures or an interpreter.
   • Involve others who can support the person to understand information and make a decision.
   • Consider if you can delay the decision until the person regains capacity.

3. If attempts to enable capacity have not succeeded:

   • Identify the decision-maker: the person proposing the decision &/or taking the action (unless decision is within the authority of a Lasting Power of Attorney (LPA), Court Deputy (CAD), Court Order or Advanced Decision to Refuse Treatment(ADRT).
   • Explain to all parties that the Mental Capacity Act must be followed.
   • Refer to the Independent Mental Capacity Advocacy (IMCA) Service (check eligibility criteria) or generic advocacy.

4. Carry out the 2-stage assessment of capacity (below), or check that the decision maker has done so. (The assessment should be recorded to evidence how the conclusion has been reached.)

   Stage 1 (DIAGNOSTIC TEST): Does the person have a permanent or temporary condition that is affecting the functioning of their mind or brain? A condition could include:
   • Mental illness;
   • Dementia;
• Significant learning disabilities;
• Effects of brain damage;
• Physical or medical conditions that cause confusion, drowsiness or loss of consciousness, delirium;
• Head injury including stroke;
• Symptoms of alcohol or drug use;
• No formal diagnosis, but signs of mental impairment are evident.
If the impairment is temporary the decision may be deferred (unless urgent).

Stage 2 (FUNCTIONAL TEST): If so, is it sufficient to prevent the person from making the particular decision at the time it needs to be made? Follow the four points below:
• Does the person understand the information relevant to the decision that needs to be made?
• Are they able to retain the information long enough to make the decision?
• Can they weigh up this information & use it to make a decision?
• Can they communicate their decision in any way?
If the answer is ‘no’ to any of the above, then there is a reasonable belief that the person cannot make the decision for themselves: they lack capacity.

5. Make a best interests decision on behalf of the person by following the best interests checklist, or check that the decision-maker has done so.
(The best interests process should be recorded as evidence of lawful decision-making.)

• Encourage the person to participate.
• Identify all relevant circumstances.
• Find out the person’s views, past & present – eg: are there any written statements, or advanced decisions to refuse treatment (ADRT)?
• Avoid discrimination.
• Assess whether the person might regain capacity.
• If the decision concerns life-sustaining treatment do not make assumptions about the person’s quality of life.
• Consult others, eg: other family members, friends, paid staff, IMCA, LPA, CAD.
• Avoid restricting the person’s rights.
• Take all of this into account – eg: What are the most important factors? And Have you weighed the benefits v burdens of each option?

6. Identify whether the decision involves restraint and/or restrictions and that these are compliant.
(Evidence that restraint or restrictions meet criteria below should be recorded.)

Restrain or restrictions can be used, but only if:
• The person lacks capacity to consent & it is in their best interests to protect them from harm, and:
• Restraint /restrictions are necessary to prevent harm to the person, and are a proportionate response to the likelihood and severity of harm.
Notes:
• A person can only be deprived of liberty under the Deprivation of Liberty Safeguards (DoLS), the Mental Health Act, or a court order.
• Contact with others cannot be prevented or restricted - eg: under a Safeguarding Plan - unless agreed by all parties, or under short-term DoLS or a court order.

7. Advice & help

If in doubt, refer to the MCA or DoLS Codes of Practice, available from the Trust’s Documents Library. For complex, serious or disputed issues seek advice.

Contact: Robert Ward, MCA Lead, Tel (01253) 303665, Bleep 538 (BVH site only).
Unit 5 assessment:
MCA / DOLS

1. What is the First Key Principle of the Mental Capacity Act 2005?
(a) If a person lacks capacity, you must act in their best interest
(b) An unwise decision does not mean someone is unable to make a decision
(c) Always assume the person has capacity unless proved otherwise
(d) An act or decision when making a best interest decision must aim to be least restrictive.

2. What are the names of the two types of Lasting Power Attorneys (LPAs) that can be applied for?
(a) Finances & Caring
(b) Managing Affairs & Wellbeing
(c) Managing Money & Healthcare
(d) Property/Affairs & Personal Welfare

3. What are the names of the two key stages when assessing a person's capacity?
(a) Diagnostic & Functional Test
(b) Thinking & Memory Test
(c) Cognitive & Impairment Test
(d) Mind & Solution Test

4. A gentleman with severe dementia signs his own consent form to undertake an operation. The medical team goes ahead and completes the operation. Is this lawful under the Mental Capacity Act 2005?
(a) Yes (b) No

5. We talk about making a ‘best interest decision’ when someone lacks capacity: who must we consult with - by law - as stated in the MCA 2005?
(a) Social worker
(b) Family member or nearest relative
(c) GP
(d) Generic advocate

6. When would you need to contact an Independent Mental Capacity Advocate (IMCA)?
(a) The person lacks capacity because of a learning disability
(b) The person lacks capacity because of a mental illness
(c) The person lacks capacity and has no family, carer, or friends
(d) The person lacks capacity and has legal representation

7. When someone wants to make ‘an advance decision to refuse treatment’, must this be done through a solicitor?
(a) Yes (b) No
8. When a patient lacks capacity, can covert medication be used, acting in the patient’s best interest?
(a) Yes (b) No

9. What does ‘DOLS’ stand for?
(a) Deprivation of Legal Status
(b) Deprivation of Liberty Safeguards
(c) Denial of Legal Statute
(d) Deprivation of Life Situations

10. What are the two specific DOLS applications that can be made?
(a) Urgent & Standard
(b) Immediate & Gradual
(c) Emergency & Assessment
(d) Safety & Protection
Unit 5: MCA / DOLS Completion Statement

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Date Sent: ………………………………………
INTRODUCTION

All handling of objects, people and animals carries a risk of injury for the handler and others.

More than a quarter of the accidents reported to the enforcing agencies are associated with manual handling – the transporting or supporting of loads by hand or by bodily force. Lifting implies that you are taking most or all of the full weight of the object. This results in severe stress on the soft tissues of the spine, ligaments and discs, so it can lead to injury.

Injury can result in staff being absent from work. Recurrent problems will affect the individual’s ability to continue working, their social and home life. Severe injury may lead to the individual not being able to continue in their chosen profession and leave.

Research (HSE, RoSPA) has shown that the repeated use of incorrect lifting techniques to move loads, and working in stressful postures increases the likelihood of injury to the spine.

In light of this research and evidence gathered from injury statistics, legislation is now in place, outlining measures and responsibilities for both employer and employee to be taken to manage the problems associated with manual handling.

Legislation

There are 5 main pieces of legislation relating to Lifting and Handling

• Health and Safety at Work Act 1974.
• Management of Health and Safety at Work Regulations 1999.
• LOLER (Lifting operations and Lifting Equipment Regulations 1998):

These set out both Employer and Employee responsibilities.

Employer Responsibilities

Under the Health and Safety at Work Act, employers are responsible for the health, welfare and safety of their employees, and must provide instruction, supervision and training for them.

Under the Manual Handling Operations Regulations, emphasis is placed on the avoidance of hazardous manual handling operations, and the provision of a safe system of work.

Under the Management of Health and Safety at Work Regulations, emphasis is placed on Risk Assessments and the provision of equipment appropriate for the task.

Under the Workplace Regulations, emphasis is placed on maintenance of the workplace, equipment and to ensure all are in good state of repair.
Employee Responsibilities

Under the Health and Safety at Work Act, the employee is responsible for his/her own health, safety and welfare and should co-operate with the employer to carry out his/her duties. Under the Manual Handling Operations Regulations, the employee is required to make use of any safe system of work provided by the employer.

Under the Management of Health and Safety at Work Regulations, the employee is required to use any equipment/ machinery/ aids in accordance with the training and instructions of the employer.

Employees are required to alert management to new risks in the workplace.

Please see Trust policy

This document has been produced to set out guidelines concerning the safe movement of loads – objects or people

You are required to:
• Work within the framework set out by the above document.
• AVOID hazardous manual handling operations as far as is reasonably practicable.
• ASSESS your course of action.
• REDUCE your risk of injury, by acting on the information you have obtained.

All staff are to be made aware of this information and it is to be documented, read, acted upon and changed as necessary.

Definitions

Load - is a discrete moveable object (thing, person or animal)
Lifting – the transporting and/or supporting of a load by hand or bodily force

THEORY
Anatomy

The spine is one of the main components of the skeleton. It is made up of 33 vertebrae – 7 cervical, 12 thoracic, 5 lumbar, the rest forming the sacrum and coccyx.

Its functions are to provide central support for the body, attachments for muscles and ligaments, allow movement and provide protection for the spinal cord.

Between the vertebrae are the discs, these act as spacers between the bones of the spine, as shock absorbers in the spine, aid smooth movement, and try to maintain the weight bearing pressures through the spine as evenly as possible.

The most vulnerable areas of the spine are the lumbar (lower back), and the cervical (neck) regions. They are the most mobile, and susceptible to injury. The lower back is also the main weight bearing part of the spine. The spine is supported by muscles and ligaments. The trunk muscles are postural muscles and are not as strong as the muscles found in the arms and legs.

There are many causes of pain and discomfort, but can be broadly divided into 2 groups – problems with the bony structures of the spine, and problems with the soft tissues – the muscles, ligaments and the discs.
Apart from some specific medical conditions, the majority of musculo-skeletal problems come about as a result of mechanical loading of the spine – the 2 most common culprits are lifting of loads and poor working postures.

**Posture**

Correct posture is essential for everyone, it brings with it many advantages, particularly to the spine because it:

- There are 33 vertebrae in the human spine
- Re-aligns the spine, keeps the weight bearing stresses through the bodies of the vertebrae and the intervertebral discs as even as possible.
- Causes less weight bearing stresses on the soft tissues of the spine, the muscles and ligaments, which are not designed to be over-stretched.
- Maintains a good head position, particularly important if the person works in a sitting position, as there is less stress on the neck and upper limbs.

Good posture encourages a healthy spine, and goes some way to reducing the risk of injury to the spine.

Poor posture, standing or sitting in a slumped position, results in:

- Mechanical damage to the soft tissues of the spine – the discs, muscles and ligaments.
- Increasing fatigue in these soft tissues.
- Herniation of the discs – a “slipped disc”.
- Increasing neck and low back pain.

In recent years research has shown that there is a link between poor working postures and cumulative back problems.

Good posture can be attained by:

- Making the effort to sit and stand correctly.
- Regularly changing position – standing, walking and stretching the spine.
- Working at the correct height for the particular task to be carried out.
- Adjusting seating, if available, for the individual.
- Wearing appropriate footwear.

**Lifting**

As the majority of injuries related to the moving of objects affects the spine, changes to the way we lift things is essential to reduce injuries.
This entails

• Risk Assessments to be carried out, to identify problems and promote safe working.
• Assessing each situation as it arises.
• Using appropriate equipment that is available to help you.
• Altering how you manually lift anything – instead of the smaller, weaker muscles in the back, use the longer and stronger muscles in the legs and arms.

At all times, good posture and handling techniques will help to protect the spine from musculo-skeletal injury.

**Moving Loads**

A load is a discrete moveable object – a thing (inanimate), a person (animate), or an animal (animate).
• It takes too long.
• It is perceived as being more difficult, to bend the knees rather than bend the back.
• We have become lazy and have developed bad lifting habits.
• We do not perceive the risks in lifting lighter and smaller objects compared to larger, heavier objects i.e. boxes of files compared to tables and furniture.

As many, if not more, back problems result from cumulative stress, so repeated lifting of lighter, smaller objects incorrectly is as bad for you as moving a single heavier or larger object.

**Principles of Safer Handling**

• Wear appropriate clothing and footwear.
• Never manually handle, unless you have no other option. Always ask – “do I need to lift this?”
• Assess the object to be moved prior to commencing a manoeuvre.
• Always select the appropriate manoeuvre and equipment for the task in hand.
• Make the load smaller/lighter if possible.
• Identify a team leader, to give instructions and explanations to everyone.
• If it is a person to be moved, explain the procedure to them.
• Prepare the area, clear away objects and try to create space.
• Apply the brakes on any equipment if necessary.
• Make a stable base with your legs and feet, feet apart for balance, knees bent so you can make use of the power in your leg muscles.
• Keep the object or person as close to you as possible.
• Make sure of a good hand grip.
• Avoid static stooping i.e. legs straight, spine bent forwards, arms stretched, as much as possible.
• Know your own limit or capacity, if you cannot move something, ask for help.
• Give clear, precise instructions.
• Raise the head on movement, this keeps the spine in good alignment and gives you good visibility.
• Do not twist your spine, this generates increased weight bearing forces within the discs and soft tissues of your lower spine.

All of these principles reinforce the need to assess the situation, keep your balance and make use of the power in the stronger leg muscles rather than the weaker back muscles. Good posture is encouraged, as this also reduces the strain on the soft tissues in the back.
ASSESSMENT

Assessment prior to moving any object has four components:

- **Task** – what are you trying to do, is there any other way of making the task (job) simpler, is there any equipment to help you?
- **Individual Capability** – can you do the task? Do not exceed your own capabilities, do you know how to use the appropriate equipment, if not - ask.
- **Load** – what are you trying to move, is there any other way of lightening the load, can you divide it into smaller parts. If it is a patient, can they help you?
- **Environment** – where are you and where do you want to be. Can you create space around you, is the area clear of obstacles, can you see where you are going?

It is important to **plan** what you are going to do, communicate this to others if they are going to help you, use equipment to help you, and act on this information.

Moving People

**Patient Assessment – Why have a Safer Patient Handling Procedure?**

To eliminate hazardous manual handling operations in all but exceptional or life threatening circumstances.

Nursing and other care related professions, are high risk professions for developing musculo-skeletal disorders – particularly back problems, by persisting in manually moving patients.

It is acceptable to give a patient some support, but not to take most or all of their weight.

**The Manual Handling Operations Regulations** establish a hierarchy of measures:

- Avoid hazardous manual handling operations so far as is reasonably practicable.
- For those operations that cannot be avoided, the situation must be assessed.
- Reduce the risk of injury from those operations as far as is reasonably practicable.

When dealing with patients:

- Avoid lifting/manually moving them, encourage them to do what they can for themselves.
- Assess what they can and cannot do for themselves, and then use the most appropriate technique or piece of equipment to move them.
- The number of staff needed to move the patient safely can vary so clinical staff should also work closely with carers/relatives or outside agencies to reduce the risk of injury to both staff and patient.

It is essential to assess the patient’s level of mobility.
All patients must be assessed for their moving and handling needs, as with all other protocols – documented, changed as necessary and acted upon. The patients and their carers/relatives must be made aware of the Trust Safer Handling Policy and why we use safer handling techniques.

What needs to be documented:
• What the patient can or cannot do for themselves.
• What equipment and numbers of staff are required to move them.
• If the patient uses any mobility aids – sticks, walking frame.
• If the patient’s condition changes, they need to be re-assessed.

All staff must know and act on this information

Acceptable and Unacceptable Techniques
Staff must only use acceptable Moving and Handling Techniques approved by the Trust, these are described below.

After assessing the patient
• Are they being nursed on the most suitable bed and mattress.

Then, each time you attend the patient to move them:
• Encourage them to do what they can for themselves, and give them time to do so.

Within the hospital all adult patients are nursed on electric profiling beds, these are designed to be of help to the staff, as well as to provide more comfort for the patient.

To perform the following moves:-

• Rolling side to side – the minimum of two people are required (more depending on the size and condition of the patient) to roll the patient, if they require to be positioned on either side or moved across the bed use sliding sheets, to reduce the effort required by the staff.

• Lying to sitting – use the bed to raise the patient into sitting. Ensure the patients hips are positioned over the “break” in the bed, if the patient has slid further down the bed, lower the back rest, slide the patient up the bed to place their hips in the right position, then use the bed to sit them up. This also applies to trolleys. **DO NOT DRAG THE PATIENT UP THE BED BY PULLING ON THEIR ARMS.**

• Move up the bed – slide recumbent patients up the bed using sliding sheets, and the minimum of two people (more may be required depending on assessment). Another alternative, if there are insufficient numbers of staff, is to use the hoist.

• Lying to sitting over the edge of the bed – if the patient is lying flat, roll them onto their side, then ease them up into sitting. If semi-recumbent or sat up in bed, use the bed to sit them as upright as possible. Have the members of staff positioned one behind the patient to support the patient’s trunk, and the other in front to support the patient’s legs.

• Sitting to standing – the patient must be able to bear their own weight, if not use the HOIST. Staff are to position themselves on either side of the patient, one arm supporting the patient’s trunk, the other supporting the patient’s upper arm, block the feet if necessary and “rock” the patient onto their feet. **DO NOT DRAG THE PATIENT UPRIGHT BY PULLING ON THEIR ARMS.**
Transfer to a chair – once on their feet, allow the patient time to stand as upright as possible, get their balance, before asking them to step round to sit down in a controlled fashion. Turning them quickly, results in the patient losing their balance and not being able to help you. If you cannot get the patient onto their feet with two members of staff, either from the bed or from the chair back to bed, asking for more staff is not the most appropriate thing to do. To be surrounded by staff and manhandled into a bed or a chair, is not SAFE, DIGNIFIED OR NOT OFFERING THE BEST QUALITY OF CARE TO THE PATIENT, NEITHER IS IT SAFE FOR THE STAFF. If you cannot get the patient onto their feet use the appropriate hoist.

Support whilst walking – you are there to provide support and guidance, not hold the patient upright. If they use a walking aid use this, and you stand to the side. They can see you, but you are not in the way.

Emergencies/life-threatening situations – if out of bed (including sitting on a chair, commode or wheelchair) lower the patient to the floor. Try to protect their head, but imperatively you do not put yourself at risk. Once on the floor deal with resuscitation there.

Fallen/falling patient – contact emergency services while keeping the patient as comfortable as possible until help arrives

Unacceptable Techniques

Refer to the Guide to the Handling of People 5th edition
These moves were identified in 1980 as being dangerous to staff and patient, they were condemned by the RCN in 1984 as a means of moving patients, and MUST NOT be employed.

Lying to sitting – by pulling the patients arms, it is painful and damaging to the patient and can cause harm to the staff’s neck, shoulder and back muscles.

Move up the bed – by pulling the patient’s arms, it causes damage to the shoulders and can lead to the development of pressure areas. It also strains the staff’s neck, shoulder and back muscles.

Sitting to standing – by pulling the patient’s arms, this will cause the same problems as above. The patient is in danger of falling as the staff do not have full control of the situation.

Manually lifting a patient out of a bed or chair – the staff are carrying the whole weight of the patient, and may drop the patient.

Manually lifting a patient off the floor – unless in exceptional circumstances, because of the potential harm to patient and staff alike.

Always assess the situation first, then use the most appropriate and safe technique to move the patient. Use equipment to help you – it may take more time, but both you and the patient will be safe.
Unit 6 assessment: Moving & Handling

1. Is a person considered to be a ‘load’ in legal terms?
   (a) Yes (b) No

2. Roughly what percentage of accidents reported to enforcing agencies are associated with manual handling?
   (a) Less than 25%
   (b) More than 25%
   (c) 50%
   (d) 70%

3. Apart from medical conditions, what causes most musculo-skeletal problems in the workplace?
   (a) Lifting of loads
   (b) Poor working postures
   (c) Both of these

4. How many vertebrae are there in the human spine?
   (a) 29 (b) 33 (c) 37

5. Are leg muscles more powerful than trunk muscles?
   (a) Yes (b) No

6. Which of the four main pieces of legislation places emphasis on the employer to conduct risk assessments and provide equipment appropriate for tasks?
   (a) Health & Safety at Work Act 1974
   (b) Manual Handling Operations Regulations 1992
   (c) Management of Health & Safety at Work Regulations 1999
   (d) Workplace (Health, Safety and Welfare) Regulations 1992

7. Which of the four main pieces of legislation says employees are responsible for their own health, safety and welfare and should co-operate with their employer to carry out duties?
   (a) Health & Safety at Work Act 1974
   (b) Manual Handling Operations Regulations 1992
   (c) Management of Health & Safety at Work Regulations 1999
   (d) Workplace (Health, Safety and Welfare) Regulations 1992

8. What are the four components of any assessment of manual handling risk?
   (a) Task, load, location, individual fitness
   (b) Task, load, location, individual capability
   (c) Task, load, environment, individual capability
9. You’re a nurse who needs to move a bed patient from side to side. Can you do this on your own, or should you ask for help?
(a) You can do it on your own
(b) There must be at least two people
(c) Can vary with patient’s own capabilities

10. What is probably the best way of moving a recumbent patient up the bed?
(a) Use sliding sheets with two people
(b) Use sliding sheets with a minimum of four people
(c) Manual handling with two people
(d) Manual handling with a minimum of four people
Unit 6: Moving & Handling Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

Forename: (Block Capitals)

Job Title: ........................................................................................................................................

Department/Ward: ...........................................................................................................................

Division/Directorate: ........................................................................................................................

Date Completed: (This must be within 12 weeks of receipt) ...........................................................

Staff Signature: ............................................................................................................................... 

Manager: (Printname) ....................................................................................................................... 

Manager: (Signature) ........................................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: .................................................................
Unit 7
Safeguarding Children (Level One)

Safeguarding and Protecting Children is Everyone’s Responsibility

NHS Blackpool Teaching Hospitals Foundation Trust workforce has a duty of care to ensure they safeguard and protect children at risk of harm and neglect and promote their welfare. All those who come into contact with children and their families as part of their day to day work, and those who do not, have a duty to safeguard and promote the welfare of children. All staff have a duty to familiarise themselves with the risk factors signs and symptoms of child abuse and be aware of the action to be taken should such an incident present itself. The aim of this unit is to ensure that children and young people can ‘stay safe’ by minimising the risk and incidence of child abuse, thus enabling them to achieve. All children have the right to be safeguarded from harm and exploitation. One agency alone cannot protect children and neither can procedures alone, promoting children’s wellbeing and safeguarding them from significant harm depends on effective information sharing collaboration and understanding between agencies and professionals.

Objectives
• Recognise your responsibility in relation to safeguarding and protecting children
• Recognise signs of child maltreatment
• Recognise the impact of child maltreatment
• Participants will be aware of the advice and support available within the organisation
• Where to access safeguarding policy’s (Internal, Blackpool and Lancashire Safeguarding children Board Procedures)
• Participants will know how to act upon their concerns and to know what to do if they feel that their concerns are not being taken seriously or they experience barriers to referring a child/family.

Staff need to:
• Be aware of the support systems in place for staff
• Know who to contact for advice
• Have an understanding and acceptance that child abuse occurs

This unit will give a basic introduction at level one to safeguarding and protecting children. All staff who need to complete level 2 to 6 (Intercollegiate Document 2010) will need to complete further training. (Please see Safeguarding Training Strategy).

If you are unsure about what training you need please discuss this with your line manager. Lancashire’s Safeguarding Children procedures can be found at www.lancashire.gov.uk. The organisations Internal Safeguarding Children procedures can be found on the Trusts Intranet.
Where are you on the continuum? This may fluctuate depending on your experience and knowledge.

So far example; If you were on the ‘obsessive’ side of the continuum and have the belief that everyone is an abuser this could lead to increased and unnecessary referrals, loss of objectivity and stress for the families and practitioner. Similarly, if you are of the belief that there is no such thing as child abuse this could lead to children being left in difficult and dangerous situations and not receiving the appropriate safeguarding services. The healthy position to be in is to recognise that children can be abused and at times require protection and that as practitioners we need to be able to recognise abusive situations and work to our roles and responsibility.

When we have to deal with abuse we may feel a mixture of some or all of the following:

Dealing with child abuse can lead to a mixture of feelings that may include denial, guilt, fear, anger and pain. These are all normal emotions when dealing with such a sensitive subject. However, it is incumbent on professionals working in the NHS to act professionally to safeguard children and support when dealing with cases can be sought from managers, safeguarding team.

It is important to safeguard children as there are many children in society who are living in difficult situations as shown by the figures below:

- **2.5%** of children under 11 years and **6%** of young people aged 11 – 16 years had experienced some form of maltreatment from a caregiver within the previous year (Radford et al 2011)
- An estimated **250,000 – 350,000** in the UK have parents who are problematic drug users (Home Office 2003)
- In the last year almost 30,000 young people contacted ChildLine about physical abuse (April 2011 – March 2012). However, there are people out there who care and can help put a stop to it (www.

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### OBLIVION

**What?**
- ‘There’s no such thing as child abuse’
- ‘Abuse doesn’t happen amongst people I know’
- ‘Too much is made of abuse – it isn’t that common’

### REALITY

**Enough Awareness to**
- Recognise abusive situations
- Help children who are abused
- Protect children
- Prevent abusive situation

### OBSESSION

‘Everyone Abuses children’
- ‘Abusive is very common in some types of family’
- ‘Any single person who works with children is an abuser’

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**Both extremes can be abusive**

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So far example; If you were on the ‘obsessive’ side of the continuum and have the belief that everyone is an abuser this could lead to increased and unnecessary referrals, loss of objectivity and stress for the families and practitioner. Similarly, if you are of the belief that there is no such thing as child abuse this could lead to children being left in difficult and dangerous situations and not receiving the appropriate safeguarding services. The healthy position to be in is to recognise that children can be abused and at times require protection and that as practitioners we need to be able to recognise abusive situations and work to our roles and responsibility.

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- In the last year almost 30,000 young people contacted ChildLine about physical abuse (April 2011 – March 2012). However, there are people out there who care and can help put a stop to it (www.
• The number of children subject to a child protection plan will vary from month to month, on average the organisation has **585** subject to a child protection plan at any one time
• The category with the highest number of children registered under is neglect, children can be registered under more than one category.

**Safeguarding and promoting the welfare of children is:**

• Protecting children from maltreatment
• Preventing impairment of a child’s health and development
• Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully. (Working Together 2010)

**A definition of abuse is:**
The abuse of power by a person that is developmentally older / stronger than another, resulting in some distress, harm or neglect of necessary attention for the victim.

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or failing to act to prevent harm. A child may be abused in a family or in an institutional or community setting by those known to them or more rarely by a stranger ie: the internet. They may be abused by an adult or adults or another child or children. Abuse of children falls into 4 categories

**Physical Abuse**
Physical Abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may, also be caused when a parent or carer fabricates the symptoms of or deliberately induces illness in a child. In experience, immobile babies do not bruise themselves; bruising of any kind in an immobile baby should be questioned. Parental explanations – fell on a plastic toy or slept on his dummy (a recent explanation for an injury) are often accepted. Often the same story is given to explain a series of injuries.

**Physical abuse may involve the following:**
• Hitting
• Shaking
• Slapping
• Punching
• Suffocating
• Stabbing
• Burning or scalding
• Female genital mutilation
• Prolonged deprivation of food or water
• Inappropriate restraint
• Giving a child alcohol or inappropriate drugs
• Fabricated & induced illness
The following may indicate physical abuse;

- Injuries that the child cannot explain, explains unconvincingly or have not been treated
- Bite marks or cigarette burns, bruising resembling hand or finger prints
- Blunt instrument marks or iron burns
- Immersion burns or scald marks
- Bruising in immobile babies

Sexual Abuse
Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities not necessarily involving a high level of violence whether or not the child is aware of what is happening. The activities may involve physical contact – including assault by penetration for example; rape or oral sex or non – penetrative such as masturbation, kissing, rubbing or touching outside of clothing. This may also include non contact activities such as involving children in looking at, or in the production of, sexual images, watching sexual activities or encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the Internet). Sexual abuse is not solely perpetrated by adult males – women can also commit acts of sexual abuse as can other children.

Sexual abuse may involve the following:
- Physical contact (Inappropriate touching)
- Penetrative sex
- Prostitution
- Use of pornographic material
- Use of internet
- Visual ie: television/videos

Physical signs which may indicate sexual abuse:
- Bites, slaps/grasp/punch marks
- Sexually transmitted infections
- Recurrent urinary tract infections
- Soreness or injury to genitals, anus, thighs, lower abdomen, buttocks
- Soreness in throat or mouth
- Vaginal bleeding / discharge
- Torn, stained or bloody underwear
- Pregnancy

Emotional signs which may indicate sexual abuse
- Sexual knowledge inappropriate for age
- Sexualised behaviour in young children
- Sudden changes in behaviour, running away, self harming
- Suicide attempts, night mares, bedwetting
**Neglect**

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance misuse. Once a child is born neglect may involve a parent or carer failing to provide adequate clothing, food/shelter (including exclusion from home or abandonment) or, failing to protect a child from physical harm or danger or ensuring adequate supervision including the use of inadequate care givers or failing to ensure access to appropriate medical care or treatment. It may also include neglect of unresponsiveness to a child’s basic emotional needs.

Neglect may involve failing to provide:
- Food and clothing, shelter including exclusion from home or abandonment
- Emotional warmth
- Access to health care
- Parental substance misuse
- Adequate supervision
- Protection from physical and emotional harm or danger

The following may indicate neglect of a child:
- Unkempt
- Under /overweight
- Inappropriately dressed for conditions / age
- Untreated medical conditions
- Playing out late
- Hungry / stealing food
- Dirty / smelly? (consider circumstances)
- Untreated head lice
- Dental decay

**Emotional Abuse**

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate or valued only in so far as the meet the needs of the other person. It may include not giving the child opportunities to express their views, deliberately silencing them or making fun of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning or preventing the child participating in normal social interaction. It may involve hearing or seeing the ill treatment of another it may involve serious bullying including cyber bulling causing children frequently to feel frightened or in danger or the exploitation or the corruption of children. Some level of emotional abuse is involved in all types of mal treatment of a child, though it may occur alone. *(Working Together 2010)*

A child may believe they are:
- Worthless
- Unloved
- Inadequate
- Experience attachment difficulties
- Inappropriate expectations may be imposed on a child
The following may indicate emotional abuse of a child:
- Physical, mental and emotional developmental delay
- Fear or over-reaction to mistakes, low self-esteem
- Sudden speech disorders, speech delay or mutism
- Fear of new situations
- Inappropriate emotional responses to stressful situations
- Neurotic behaviour
- Self-harming
- Running away, drug/solvent abuse
- Continually putting themselves down
- Frozen awareness
- Parents excessively negative towards child, highly critical/low warmth

What is a Child Looked After?
............ Children who are subject to care orders and those who are voluntarily accommodated.
(Childrens Act 1989)
............ Those looked after by the state, according to relevant national legislation which differs between England, Northern Ireland, Scotland & Wales (NSPCC)
............ Relates to children and young people who are provided with accommodation by Childrens Integrated Services (Clin 35 2010)

Internet Safety- CEOP (Child Exploitation and Online Protection)
CEOP works across the UK to
- Maximise international links to tackle child sex abuse wherever and whenever it happens.
- Provides internet safety advice for parents and carers
- Provides information on internet safety and safe surfing for young people aged 11 to 16 years
- Reporting facility enabling anyone to report any inappropriate or potentially illegal activity with or towards a child online

DO YOU KNOW WHO YOUR CHILD IS TALKING TO?
Hi, you sound really cute, how old are you, what do you do after school
“I’m 14, a bit of a fitness fanatic and I often go power lifting after school.”

99% of children aged 8 – 17 access the internet
90% of children 5 – 16 now have a computer at home (Ofcom, 2008)
74% have internet access at home
24% have broadband at home
22% of boys and 19% of girls had internet access in their bedroom
24% rely on school as main source of internet access
At home less than half of the computers were located in a public place. (Safekids.co.uk)

427 children were subject to safeguarding or protection as a result of CEOP in 2011/2012
Children and young people are not always aware of the risks associated with the internet and social network sites. Parents can also be totally perplexed by the digital world and what their children are accessing.

• Most mobile phones now have internet access which can make children and young people even more vulnerable to the risks of grooming by perpetrators and sites that are not suitable.
• Children under the age of 13 years should not have access to Facebook, and there are systems in place to prevent people under the age of 13 having accounts.
• Young people can develop on line friendships with people that are not known to them placing them at risk of grooming. Sex offenders often take advantage of a young person’s trusting nature and use a range of sophisticated techniques to make contact and establish relationships on line.
• Children and young people are put at further risk if they meet up with people they have met on line.
• Children and young people are not always aware that the internet is a public place and they must be careful about revealing too much personal information about themselves online. This can include the school they attend, their address, 43% of teenagers believe that is completely safe to post personal information on line(Microsoft2010)
• Children and young people can be exposed to sites that are not age appropriate if they lie about their age eg; gaming sites.
• Children and young people need to be aware of the consequences of sharing intimate or nude images online or via their mobile known as sexting.
What to do if you suspect abuse?
It is the responsibility of any person who has knowledge of or suspicion that a child is suffering, or is at risk of suffering significant harm due to abuse, to refer their concerns to the social services department or the police (the police in cases of emergency). Dependant on your role within the organisation concerns may be discussed with your line manager or the child protection team prior to the referral being made, providing this does not cause delay. Familiarise yourself with the Safeguarding Children Procedures and know who to contact if you need support or advice.

For advice please contact the Safeguarding Team:  
Blackpool Office: 01253 651265  
Garstang Office 01995 607622/623/624

Information Sharing

“No enquiry into a child’s death or injury has ever questioned why information was shared. It has always asked the opposite”
(Georgina Nunney – Solicitor Lewisham Making it Happen ECM 2008).

Golden rules for information sharing remember that Data Protection Act is not a barrier to sharing information
• Be open and honest
• Seek advice where in doubt
• Share with consent where appropriate
• Consider safety and well being
• Necessary, proportionate, relevant, accurate, timely and secure
• Keep a record

(Pocket Guide to Information Sharing HM Gov 2008)

How to make the Referral (See flow chart overleaf)
• Have the facts ready and to hand
• May need to gather information from other professionals or agencies
• Determine if a child in need of protection or need of services
• Seek advice from Safeguarding team if unsure
• Use the correct form
• Follow the BtHFT procedures
• Be clear and succinct

If staff feel that their concerns are not being taken seriously or they experience any other barriers to referring a child/family please contact the safeguarding team
Practitioner has reasonable cause to suspect that a child is suffering or likely to suffer, significant harm

**SECTION 47 referral required**

Good practice to gain consent from parent / carer, unless to do so would further endanger the child or practitioner. Do not involve the parents / carer in cases of Fabricated and Induced Illness (FII) and in some cases of sexual abuse, please seek advice from the safeguarding.

**For children residing within North Lancashire boundaries telephone:-**
Contact the Contact Centre and Referral Team by telephone on:-
**08450 530 009 between 8.45am and 5.00pm**
**0845 6021043 Out of office hours and at weekends**
A Central Customer Care Officer will take the initial call and record preliminary details. A Social Worker from the Contact and Referral Team will be available to discuss the case if required.
Offer a clear, concise account of concerns about the child’s welfare specifying whether these require urgent action to safeguard the child.

**Completed referral forms (CAF FORMS) should be forwarded to Social Care WITHIN 48 HRS by either**
FAX: 01772 538223
Or by **SECURE E-MAIL** which can be set up through the following link
http://securemail.lancashire.gov.uk (support for technical problems with this process 01772 532626)

**For children residing within Blackpool boundaries:-**
Contact Children’s Social Care on telephone - **01253 477299**
For Out of Office Hours and at weekends ring **01253 477600**
A Duty Social Worker will record the details of the referral. Provide a clear, concise account of concerns about the welfare specifying whether these require urgent action to safeguard the child.

**Completed Referral forms to be sent within 2 working days to:-**
Duty and Assessment team, Blackpool Social Services Department, The Stadium, Seaside’s Way, Blackpool FY1 6JX  **FAX NUMBER 01253 477009**
**If a medical assessment of the child is necessary Children’s Social Care either Blackpool or Lancashire will arrange for this to be completed.**

If the referrer has not been informed of the outcome of the referral within 48 hours, the referrer must contact Children’s social care / integrated services to determine the outcome of the referral.

A copy of the referral form should be held within the child’s records

Liaise with other health professionals (including the GP) known to have involvement with the child or family and inform them of the referral.
<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Base</th>
<th>Telephone Number</th>
<th>Mobile</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazel Gregory</td>
<td>Head of Safeguarding Children &amp; Adults</td>
<td>Blackpool Stadium</td>
<td>01253 651262</td>
<td></td>
<td><a href="mailto:hazel.gregory@bfwhospitals.nhs.uk">hazel.gregory@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
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<td>07881 518 771</td>
<td><a href="mailto:rebecca.calvert@bfwhospitals.nhs.uk">rebecca.calvert@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Tracy Dixon</td>
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<td><a href="mailto:lisa.farrel@bfwhospitals.nhs.uk">lisa.farrel@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Rebecca Calvert</td>
<td>Named Nurse Children Looked After</td>
<td>Garstang</td>
<td>01995 607624</td>
<td></td>
<td><a href="mailto:rebecca.calvert@bfwhospitals.nhs.uk">rebecca.calvert@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Lisa Farrell</td>
<td>Named Nurse Children Looked After</td>
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</tr>
<tr>
<td>Alison Taylor</td>
<td>Safeguarding Practitioner (Domestic Abuse)</td>
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</tr>
<tr>
<td>Terri Crossland</td>
<td>Specialist Nurse Awaken Team</td>
<td>Blackpool Acute</td>
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</tr>
<tr>
<td>Angela Foster</td>
<td>Named Midwife Domestic Abuse</td>
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<td><a href="mailto:angela.foster@bfwhospitals.nhs.uk">angela.foster@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Andrea Goodey</td>
<td>YOT</td>
<td>Blackpool Acute</td>
<td>01253 477656</td>
<td></td>
<td><a href="mailto:andrea.goodey@bfwhospitals.nhs.uk">andrea.goodey@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Maggie Callaby</td>
<td>Team Secretary</td>
<td>Blackpool Acute</td>
<td>01253 477625</td>
<td></td>
<td><a href="mailto:maggie.callaby@bfwhospitals.nhs.uk">maggie.callaby@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Lynn Grimes</td>
<td>Team Secretary</td>
<td>Blackpool Acute</td>
<td>01253 477630</td>
<td></td>
<td><a href="mailto:lynn.grimes@bfwhospitals.nhs.uk">lynn.grimes@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Marie Haynes</td>
<td>Team Secretary</td>
<td>Blackpool Acute</td>
<td>01253 477630</td>
<td></td>
<td><a href="mailto:marie.haynes@bfwhospitals.nhs.uk">marie.haynes@bfwhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>Julie Swire</td>
<td>Team Secretary</td>
<td>Blackpool Acute</td>
<td>01253 477630</td>
<td></td>
<td><a href="mailto:julie.swire@bfwhospitals.nhs.uk">julie.swire@bfwhospitals.nhs.uk</a></td>
</tr>
</tbody>
</table>

**SAFEGUARDING CHILDREN, YOUNG PEOPLE AND ADULTS TEAM**

- Provides education and training relating to Safeguarding issues
- Supports the development of integrated working with partner agencies in both the independent and statutory sectors.
- Provides advice, guidance and support if you have concerns regarding a child/adult’s welfare.
- Provides advice relating to the health needs of all Children Looked After
- Provides education relating to the health needs of all Children Looked After
- Provides education relating to the health needs of all Children Looked After
- Provides education relating to the health needs of all Children Looked After

**Blackpool Teaching Hospitals NHS Foundation Trust**

**NEVER DO NOTHING!**

It is your responsibility to make a child/adult protection referral to social services if you have a concern regarding a child/adult’s welfare.

Staff can access the Pan Lancashire Safeguarding Children Procedures at:

http://panlancashire.safeguardingchildren.proceduresonline.com/index.htm

Safeguarding Adults Multi-Agency Policy and Procedure at:

http://panlancashire.safeguardingchildren.proceduresonline.com/index.htm

**Social Service Departments - Children Referrals & Adult Alerts**

- **Blackpool Residents**
  - Children Team – 01253 477299
  - Adult Team – 01253 477752
  - Out of Hours – 01253 477760

- **Lancaster, Morecambe, Wyre & Fylde**
  - Children/Adult Team – 0845 053 0009
  - Children/Adult Out of Hours – 0845 602 1043

**Address**

- **Base: Blackpool Stadium**
  - Seaside's Way
  - Blackpool FY1 6JX
  - Fax: 01253 651250

- **Base: Garstang Clinic**
  - Kepple Lane
  - Garstang PR3 1PB
  - Fax: 01995 607628

- **Base: Blackpool Acute**
  - Blackpool Victoria Hospital, Victoria Centre, Whinney Hays Road
  - Tel: 01253 652380
  - Fax: 01253 651250
1. How many categories of child abuse are there?
   (a) One
   (b) Two
   (c) Three
   (d) Four
   (e) Five

2. If a child was unkempt, appeared hungry or was stealing food and had untreated medical conditions, what type of abuse might this indicate?
   (a) Physical
   (b) Emotional
   (c) Sexual
   (d) Neglect

3. If a child had injuries it could not explain, such as cigarette burns, or had been subject to inappropriate restraint, what type of abuse might this indicate?
   (a) Physical
   (b) Emotional
   (c) Sexual
   (d) Neglect

4. What % of children (aged 8-17) have access to the Internet?
   (a) 50%
   (b) 75%
   (c) 86%
   (d) 99%

5. What category of abuse has the highest number of children registered against it?
   (a) Physical
   (b) Emotional
   (c) Sexual
   (d) Neglect

6. How many children were subject to safeguarding or protection enquiries as a result of CEOP in 2011/12?
   (a) 330
   (b) 427
   (c) 439
   (d) 498

7. Who within the Trust has responsibility for safeguarding children?
   (a) Health visitors
   (b) School nurses
(c) Safeguarding team  
(d) Managers  
(e) Everybody

8. **On completion of this unit staff need to:**  
(a) Be aware of support systems for staff  
(b) Know who to contact for advice  
(d) Have an understanding and acceptance that child abuse occurs  
(e) All of the above

9. **In the Trust’s 2011/2012 year, how many children were subject to a child protection plan, on average?**  
(a) 400  
(b) 425  
(c) 472  
(d) 530  
(e) 585

10. **Is it abusive if parents or carers fabricate the symptoms of, or deliberately induce, illness in a child?**  
(a) Yes  
(b) No
Unit 7: Safeguarding Children (Level 1) Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

Forename: (Block Capitals)

Job Title: .................................................................

Department/Ward: ..................................................

Division/Directorate: ...............................................

Date Completed: (This must be within 12 weeks of receipt) ..............................................................

Staff Signature: ........................................................

Manager: (Printname) ................................................

Manager: (Signature) ..............................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: .......................................................
Unit 8
Safeguarding Adults

All staff have a role to play in safeguarding adults. If you as an employee of Blackpool Teaching Hospitals NHS Foundation Trust have concerns about the welfare of any vulnerable adult whilst at work, you have a duty to act upon your concerns.

The aim of this unit is to ensure that vulnerable adults are safeguarded from harm and exploitation. In recent years there have been a number of high profile cases of shocking and systematic abuse of people who rely on others for their personal care, for example the emotional and physical abuse of elderly patients on Rowan Ward, Manchester Mental Health & Social Care Trust and the deaths of Steven Hoskin & Kevin Davies in 2006. These vulnerable adults were subjected to exploitation or physical and emotional abuse.

Safeguarding adults encompasses all aspects of adult protection which enables an adult to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect.

Objectives

• Recognise your responsibility in relation to safeguarding and protecting vulnerable adults
• Recognise signs of abuse / maltreatment
• Participants will be aware of the advice and support available within the organisation
• Know where to access Safeguarding Adults Guidance and Procedures
• Participants will know how to respond when abuse is witnessed, disclosed or suspected

Staff need to:

• Be aware of the support systems in place for staff
• Know who to contact for advice
• Have an understanding and acceptance that abuse can occur

Definitions of abuse

The ‘No Secrets’ document (Department of Health, 2000) identifies that “Abuse is a violation of an individual’s human and civil rights by any other person or persons”. Abuse may consist of a single act or repeated acts of harm and can occur in any relationship and result in significant harm to, or exploitation of the person subjected to it.

A vulnerable adult is a person:

• Who is over the age of 18
• Who is or may be in need of Hospital Trust services and/or Community Care services by reason of age, illness, mental or other disability.
• Who chooses to or may be unable to take care of him or herself.
• Who is unable to protect him or herself against significant harm or exploitation
• Who may not have mental capacity to make a safe decision

All people/persons have the RIGHT to live their lives free from violence and abuse (Human Rights Act 1998). This right is underpinned by the duty on public agencies under the Human Rights Act (2000) to
intervene to protect the rights of citizens. The Act gave all people constitutional rights that were intended to prevent discrimination and unfair treatment. Article 2, 3, 5 & 8 are important when safeguarding adults.

- Article 2: The Right to Life
- Article 3: Freedom from torture (including humiliating and degrading treatment)
- Article 5: Right to Liberty and Security
- Article 8: Right to family life (one that sustains the individual)

**Types of Abuse**

- Psychological
- Physical
- Sexual
- Discriminatory
- Neglect/Acts of Omission
- Organisational/Institutional
- Financial/ Material

**It is important that everyone is aware of the signs and symptoms of abuse.**

Vulnerable adults may not know that they are being abused – so they may not be in a position to bring it to your attention. Some people may have difficulty recognising that money has gone missing or that a particular set of behaviour is inappropriate. Other adults may have communication problems and find it difficult to make themselves understood. In situations like this, you should be particularly vigilant to the possibility that abuse may be taking place.

Some of the signs are common to several types of abuse, others are more specific. These are just some of the signs and symptoms that may raise alarm bells. Remember, signs and symptoms of abuse do not prove that abuse has taken place but they do raise grounds for concern and there is a need for the incident to be assessed and if appropriate, an “alert” raised.

**Physical Abuse**

Physical Abuse and mistreatment is caused either deliberately or by lack of care. It can include hitting, slapping, pushing, kicking, shaking, punching, suffocating, stabbing, poisoning, burning or scalding, drowning, suffocating, inappropriate use of restraints and inappropriate moving and handling techniques. It may also involve misuse of medication including denial of prescribed medication. Physical harm may also occur as a result of prolonged deprivation of food or water.

**Indicators may be:**

A history of unexplained falls or injury, unexplained marks and bruises of varying ages, rope or cigarette burns, unexplained burns or scalds, signs of over and under use of medication and evidence of excessive
or inappropriate use of restraints. There may be changes in the victims behaviour or observation of flinching around the abuser.

**Psychological Abuse**
All abuse is likely to have a psychological impact for the victim. Psychological abuse can be described as acts of behaviour that can cause emotional distress or anguish. These include threats of harm, abandonment or isolation, denial of choice, verbal abuse, humiliation and intimidation. It can also include deprivation of contact with others.

**Indicators may be:**
Appearing very withdrawn, tearful, agitated, being anxious, lacking confidence or presenting with low self esteem. The victim may appear to be fearful or flinching when approached. There may be evidence of self abuse.

**Neglect/Omission**
Neglect is not paying attention to the needs of vulnerable people or leaving them uncared for. It can include ignoring medical or physical care needs and failing to provide access to health or social care. It also includes the withholding essential necessities of life such as medication, heating and adequate nutrition and fluids.

**Indicators may be:**
A poor physical condition, a presence of pressure ulcers, unexplained weight loss, poor hygiene, an unkempt appearance, lack of food and heating. Health staff may have had difficulty in gaining access to the person and medical advice or support may not have been sought.

**Sexual Abuse**
Sexual abuse includes rape, sexual assault, inappropriate touching or sexual acts to which the person has not consented, or is forced into by another person or persons. The vulnerable adult may or may not understand what is happening to them. It can include non contact abuse such as involving an individual in the making of or exposure to pornography. Sexual abuse can be experienced by all ages from young to the elderly regardless of disability, race, culture or gender.

**Indicators may be:**
A significant change in sexual behaviour, over or inappropriate sexualised behaviour, pain, itching to abdominal, genital or anal areas, bruises or bleeding to abdominal, genital or anal areas, bite marks, torn or bloody underwear, sexually transmitted diseases, recurrent urinary tract infections, pregnancy, unusual difficulty in walking or sitting.

**Financial Abuse**
Financial abuse is the illegal or improper use of someone's property, finances or other assets either without their informed consent or where consent is obtained by fraud for example; theft, fraud, exploitation, pressure in connection with property, wills or other financial transactions, misuse of property, possessions or benefits.

**Indicators may be:**
Unexplained withdrawals from bank or building society accounts, unexplained disappearance of financial documents such as bank statements, items from the home disappear, bills not being paid. There may be evidence of a reluctance to pay for goods and services from the person in control of funds.

**Discriminatory Abuse**
Discriminatory abuse is an act (or omission), or remarks showing prejudice towards a person's age, gender, disability, race, colour, sexual or religious orientation.
**Indicators may be:**
A change in a victim's behaviour such as being withdrawn, anxious and/or fearful. There may be a tendency to isolate themselves and a reluctance to go out. A victim of discriminatory abuse may find that because of prejudice they are refused access to services or there is a refusal to attend places that they have previously visited.

**Organisational/Institutional Abuse**
This refers to any activity that is delivered in a way that suits the needs of the organisation and staff rather than the needs of the patient, for example; a staff focussed approach and a rigid routine. Institutional abuse happens when the people working in a place or organisation do not:
- Value all people equally
- Understand that different people have different needs
- Change the way they deliver a service so that it meets different needs.
Institutional abuse often happens over a period of time – staff become used to it and may not realise it is wrong. It may be intentional or due to ignorance or thoughtlessness. It can include whole staff teams and can range from neglect to outright assault. If staff become aware that abusive practice is occurring within an organisation but take no action to deal with the abuse it can then become part of the organisational culture.

**Abuse is everyone’s business**
We all have a responsibility to protect vulnerable adults from being abused by the people they come into contact with.

---

**Abuse can happen in:**
- A residential care home
- A hospital
- A day care unit
- In any collective care settings

**Anyone can be an abuser:**
- Family
- Doctors
- Nurses
- Social care staff

**Vulnerability is increased:**
- By the situation people find themselves in
- By dependence on others (physical needs or financial needs)
- When at risk from those who intend to harm
- When at risk from those who do not understand what they are doing
- When at risk from self!
Mental Capacity
Sometimes a vulnerable adult may lack the mental capacity to make key decisions in their lives, like where to live or whether to accept care and treatment. Legislation to protect people at times like this is now in force via The Mental Capacity Act 2005 (MCA). The Act makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

The consideration of capacity is crucial at all stages of Safeguarding Adults procedures and informs issues to be considered around consent and decision making. For example:
- Choosing to remain in a situation where a vulnerable adult risks abuse
- Determining whether a particular act or transaction is abusive or consensual
- Determining how much a vulnerable adult can be involved in making decisions in a given situation.

Capacity to consent means:
- You do things of your own free will ie; you act as an autonomous person.
- You can understand and retain basic information and use and weigh up the information to process it through to a logical outcome or conclusion by communicating it by any means.
- There has been no undue influence or pressure on you in arriving at your decision

If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in their best interests.

The Deprivation of Liberty Safeguards (DOLS) came into force on 1st April 2009 and provides a legal framework for Local Authorities and Primary Care Trusts to authorise the deprivation of a person’s liberty if it is deemed to be in their best interests – and necessary to protect them from harm. These safeguards are only applicable to those adults who lack capacity to decide about their care and treatment and who are resident in either a care home or a hospital and where intensive use of restriction and restraints are being used on the person and will need to be on-going to receive care and treatment. The safeguards are not to be applicable to Adults detained under the Mental Health Act 1983, who have safeguards already in place.

The deprivation of a person’s liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned. Where possible we should always look for the least restrictive option for the person that is in their best interest.

Identification of Abuse
A staff member may have concerns following:
- A direct disclosure by the adult, a service user may inform you that they have / or experienced abuse.
- A third party report highlighting concerns about an adult who potential may be vulnerable
- An observation of the behaviour, the presentation of the adult or the circumstances within which they find themselves.

Dealing with disclosure and confidentiality - Disclosures can come in many forms and are quite often unexpected. Disclosures may come from victims of abuse and from the abusers.

When a disclosure is made, health staff must:
- Stay calm and try not to show shock or disbelief.
- Reassure the person that they are doing the right thing
- Recognise that abuse is happening
- Listen carefully to what is being said and allow the person to freely recall events.
- Avoid asking detailed or probing questions.
- Explain about sharing information/confidentiality. Don’t make promises you cannot keep.
- Ask the person about their views and what they think should happen next.
- Consider the risks to others, adults and children. There may be a potential for more than one person to be at risk due to the concern you have.
Responding to a disclosure

- Follow the Safeguarding Adults procedure for Blackpool Teaching Hospital NHS Foundation Trust (found on the intranet)
- Ensure the immediate safety of the adult
- Seek medical help if needed, In an emergency call 999
- Preserve evidence if appropriate
- Complete a clear objective record of what was disclosed/witnessed and actions taken
- Complete an untoward Incident report (UIR)
- Raise the Safeguarding alert with the appropriate Local Authority (Where the abuse has taken place) - see flowchart.
- Discuss with an appropriate colleague/line manager
- Inform the Safeguarding team of the incident and any actions taken.

Raising the Alert

Do you have concerns that a vulnerable adult has been abused?

Is the person (or yourself) at risk or in any immediate danger of further abuse?

Discuss concerns with the person – consider capacity consent and confidentiality.

If appropriate discuss concerns and the potential need to report and alert with an appropriate colleague for advice. For example Supervisor: Line Manager, Safeguarding Team.

Discuss concerns with the person – consider consent and confidentiality.

TAKE IMMEDIATE ACTION TO MAKE THE SITUATION SAFE
IN AN EMERGENCY DIAL 999

If not appropriate or colleague unavailable

As soon as possible record any disclosures or observations related to the incident. Remember to sign, date and time the record.

Complete Untoward Incident Report (UIR)

Any concerns relating to a response from Adult Social Care should be discussed with the safeguarding team. For advice please contact the Safeguarding Team:

Blackpool Office: 01253 651262/651265
Garstang Office: 01995 607622/623/624
Unit 8 assessment:  
Safeguarding Adults

1. Who within the Trust has responsibility for safeguarding adults?
   (a) Adult Services
   (b) Safeguarding Team
   (c) Managers
   (d) Everybody
   (e) Social Services

2. What type of abuse are adults likely to suffer from?
   (a) Psychological
   (b) Financial / material
   (c) Sexual
   (d) Neglect / acts of omission
   (e) Discriminatory
   (f) Physical
   (g) All of the above

3. Susan spots a lady eating lunch outside the dining area. When she asks why she is not eating with everyone else, she is told that it is as a punishment for making a noise during the night. Does this constitute abuse?
   (a) Yes
   (b) No

4. A gentleman resident in a care home is not given support to undertake Muslim worship. Is this abusive?
   (a) Yes
   (b) No

5. Michael is blind, has learning disabilities, and lives in a care home posing no risk to anyone but himself. However, you are told that when he becomes agitated you must lay him face-down on the floor and restrain him until he calms down. Which group of abuses is this?
   (a) Discriminatory, physical, neglect / act of omission
   (b) Discriminatory, physical, psychological
   (c) Institutional / organisational, physical, psychological

6. Unexplained injuries and falls, marks and bruises, and cigarette burns may be indicators of which type of abuse?
   (a) Neglect
   (b) Physical
   (c) Sexual
   (d) Financial
   (e) Psychological
7. Which type of abuse shows prejudice towards a person’s age, gender, disability, race, colour, sexual or religious orientation?
(a) Neglect
(b) Physical
(c) Psychological
(d) Discriminatory
(e) Sexual
(f) Financial

8. In what year did Deprivation of Liberty Safeguards come into force?
(a) 2008
(b) 2009
(c) 2010
(d) 2011

9. Can you deprive someone of their liberty if they have capacity?
(a) Yes
(b) No

10. What legislation protects people who lack the mental capacity to make key decisions in their lives?
(a) Mental Capacity Act (2005)
(b) Human Rights Act (1998)
(c) No Secrets (2000)
Unit 8: Safeguarding Adults Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

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Surname: (Block Capitals)

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Forename: (Block Capitals)

........................................................................................................................................................................

Job Title: ................................................................................................................................................................

Department/Ward: ..................................................................................................................................................

Division/Directorate: ............................................................................................................................................

Date Completed: (This must be within 12 weeks of receipt) ..............................................................................

Staff Signature: .....................................................................................................................................................

Manager: (Printname) ...........................................................................................................................................

Manager: (Signature) .............................................................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: .............................................................

VERSION 4 - JUNE 2014
Equality is about treating individuals fairly, supported by legislation designed to address unfair discrimination that is based on membership of a particular group. Diversity is about the recognition and valuing of difference; creating a working culture and practices that recognize, respect, value and harness differences for the benefit of the organization and the individual.

Equality and diversity are not inter-changeable but are inter-dependent. There is no equality of opportunity if difference is not recognised and valued.

Definition of Disability
Under the Disability Discrimination Act a person has a disability if they have: A physical or mental impairment, which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities and has lasted or is likely to last 12 months or over.

The equality Act 2010 brings together all equality legislation and increases the protected characteristics:

Race
Religion/ Belief
Disability
Gender
Sexual Orientation
Age

There are three new areas which are:

Gender Identity (or assignment)
Pregnancy and Maternity
Marriage and Civil Partnership

Pre-employment Health-related Checks
The Equality Act limits the circumstances when employers can ask health-related questions before you have offered the individual a job. Up to this point the employer can only ask health-related questions to help you to:

a. Decide whether you need to make any reasonable adjustments for the person to the selection process
b. Decide whether an applicant can carry out a function that is essential (intrinsic) to the job
c. Monitor diversity among people making applications for jobs
d. Take positive action to assist disabled people
e. Assure yourself that a candidate has the ability where the job genuinely requires the jobholder to have a disability (e.g. a counselling service for people with mental health conditions requires a
counsellor who has personal experience of mental health conditions. At interview employers are allowed to ask if candidates have the condition).

Public Sector Duties
The race, disability and gender duties are known as public sector duties. They are statutory duties, meaning that they are legally enforceable. All public bodies (like councils and hospitals) that are subject to the duties are legally obliged to pay ‘due regard’ to the need to take action on race, disability and gender equality. In the Equality Act 2010 the duties are extended to include other protected characteristics but gives only partial cover for marriage and civil partnership in relation to employment and vocational training.

General and specific duties
The legislative framework has two main components: the general duty and the specific duties. The general duty sets out the main objectives of each of the duties, whilst the specific duties are the steps that public bodies have to take to help them to meet the general duty. Although the specific and general duties vary for race, disability and gender, all three duties share a common vision: for public services to mainstream equality to ensure that all individuals are able to benefit equally from public services, regardless of their race or gender, or whether or not they are disabled.

Human Rights
The Human Rights Act 1998 came into force in October 2000 and enabled people to enforce the European Convention on Human Rights in the UK courts. Article 14 of the Human Rights Act 1998 refers to the prohibition of discrimination, and states that the enjoyment of the rights and freedoms set out in the European Convention on Human Rights shall be secured without discrimination on the grounds of sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

All staff have a responsibility to ensure that equality is integral to their day to day activities and understand the need to adopt a proactive approach, in mainstreaming equality into all decisions and activities. All staff have a responsibility to be aware of the Single Equality Scheme and all other Trust’s policies which reflect equality and diversity and equality of opportunity.

All staff are to understand the core dimension for equality and diversity in accordance with their job description and the Trust’s expectations regarding dignity and respect.

Completing this section on equality and diversity does not qualify you for full competency sign off on this topic. Staff must complete either the half day (the e-learning programme is an equivalent substitute for the half day only) or full day training day depending on your job role. Please contact OLM via email OLM@bfwhospitals.nhs.uk or on ext 5392 to book a place on the course.

Additional equality and diversity workshops on specific topics are held throughout the year. Please watch for information being posted on the intranet.

Discrimination Definitions Direct Discrimination takes place when one person or group of people are treated less favourably than other people on the grounds of their race, sex, disability, sexual orientation, religion or belief, marital status, age, creed, colour, nationality, national origin or ethnic origin. This includes discrimination on the grounds of perceived characteristics whether or not that perception is correct. It can also be directed against someone because they associate with or defend someone of a particular group, even though they are not a member of that group themselves.
**Associative Discrimination**
This is direct discrimination against someone because they associate with a person who possesses a protected characteristic e.g. race, religion or belief, sexual orientation, disability, age, gender, gender reassignment, marriage and civil partnership and pregnancy and maternity.

**Perceptive Discrimination**
This is direct discrimination against an individual because others think they possess a particular protected characteristic e.g. age, race, religion or belief, sexual orientation, disability, gender reassignment and gender. It applies even if the person does not actually possess that characteristic.

**Indirect Discrimination** takes place when a criterion, provision or practice is applied which adversely affects, or favours, one particular group more than another and cannot be shown to be a proportionate means of achieving a legitimate aim (and so is not justified). Examples are:

- insisting on an unnecessary physical requirement which might discriminate against women or people with disabilities;
- using marginally relevant employment experience such as minimum time spent in a particular occupation rather than facts about performance in a range of tasks.
### Barriers - Questions to consider

<table>
<thead>
<tr>
<th>Category</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical / Environmental</td>
<td>Are buildings, activities, physically accessible to everyone? Is the building in the best location to meet everyone's needs? e.g. older people, wheelchair users, young children and carers, people living in isolated locations.</td>
</tr>
<tr>
<td>Sensory</td>
<td>Can they be used by people with hearing or visual impairments? What adjustments need to be made?</td>
</tr>
<tr>
<td>Intellectual</td>
<td>Do people who do not have extensive background knowledge or people for whom English is an additional language feel excluded? Can they be used by people with learning disabilities?</td>
</tr>
<tr>
<td>Cultural</td>
<td>Are the interests, life experiences and culture of the whole community reflected and represented?</td>
</tr>
<tr>
<td>Attitudinal</td>
<td>Is the ward or department welcoming, especially to new users? Do people feel confident in using it? Do staff have an open attitude to diversity? Are we focusing on people - our users and potential users?</td>
</tr>
<tr>
<td>Financial</td>
<td>Secured or prioritised funding – ‘core’ or ‘project specific’?</td>
</tr>
<tr>
<td>Information</td>
<td>Are our services marketed effectively to all potential users? Do we provide equal access to all our resources? Is information provided in alternative formats, Plain English, community languages etc?</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Are users and potential users consulted? Do we value their input and work in partnership to develop services and facilities that are wanted?</td>
</tr>
<tr>
<td>Employment</td>
<td>Do we follow employment law and actively promote equal opportunities in recruitment and staff development? How far does our workforce reflect the diversity of the community?</td>
</tr>
<tr>
<td>Technological</td>
<td>Does our use of ICT and new media, such as websites, facilitate access for everyone? Do we exploit new technology to enable greater access?</td>
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</tbody>
</table>

### Positive Action

The Equality Act allows employers to take positive action if they think that employees or job applicants who share a particular ‘protected characteristic’ suffer a disadvantage connected to that characteristic, or if their participation in an activity is disproportionately low.

Formerly known as ‘strands’, in the Equality Act they are referred to as ‘protected characteristics’ and have been extended to include three new areas. These are: Gender, sexual orientation, race, disability, age, religion and belief, pregnancy and maternity, marriage and civil partnership and gender identity/reassignment.
Unit 9 assessment: 
Equality & Diversity

1. Equality is about treating individuals fairly, supported by legislation designed to address unfair discrimination?
   (a) True
   (b) False

2. What is the definition of ‘disability’ for the purposes of the disability discrimination legislation?
   (a) It’s defined as a physical impairment which prevents people walking more than a hundred yards or a mental impairment which requires specialist care in a hospital or other medical institution.
   (b) It’s defined as a physical or mental impairment which has a substantial and long-term adverse effect on ability to carry out normal day-to-day activities and has lasted or is likely to last 12 months or over.
   (c) It’s defined as a physical or mental impairment which has a substantial or long-term adverse effect on ability to carry out normal day-to-day activities.

3. What has Article 14 of the Human Rights Act got to do with equality?
   (a) It refers to the prohibition of discrimination on various grounds, including sex, race, etc.
   (b) It refers to the prohibition of discrimination against prisoners and grants them the right to lead ‘a normal family life’.
   (c) It refers to the prohibition of discrimination on the specific grounds of sex, race, colour, and religion.

4. Do the laws also protect someone who is not in the protected groups but associates with someone who is?
   (a) No
   (b) Yes

5. Does the Equality Act limit the circumstances under which employers can ask health-related questions?
   (a) Yes
   (b) No
Unit 9: Equality & Diversity Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

Forename: (Block Capitals)

Job Title: ...........................................................................................................................................

Department/Ward: ...............................................................................................................................

Division/Directorate: ...........................................................................................................................

Date Completed: (This must be within 12 weeks of receipt) ...............................................................

Staff Signature: ....................................................................................................................................

Manager: (Printname) ............................................................................................................................

Manager: (Signature) .............................................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, Blackpool Stadium, Seaside Way, Blackpool, FY1 6JX

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: .................................................................
HEALTH AND SAFETY AT WORK ACT 1974
Scope of the Health and Safety at Work Act
This is the main piece of legislation
1. Everyone in the Trust has legal duties under the Act.
2. Everyone in the Trust is protected by the Act.
3. The Act allows Health and Safety Executive (HSE) inspectors to visit work areas and help us improve the performance of all Staff in how we manage Health and safety.

General provisions of the Act

1. Under the Act, the Trust has a legal duty to provide:
   a. safe plant and equipment, and safe methods of work
   b. safe use of work articles and substances
   c. information, instruction, training and supervision
   d. a safe place of work with safe access and egress
   e. a safe work environment with adequate welfare facilities.

2. Under the Act, you as an Employee have legal duties to:
   a. safeguard your own safety and health and that of others who may be affected by your actions
   b. co-operate with your employer to help them comply with their legal duties
   c. not interfere with anything provided for health and safety.

Penalties

Breaches of the Act are criminal offences which may be punished by fines or prison or both. Individuals, as well as companies, can be prosecuted for breaches of the Act.

LEGAL DUTIES OF EMPLOYEES
Framework of Health and Safety Law

The Health and Safety at Work Act 1974 provides general guidelines on the way in which work activities are to be carried out. More detailed guidance is provided through the issue of regulations which also carry the full force of law.

Employees’ legal duties under the Health and Safety at Work Act

1. You must safeguard your own health and safety and that of others (e.g. other operatives and members of the public) who may be affected by your actions
2. You must co-operate with your employer to help them comply with their legal duties
3. You must not interfere with anything provided for health and safety.
Employees’ legal duties under regulations
Some of the legal duties imposed on employees by Regulations are:

• General safety – to follow the training and instructions provided when using machinery, equipment, dangerous substances, transport equipment or safety devices. Report any defects which you believe could endanger Health or Safety.

THE BENEFITS OF SAFETY
Be safe, be sure

1. For years, workplaces have had a poor safety record with far too many accidents and too much ill health.
2. Too many accidents are caused by people who knowingly work or behave in an unsafe manner.
3. With care, most accidents are totally and easily preventable.
4. When you are working, be aware of the safety of others as well as yourself. You have a legal duty to do so.

What you must do
1. Comply with safety training and instruction, and with safety rules; Trust and Departmental induction should inform you of the hazards.
2. Avoid the temptation to cut corners to get the job done more quickly: there could be a high price to pay.
3. Be aware of how the job you are doing could affect other people around you.
4. Consider the effects of medication, alcohol and illness on your ability to work safely and take a responsible approach.
5. Ask your manager or supervisor if you have any doubts on safety issues.
6. Report to your manager or supervisor anyone who you see working or behaving in an unsafe manner.

The costs of accidents
1. A poor safety record could result in the Trust being fined and suffering increased insurance premiums.
2. Money lost like this cannot be used elsewhere, so this is a waste of resources.
3. Employees and supervisors who demonstrate or tolerate poor safety practice may find themselves out of work.
4. The personal cost of knowing that you have caused a serious accident, or worse, could last a lifetime.

The benefits of safety
1. Fewer accidents, resulting in less pain and suffering.
2. Individuals have less time off, avoiding possible loss of personal income.
3. Less disruption to the job as a whole with less inconvenience to individuals and the Trust.
4. Fewer accident investigations, fines and insurance premium increases; more money available for other things.
5. Higher employee morale and a more contented workforce.

REMEMBER ACCIDENTS ARE CAUSED BY UNSAFE PEOPLE CREATING UNSAFE SITUATIONS
**Risk Assessment**

**Definitions**

1. Hazard – anything with the potential to cause harm but doesn’t necessarily have to.
2. Risk – the likelihood of the hazard causing harm.
3. Risk assessment - determining the measures that need to be taken to reduce the risk of the hazard causing harm.

**Employer Responsibility**

1. There is a legal requirement under the Management of Health and Safety at Work Regulations 1999 to identify hazards and undertake risk assessment.
2. Some pieces of legislation specifically ask for risk assessments to be undertaken e.g. COSHH, noise.
3. Risk assessments should be easily accessible and all staff should be aware of their contents in relation to the job they do.
4. Risk assessments need to be kept up to date and relevant and should be reviewed either
   - when there has been a significant change e.g. new member of Staff, the introduction of new machinery or processes, or
   - there has been a major accident or near miss, or
   - it has been 18 months since the last review.
5. Risk assessment is a management responsibility and must be undertaken by a competent person.

**There are 5 steps to risk assessment**

1. Identify the hazards
   a. This should be done with some input from the persons undertaking the task.
2. Decide who can be harmed and how
   a. Again consultation should be made with staff to ensure that everyone at risk has been identified.
3. Identify what controls are already in place and what further controls are required to make the task safer
   a. Again there should be some input from the persons undertaking the task as they understand what works and what doesn’t work
   b. Employees should be involved in steps 1 – 3.
4. All significant findings need to be written down using the Trust’s Risk Assessment Pro-forma
   a. This has to be done by a “competent person” e.g. someone who has a good understanding of the processes being looked at, the competence of Staff undertaking those tasks, and the working environment including any equipment in use.
5. Review risk assessments to ensure they are still valid and appropriate.
Your Duties

1. Out of risk assessments should come safer ways of working, some of which may be written down as Safe Working Practices or protocols.
2. As an employee you have a duty to comply with and follow safe systems of work devised.
3. If you think what is being asked of you is unworkable or liable to create different hazards, then you must discuss this with your Manager. You should never disregard a safe system of work unless it is in an emergency and to follow them would put someone’s life at risk.

REMEMBER:
RISK ASSESSMENT IS NOT A PAPER EXERCISE; IT IS THERE TO HELP KEEP YOU SAFE AND PREVENT ACCIDENTS.

Accident reporting

1. All people on site must ensure that all accidents, no matter how minor, are recorded in the Trust’s Accident Reporting form, which can be found on the Trust’s Intranet System.
2. Health and safety law requires that the following types of accident are reported to the HSE (Health and Safety Executive):
   • fatalities and major accidents;
   • injuries resulting in more than 3 days off work or inability to carry on with normal work;
   • dangerous occurrences.
3. By receiving such accident reports the HSE can establish accident trends, highlight areas of weakness and effectively target preventative measures.
4. All people on site must ensure that all accidents, no matter how minor, are recorded in the Trust’s Accident Reporting form, which can be found on the Trust’s Intranet System.
5. In the future, you may want to establish a link between a current health problem and a previous accident to claim compensation.
6. Accidents to members of the public arising out of Trust activities must also be reported.

Accident investigation

1. The Trust has a duty to thoroughly investigate all accidents to establish the cause and prevent recurrence.
2. The HSE will also investigate fatalities and other serious accidents.
3. If you are involved in an investigation:
   a. listen carefully to the questions and remain calm
   b. state honestly what you saw or heard
   c. do not be afraid to say when you do not know an answer
4. Remember that the reason for the investigation is to prevent the accident happening again.
RIDDOR
TRANSPORT SAFETY

Delivery Vehicles

1. Large vehicles often have to reverse into small spaces. Do not block access roads etc where delivery vehicles are regularly used.
2. DO NOT cross behind reversing delivery vehicles, the driver may not have seen you.
3. When loading or off loading a delivery vehicle use good manual handling techniques.
4. If walking near vehicles being loaded/unloaded be aware that objects can fall from vehicles.

Driver Safety

1. Leave sufficient time to reach your destination. Don't break the national speed limits.
2. If the journey is longer than 2 hours, take a break of 15-20 minutes every 2 hours or sooner if you feel tired.
3. Always leave at least 2 car's length between you and the vehicle in front.
4. Be considerate to other road users and follow the Highway Code.
5. When reversing look out for pedestrians and obstacles.

Pedestrian Safety

1. Always walk in the demarked areas designated for pedestrian use.
2. NEVER walk behind a vehicle when it is reversing. There are “blind spots” on all vehicles and the driver may not see you.
3. Do not enter a loading/delivery bay area unless you are authorized to do so.
4. If you are involved in the loading/unloading of vehicles use good manual handling techniques.

REMEMBER:
TRANSPORT CAN KILL – DO NOT BECOME A STATISTIC
NEEDLESTICK INJURIES

Outline
This section will cover the actions you should take if you discover a needle or if you prick your skin with it.

What is a needlestick injury?
An accidental puncture of the skin by any clinical sharp including a hypodermic needle, blade, suture etc, it does not have to have been in contact with a patient.

If you find a needle
1. It may have been used by a person carrying a blood borne virus and may be contaminated by infected blood
2. If you must move the syringe or needle:
   a. carry it with the needle pointing downwards;
   b. do not wrap it in paper or put it into a litter bin, dispose in an appropriate sharps bin;
   c. wash your hands thoroughly.

If you prick your skin
1. Do not panic.
2. Gently squeeze the area around the wound to encourage bleeding.
3. Do not suck the wound.
4. Wash the site of the injury thoroughly with soap and warm water at the first opportunity.
5. Apply a waterproof dressing.
6. Attend either Occupational Health or A&E for treatment immediately.

If the Source of the Sharps Accident can be identified
1. The doctor responsible for the care of the patient should obtain 10 mls of the patients blood for testing (with the consent of the patient).
2. This should be sent to the laboratory as an urgent specimen.
3. An Accident/incident form should be completed and this taken to the Occupational Health Department (or if out of hours) the A&E Department, where 10 mls of blood will be taken for comparison.

If the Source of the Sharps Accident cannot be identified
1. Advice should be sought from the Occupational Health Department (or if not available Infection Control) where the source is unknown or the testing consent cannot be obtained
2. If the injury occurs from a rubbish bag, it may be possible to trace the bag back to a ward or department, where a check can be undertaken for “High Risk” patients
3. An Accident/incident form should be completed and this taken to the Occupational Health Department (or if out of hours) the A&E Department, where 10 mls of blood will be taken for comparison
4. If dealt with properly and promptly, the risks of a resulting health problem are minimal
5. Think about the consequences of not acting promptly and possibly being off work for several weeks while you recover.
REMEMBER:
IF YOU SUFFER A NEEDLESTICK INJURY AND DO NOT FOLLOW THIS GUIDANCE, YOU COULD BE EXPOSED TO THE HIV VIRUS, HEPATITIS B OR HEPATITIS C – ALL OF THEM VERY UNPLEASANT

ERGONOMICS

General information.

1. Ergonomics is concerned with the “fit” between people and their work.
2. It puts people first taking into account their capabilities and limitations.
3. Tasks, equipment, information and environment should suit each worker.
4. To assess the “fit” between a person and their work, you have to consider many aspects:
   • job being done and demands on worker
   • equipment (how appropriate etc)
   • information
   • physical environment
   • social environment

Physical aspects of person
   • body size/shape, fitness/posture
   • senses/stresses/strains on muscles/joints/nerves

Psychological aspects
   • mental abilities, personality, knowledge/experience

Improving Health and Safety

1. Applying ergonomics reduces the potential for accidents, injury and ill-health and improves performance and productivity.
2. Consider the layout of controls and equipment, these should be positioned in relation to how they are used.
3. The items most often used, should be placed within easy reach without the need for stooping, stretching or hunching.

Workplace Problems
Ergonomics can resolve the following issues:
DSE (Display Screen Equipment)

- poorly positioned screen e.g. too high/low/close/far/offset
- mouse too far away and requires stretching to use
- Chairs not properly adjusted
- Glare on screen from overhead lights or windows
- Hardware/software not suitable for task/person causing frustration/distress
- Not enough breaks/changes of activity

**Risk of poor productivity, stress, eye strain, headaches**

Manual Handling

- load too heavy/bulky placing unreasonable demands on person
- load lifted from floor or above shoulders
- frequent/repetitive lifting
- awkward postures e.g. bending/twisting
- load cannot be gripped properly
- uneven/wet/sloping floor surfaces
- time pressures/too few rest breaks
- there are 33 vertebrae in the human spine

**Risk of low back pain/injury to arms/hands/fingers**

Work related stress

- work demands too high/low
- employee has little say in how they organise their work
- poor support from management/colleagues
- conflicting demands e.g. high productivity/quality

**Risk of work related stress could lead to ill-health and reduced performance/productivity**

Solutions

1. A minor alteration may be all that is necessary to make a task easier/safer to perform:
   - height adjustable chairs
   - removing obstacles from under desks for more leg room
   - storage on shelves – most frequently used/heaviest stored between waist and shoulder height
   - raised platforms to reach badly placed controls
   - job rotation to reduce physical/mental fatigue
2. Any alterations should be properly evaluated by people who do the job.
3. Be careful that a change introduced to solve one problem does not create another.

**REMEMBER:**

GOOD ERGONOMICS SENSE MAKES GOOD ECONOMIC SENSE.
IT DOESN’T HAVE TO COST A LOT TO REDUCE INJURIES OR ABSENCE FROM WORK

DISPLAY SCREEN EQUIPMENT

1. A work station consists of a desk, chair, surrounding environment, computer and its peripherals
2. Know how to adjust your chair and workstation to reduce the risk of Muscular skeletal injury
Positioning
- Adequate lighting, contrast, no glare or distracting reflections
- No distracting reflections
- Distracting noise minimised
- Leg room and clearance to allow postural changes
- Window covering if needed to minimise glare

Software:
- Appropriate to task and, if necessary, adapted to user
- No undisclosed monitoring

Screen
- stable image, height and angle adjustable, readable and glare/reflection-free

Keyboard
- Usable, adjustable, detachable and readable

Work surface
- Space for equipment and documents
- Glare free

Chair
- Stable and adjustable with good lumbar support
- Footrest if user needs one
- No excessive pressure on underside of thighs or back of knees
- No obstacles under the desk
- Forearms approximately horizontal and wrist not excessively bent
- Space in front of keyboard to support hands and wrists during pauses in typing

3. If you don't know how to do it, ask your manager for assistance
4. If you begin to suffer from persistent headaches, tingling/numbness in fingers/arms, neck ache or backache, you should report these early symptoms to your manager
5. Breaks from the screen
   a. Your job should be varied enough to give you natural breaks from viewing the screen, e.g. filing, answering the telephone, conversations etc. If you do have a job that does not give you natural breaks e.g. data inputting, you must discuss with your manager how breaks from viewing the screen can be achieved
6. Eye Sight Tests
   a. Please refer to the DSE policy
7. Self Assessments can be carried out and this needs to be given to your manager for review.

SLIPS
1. Spilt liquids on the floor (whether intentional or accidental) are the biggest causes of slip accidents.
2. Dust on smooth floor surfaces (especially talc) can also cause a person to slip.
3. If you spill something on the floor, or if you come across a spillage, it is YOUR responsibility to ensure it is cleaned up.
4. Where possible cordon off the area or warn others of the risk.
5. If it is possible, you clean it up – it is not necessarily a domestic’s responsibility.
6. Plastic document pockets are particularly slippy and should not be placed on the floor – no matter how temporary.

**TRIPS**
1. Trips hazards are all around us and are usually caused by other people not thinking.
2. Always close desk and filing cabinet drawers after use.
3. Look for trip hazards when using extension leads etc. Use cable tidies or tape loose wires to the floor, the bed or to the desk.
4. Don’t leave bags etc in areas where people walk, trip over or get their foot stuck into straps/handles.
5. Clear away rubbish regularly – don’t let it build up.
6. Rugs and mats should be fitted correctly – report any defects.

**FALLS**
1. Many falls occur when people use the wrong equipment when accessing high shelving.
2. Chairs and desks are not access equipment and should not be used.
3. Try to avoid storing above head height or if you do, ensure it is items, equipment etc that you only access rarely.
4. Only step stools, step ladders or ladders should be sued to access high shelving.
5. Make sure a specific risk assessment is carried out if you are required to work alone and at height.

**AVOIDING VERBAL OR PHYSICAL HARM**

**VERBAL HARM**

1. Try not to keep people waiting either when answering the phone or dealing with a “customer”. Waiting to be “seen” can annoy people and make them potentially aggressive.
2. Listen attentively and make notes to aid understanding. Don’t be frightened to ask questions if you are not sure, to clarify points.
3. Sound and appear interested, it may have been the 100th time for you today, but it may be the first time for that person.
4. Even if you are unable to help, ensure that the enquirer is passed on to the right person who may be able to help them.
5. Avoid the use of jargon. Don’t presume that people know our routines or systems.
6. Give clear responses and explanations at all times

**REMEMBER:**
**SPEAK TO OTHERS HOW YOU WOULD LIKE TO BE SPOKEN TO**
PHYSICAL HARM

1. Always let people know where you are going and your expected return time.
2. Where persons are known to have a history of violence, take necessary precautions e.g. not working alone with them.
3. When talking to persons who may lash out, keep at least one leg length away and stand slightly to one side to reduce the impact of any attack.
4. If you are working off site, be aware of where you are parking your car e.g. park near street lighting, avoid quiet areas, work in pairs.
5. When working off site, keep in regular contact with your base, make sure that people know where you are, where you expect to be and when you should return.
6. Have a means of raising the alarm with you at all times i.e buddy system, lone workers device
7. Property is not as important as your life, it is better to let a potential attacked to have the property, than get hurt.

REMEMBER:
BETTER TO BE A LIVE COWARD THAN A DEAD HERO!!

DEALING WITH VERBAL ABUSE

Potential consequences of Verbal Abuse

1. Escalation into physical assault.
3. De-moralisation which can lead to poor performance or mistakes.
4. Increased sickness levels.
5. Higher stress levels.
6. Higher turnover of staff.
7. Difficulties attracting new staff.
8. Increased incidents of litigation.

What actions can be taken to prevent escalation of the incident

1. Remain calm, keep breathing naturally to prevent yourself becoming tense.
2. Explain as fully as possible, keeping the person talking can allow their anger to dissipate.
3. Give the person details of what they can do if they are still unhappy.
4. Limit the time ‘on hold’ if using the telephone. Consider ending the call or transferring the caller to the 6666 number if this is available to you.
5. Empathise with the individual if appropriate.
6. Don’t keep people waiting longer than is absolutely necessary
7. Be conscious of both your and the other person’s body language
8. All Verbal abuse incidents should be reported on the Trust’s Incident report form

REMEMBER:
VERBAL ABUSE COULD TURN TO PHYSICAL ABUSE IF NOT MANAGED PROPERLY

DEALING WITH PHYSICAL ASSAULTS

Be mindful of events that could lead to a physical assault

1. Provide clear communications to staff, patients and visitors.
2. Keep areas well maintained and clean.
3. Be aware of body language including your own
4. Move any portable equipment that could be used as a weapons, especially from known aggressors.
5. Plan your escape, do not become cornered.
6. If you feel uncomfortable alert others, gather support.
7. Raise the alarm, contact the police.
8. Let others know of previous or suspected problems.
9. Remain calm, keep breathing naturally to prevent yourself becoming tense.
10. Explain as fully as possible, keeping the person talking can allow their anger to dissipate.
11. Give the person details of what they can do if they are still unhappy.
12. Inform a manager.
13. Empathise with the situation if appropriate.
14. Don’t keep people waiting longer than is absolutely necessary.
15. All physical assaults should be reported on the Trust’s Incident report form.
16. Familiarise yourself with safe areas and location of telephone points to summon assistance.

If you have been involved in a serious assault, support is available from your manager, the Health & Safety Department or from Occupational Health Department.

REMEMBER:
Physical Abuse is not acceptable, incidents should be reported and perpetrators should be identified.
Unit 10 assessment:
Health and Safety

1. What is the main piece of Health and Safety legislation?
   (a) Management of Health and Safety Regulations 1999
   (b) Health and Safety at Work Act 1974
   (c) Safe Acts for Employees 1991

2. What is a hazard?
   (a) Something with the potential to cause harm
   (b) An accident
   (c) Chances of injuring oneself

3. How many steps are there in a risk assessment?
   (a) 5 (b) 7 (c) 9

4. How often should risk assessments be reviewed?
   (a) Annually
   (b) Every 5 Years
   (c) Whenever things change

5. Where can you find the Trust’s Accident Reporting Form?
   (a) In the office
   (b) Ask someone
   (c) On the Trust’s intranet

6. Should you report a near miss if no-one is injured?
   (a) Yes
   (b) No
   (c) Only if it happens again

7. Who investigates fatalities and other serious incidents?
   (a) Health and Safety Department
   (b) Line Manager
   (c) The Health and Safety Executive

8. What is a needlestick injury?
   (a) An accidental puncture to the skin by a clinical sharp
   (b) A sewing accident
   (c) A knitting injury
9. What is the biggest cause of slips in the Trust?
(a) Shoelaces undone
(b) Spilt fluids
(c) Trailing wires

10. What are Ergonomics?
(a) Money problems
(b) The ‘fit’ between people and their work

11. Who Should DSE Users give their DSE self assessment to?
(a) To their manager to review
(b) No-one: just keep a copy in your records
(c) To the IT department

12. Is verbal abuse reportable?
(a) Yes  (b) No  (c) If it upsets staff
Unit 10: Health and Safety Completion Statement

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VERSION 4 - JUNE 2014
Unit 11
Health Record Keeping - Policy and Good Practice

All individuals who work for an NHS organisation are responsible for any records they create or use in the performance of their duties. (Records Management: NHS code of Practice Part 1).

To complete this module you must first read Blackpool Teaching Hospitals procedure:

Health Record- Basic Clinical Record Keeping Standards CORP/PROC/567

http://fcsharepoint/trustdocuments/Documents/corp-proc-567.doc

It is essential that staff comply with CORP/PROC/567 for all things written about patients, whether handwritten or electronic, which then form part of that patient’s health record.

It is also recommended good practice that staff within Community Health Services comply with the following:

Identifying the author
Where a service does not utilise a staff record sheet the person making a hand written record must sign AND print their name and designation against each entry.

Abbreviations
It is acceptable to use short forms in situations where the short form is in common usage in society and would be more easily recognised by the public than the whole term. For example, HIV, am, pm, NHS. (Royal College of Nursing)

In relation to medicines management, NHS England advises it is only acceptable to use the short forms for units of measurement if they conform to the guidance issued in the British National Formulary (BNF).

Highlighter
It is not good practice to use highlighter pen to emphasise a section of a patient record. This can obscure text and affect the quality if a record has to be photocopied.

Empty Space
Where a hand written entry ends part way across a page the empty space should be scored through with a single line. Any space at the bottom of a page, for example at the end of an episode of care, should be scored out with a Z. This will prevent any further entries being made in the space remaining.

Chronology
All entries should be timed and dated using the 24 hour clock. The record should show clearly the time the activity being recorded took place as well as the time the record was written.
Structure and Content of a record
Records may be viewed by a range of others. For example, to support a claim, manage a complaint, transfer care to another provider or if access is requested by a patient. It is, therefore, essential that they are written in a way that allows information to be readily extracted by anyone who needs to do so.

Some services already use acronyms to structure their records. For example, SOAP (subjective, objective, assessment, plan) or SBAR (situation, background, assessment, recommendation).

A useful tool to assess your records against is the ROPE test.

Community Health Services
Do YOUR records pass the ROPE test?
Anyone reviewing your records should be able to quickly find out:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Reason for the contact, the contact type - telephone call, home visit, clinic appointment, time, location (patients home, care home, which clinic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>was present - their name and relationship to the patient, did the patient consent to their presence and consent to the treatment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observation</th>
<th>Subjective - history-what the patient/carers said. Objective - what you assessed, measured, observed, witnessed: Written on standard assessment templates if available. For example, falls risk assessment, wound chart, mobility assessment, moving and handling assessment.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>You and the patient need to know who is going to do what, how often starting when? Use available care plans, charts. None available? Be clear, concise and descriptive. Referring elsewhere? Who to, what for and when was it done.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Evaluate</th>
<th>What happens next? Is the intervention working? Give reasons for any changes to the treatment. State how and who is to monitor progress. Make a note of advice given and leaflets left and if you left your contact details. When your next expected contact will be or, if it is a final visit, the reasons for discharge.</th>
</tr>
</thead>
</table>

RECORD KEEPING STANDARDS

It is crucially important that staff are aware of the record keeping standards that must be used by all Health Care Professionals for the completion of all health records. All Health Care Professionals, i.e. Doctors, Nurses, Midwives and Allied Health Professionals, responsible for making clinical entries in the Health Record MUST adhere to the following standards:
Hand Written Records

• The patient’s name, NHS number and date of birth (and Hospital Number in the Acute Health Record Folder) must be recorded on every page in the health record.
• Every entry must be signed.
• Every entry in the health record is to be made in real time (dated and timed using 24 hour clock) and chronological order to reflect the continuum of patient care.
• All entries must be legible.
• Entries must be clear, relevant and unambiguous.
• Entries must be written using indelible black ink.
• White correction fluid must not be used.
• An incorrect entry must be scored out with a single line, dated, timed and signed.
• The Allergy/Attention Card filed in the patient’s Acute Health Record (or equivalent alert document can be used in a non acute environment) must be used to record:
  • Advance Directives
  • Adverse Reactions
  • Anti-Thrombotic Treatment
  • Blood Group Warnings
  • Disability and Communication Awareness
  • Drug Allergies
  • Drug Trials
  • Infection Risk
  • Research
  • Separate Health Records
  • Significant Events

Author

• Every entry in the health record must clearly identify the author. The author must ensure that when making their first entry into a patient’s health record they also complete the Staff Record Sheet.

• Some pre-printed documentation has a designated section to facilitate the capture of the author’s information on the individual document; this is used instead of completing the Staff Record Sheet e.g. Obstetric Record, Community Records and Care Pathways.

Abbreviations

• All entries must be written in full. Abbreviations must not be used unless they have first been written in full either in the content of the document or where available in the abbreviation box provided on pre-printed documentation.
Unit 11 assessment: 
Health Record-keeping - Policy and Good Practice

1. Accurate records are essential to support:  
a) High quality treatment and care  
b) Staff and patients  
c) Clinical audit

2. What must be recorded on every page of the record?  
a) Patient’s name, address, DOB (date of birth) and hospital number  
b) Patient’s name, NHS number and GP  
c) Patient’s name, DOB, NHS number (and hospital number for acute record)

3. All entries must be made using:  
a) Indelible blue ink  
b) Black or blue ink  
c) Indelible black ink

4. Identifying the author  
Where a service does not utilise a staff record sheet, the author must ensure that they:  
a) Sign and print their name on every entry  
b) Sign the final entry  
c) Sign and print their name and designation on every entry.

5. Short Forms (acronyms, abbreviations)  
Short forms may be used if:  
a) The staff in your service know what they mean  
b) The term has been written out in full on the first entry or is in common usage in society and more easily recognised by the public in abbreviated form  
c) It would take too long to write out the word/term in full

6. Every entry in the record should be:  
a) Dated and timed  
b) Dated and timed using the 24 hour clock  
c) Made in real time, dated and timed using the 24 hour clock and viewable in chronological order.

7. Incorrect entries  
a) Must be crossed out so you cannot read what was underneath  
b) Should be scored out with a single line, signed dated and countersigned  
c) Should be scored out with a single line, signed dated and timed.
ROPE test

8. When describing a contact you should include:
   a) The reason for the contact, the type of contact, who was there and whether the patient consented to the treatment and the presence of others
   b) The reason for the contact, who was there and consent to the treatment
   c) The type of contact and consent to treatment.

9. The subjective information in your record is:
   a) What the patient/relative tells you
   b) What you observe
   c) What you already know from the referral.

10. What should you record if you refer someone to another service?
    a) Which service you are referring to
    b) Which service you are referring to and why
    c) Which service you are referring to, why and when it was done.

11. What should you record if you change a treatment plan?
    a) How to monitor progress and who will monitor
    b) The reasons for the change
    c) The reasons for the change in the treatment plan, how to monitor progress and who will monitor.
Unit 11: Health Record-keeping Completion Statement

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VERSION 4 - JUNE 2014
Unit 12
Consent

Why consent is crucial
Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is a matter of common courtesy between health professionals and patients.

What consent is – and isn’t
“Consent” is a patient’s agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

• Be competent to take the particular decision;
• Have received sufficient information to take it; and
• Not be acting under duress.

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional’s advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. In order for consent to be valid, the health professional undertaking the consent procedure must ensure that the risks and benefits have been explained to the patient, the patient has consented to the procedure whilst not under any duress and all information has been given to the patient in order to for them to make the appropriate decision.

Consent of Adult Patients
No one can consent on behalf of the adult patient except in an emergency situation and if it is in the best interests of the patient.

Where adult patients lack the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no one else can give consent on their behalf. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive.

Consent of Children and Young People
Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.
Only people with ‘parental responsibility’ are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

**Obtaining Written Consent**

It is rarely a legal requirement to seek written consent, but it is good practice to do so. Written consent provides documented evidence that the procedure, risks and benefits have been explained to the patient.

It will not usually be necessary to document a patient’s consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about similar care in the past); it would be helpful to do so.

Completed forms should be kept with the patient’s notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

**Refusal of Consent**

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient’s options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act 1983.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes and other clinicians aware of the situation. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

Where a patient has refused a particular intervention, for example due to religious beliefs, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. All discussion with the patient must be documented in the patient’s case notes and other clinicians should be made aware of the situation.

**Who is Responsible for Obtaining Consent**

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

Where oral or non-verbal consent is being sought at the point where the procedure is being carried out, this will naturally be done by the health professional responsible. However, teamwork is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

Delegated Consent may be undertaken by Medical Trainees who have been identified by the appropriate Clinical Director and Nursing Staff and Allied Health Professionals who have been identified by the Associate Director of Nursing. Individuals who are identified as able to take delegated consent must undertake divisional speciality procedure specific training on consent. Individual trainees are required to be signed off by the appropriate Specialist/Consultant as competent to take delegated consent prior to them undertaking the consent procedure.
THE 12 KEY POINTS ON CONSENT: THE LAW IN ENGLAND

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot override that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.
Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient’s decision, and also increasingly the discussions that have taken place. The Trust has a policy setting out when you need to obtain written consent.

Refusal of treatment

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. No-one can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. ‘Best interests’ go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient’s needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an ‘advance refusal’), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the Reference guide to consent for examination or treatment, available from the NHS Response Line 08701 555 455 and at http://www.doh.gov.uk/consent.
Unit 12 assessment: Consent

1. Who can consent on behalf of an adult?
(a) Concerned parents
(b) Other relatives with the patient’s best interests at heart
(c) No-one, unless it’s in an emergency and in the patient’s best interests
(d) The patient’s consultant or treating clinician

2. Who cannot consent on behalf of a child or young person?
(a) Married parents
(b) Unmarried fathers
(c) The child concerned

3. Who is responsible for obtaining consent?
(a) The treating clinician.
(b) The treating clinician, or anyone who can get consent on behalf of the patient.
(c) The treating physician, or person who is undertaking the procedure and has similar skills and can get consent on behalf of another person.

4. What must you do to get ‘valid’ consent?
(a) Explain the risks and benefits to the patient; provide all the information the patient may need to make a decision; and obtain the patient’s consent in writing.
(b) Explain the risks and benefits to the patient; provide all the information the patient may need to make a decision; obtain the patient’s consent without duress.

5. Why would you obtain written consent?
(a) To document evidence that the procedure, risks and benefits have been explained to the patient.
(b) To be able to give the patient a copy.

6. What would you do if a patient who needed a blood transfusion said that he or she was a Jehovah’s Witness?
(a) Write in the patient’s case-notes and make other clinicians aware of the situation. Also, check to see if any forms need to be completed to allow the transfusion to go ahead.
(b) Mark all records DNTA/JW (‘Do Not Take Action/Jehovah’s Witness’) and make other clinicians aware of the situation.
(c) Write in the patient’s case-notes and make other clinicians aware of the situation.
(d) Check to see if any forms need to be completed to allow the transfusion to go ahead.

7. What would you do if a patient refused to give consent?
(a) Proceed regardless if you consider that is the right decision.
(b) Check if the patient is competent to make a decision and, if so, document this in the patient’s case-notes and make other clinicians aware.
(c) Obtain consent from a close relative.
Unit 12: Consent Completion Statement

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Unit 13
Venous Thromboembolism (VTE)

THROMBOSIS is the medical term given to the formation of a blood clot. This usually occurs in the veins of the legs (Deep Vein Thrombosis or DVT) and causes a painful swollen calf. Sometimes the clot will break up, move through the body to the lungs (Pulmonary Embolus or PE) causing pain on breathing and breathlessness. Venous Thromboembolism (VTE) is a term which applies to both DVT and PE collectively.

If patients are to be admitted to hospital there are things the patients can do prior to admission, these include
- If you are overweight, try and lose some weight
- If you are taking oral contraceptives or HRT try and stop these before being admitted to hospital. One month before being admitted if you are having surgery.

VTE is treatable and prophylaxis treatment should be prescribed. This can either be mechanical or chemical.

VTE is potentially a serious medical condition. A DVT can cause long term swelling of the legs and even result in ulcers. A PE is a medical emergency and can be fatal. It is vitally important that all patients over 18 years admitted to hospital are assessed for their risk of developing a VTE and again within 24 hours, as the risk carries on following discharge for up to 90 days.
Unit 13 assessment: Venous Thrombo-Embolism

1. What is a thrombosis?
   (a) A blood clot
   (b) A blood clot in the leg veins
   (c) A blood clot in the veins of the legs and lungs

2. What are the symptoms of a VTE?
   (a) A painful, swollen calf
   (b) Breathlessness and painful breathing
   (c) Either or both

3. How often should patients be assessed for VTEs in an acute setting?
   (a) Every 24 hours
   (b) Every 12 hours
   (c) Every 4 hours

4. Can a VTE cause ulcers?
   (a) No (b) Yes

5. How long does the patient remain at risk of hospital-acquired VTE following discharge?
   (a) 30 days
   (b) 60 days
   (c) 90 days
Unit 13: Venous Thrombo-Embolism Completion Statement

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PLEASE only sign and return when you are satisfied that your staff member has completed all the relevant Mandatory units and questions.

THE WORKBOOK SHOULD BE KEPT BY THE EMPLOYEE

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VERSION 4 - JUNE 2014
In acknowledgement to all staff who contributed to the production of this work book

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NHS Foundation Trust