Healthcare Policies Overview: The Drive Surgery

Policies, Procedures and/or Protocols in healthcare are vitally important as it sets a general plan of action used to guide desired outcomes and is a fundamental guideline to help make decisions. The purpose of healthcare policies and procedures are to communicate to employees [Clinical & Non-Clinical] the desired outcomes of the business. They help employees understand their roles and responsibilities within the healthcare environment when dealing with patients.

Remember – ***the policies listed below are just an overview of some of our key policies we must understand how to implement***. They can be all found on the shared drive and *if in doubt please speak with Pavani, Nimra or the Duty GP.*

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| Policy Name | Overview | Training Clinical / Non-Clinical | |
| Whistleblowing | In this policy 'Whistleblowing' means the reporting by employees [person] of suspected misconduct, illegal acts or failure to act within the requirements of the CQC & NHS regulations. The aim of this policy is to encourage employees and others who have serious concerns about any aspect of their work to come forward and voice those concerns. Dependent on how you feel, you can speak to the manager or directly to the senior GP [partner] first however if you feel unable to speak to anyone then there is a **Whistleblowing flyer with all the information you require** *on the staff board*. The policy can also be found in the shared drive and in the manager’s office. You should not feel scared as the law protects you if you feel someone has mentioned or blamed you for whistleblowing. | 3 years | |
| Complaints | Complaint policy and procedure. The Equality and Human Rights Commission is committed to providing a high quality service to everyone we deal with. We want to help our patients to resolve their complaint as quickly and smoothly as possible. We must treat all complaints as an expression of dissatisfaction with our service, which calls for a response. The **FIVE** simple steps to best handle a complaint is:  1. Listen & Understand what the patient is saying before responding  2. Empathise  3. Offer a solution  4. Execute the solution  5. Follow-up.  We all need to learn from complaints and share with the team [lessons learned to avoid a repeat]. If in doubt always call for the practice manager and if they are not available then offer them our Complaints & Comments Leaflets to complete and assure them someone will reach out to them within a few days. ALL complaints **MUST** be investigated, shared with the team, lessons learned and documented as evidence. An annual review of all complaints must also be concluded preferably at the end of the year. [March]  Complaints are a requirement by the CQC [Care Quality Commission, our regulator] and we have to follow strict guidelines to ensure we all understand about our complaints procedure.  There are two persons in charge of complaints and they are:  Pavani Malladi is our Complaints Manager and Dr Padma Gooty is our Responsible Person for all Complaints | 3 years | |
| Duty of Candour | We MUST promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports our surgery and personal learning.  We must tell our patients when they are affected by something that goes wrong, given an apology and inform them of the actions we have taken as a result.  Our management teams and culture should reflect our Core Values and Vision to encourage openness and transparency to promote good quality care.  Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered  Transparency – allowing information about the truths about performance and outcomes to be shared with staff, patients, the public and regulators.  Candour – any patient harmed by the provision of healthcare services is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.  We also need to document all incidents involving ‘duty of candour’ as to evidence lessons learned and make the improvements when things go wrong  *Since April 2019 all healthcare providers have to complete an ‘Annual Duty of Candour’ incidents identical to a complaints review to identify all incidents. [This document may be asked by the CQC on the day of inspection]* | 3 years | |
| Patient Privacy, Dignity & Respect | * When people receive care and treatment at our surgery, we must treat them with dignity and respect at all times. This includes treating them in a caring and compassionate way. * All communication with people using services must be respectful. This includes using or facilitating the most suitable means of communication and respecting a person's right to engage or not to engage in communication. * We ***MUST*** respect people's personal preferences, lifestyle and care choices. * *For clinicians*, when providing intimate or personal care, they must make every reasonable effort to make sure that they respect people's preferences about who delivers their care and treatment, such as requesting a clinician of a specified gender. * Please note that people using our services are addressed in the way they prefer. *[See our transgender flyer]* * People using the service must not be neglected or left in undignified situations. | **ONCE** available on blue stream academy | |
| Chaperone | A chaperone is an adult who is present during an intimate examination of a patient. A chaperone is there to protect both the patient and the clinician or midwife from allegations of inappropriate behaviour.  They may also be asked to assist the doctor or midwife during the examination.  Consent is required and if declined for any reason it must be made clear and recorded.  It is important and strongly advised that children & young people are provided with chaperones. Friends and relatives of the patient are not impartial observers therefore would not be suitable to act as chaperones.  A chaperone is an independent person, appropriately trained, [MUST hold a valid ENHANCED DBS certificate] whose role is to independently observe the examination/procedure undertaken by the clinician to assist the appropriate doctor-patient relationship. Either the patient or the clinician can request for a chaperone.  You will be asked to leave the consultation room and then you would need to log into SystmOne using your smartcard to update the patient’s clinical records of your observation.  The Policy can be found on the shared drive, manager’s office or you can speak to member of the management or clinical team.   * All chaperones must complete the online chaperone training with the understanding of the following: * What is meant by the term chaperone? * What is an intimate examination? * Why chaperones need to be present? * The rights of the patient. * Their role and responsibilities. It is important that chaperones should place themselves inside the screened-off area as opposed to outside of the curtains/screen (as they are then not technically chaperoning). * Policy and mechanism for raising concerns   *To enforce confidentiality, it is advised you do not discuss your chaperone role with any other member of staff.* | HCA and Non-Clinicians ONLY  3 years | |
| Safeguarding Adults | This policy can be quite in-depth however the overview is that the policy sets out the statutory requirements for all healthcare professionals to discharge its appropriate accountability for Safeguarding adults at risk of harm or abuse.  The aims of the safeguarding adults Policy [Adults at Risk]   * To stop abuse or neglect wherever possible * Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs. * Safeguard adults in a way that supports them in making choices and having control about how they want to live. * Promote an approach that concentrates on improving life for the adults concerned. * Raise public awareness so that communities as a whole, alongside professionals, play their part in identifying and preventing abuse and neglect. * Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or wellbeing of an adult. All safeguarding work with adults should be based on the following principles: * The empowerment of adults underpins all safeguarding adults work. * The focus of safeguarding adults should always be to identify and endeavour to meet the desired outcomes of the adult. * Every person has a right to live a life free from abuse, neglect and fear. • Safeguarding adults is everyone’s business and responsibility. * There is zero tolerance to the abuse of adults. * All reports of abuse will be treated seriously. * Every person should be able to access information about how to gain safety from abuse and violence and neglect. * All adult safeguarding work aims to prevent abuse from taking place, and to make enquiries quickly and effectively and take appropriate action where abuse is taking place or is suspected.   Types of abuse:  Physical abuse  Domestic violence or abuse  Sexual abuse  Psychological or emotional abuse  Financial or material abuse  Modern slavery  Discriminatory abuse  Organisational or institutional abuse  Neglect or acts of omission  Self-neglect  *Our safeguarding adults lead is Dr Padma Gooty and Dr Dania Shoeb is our deputy*  *Pavani Malladi is our Operational and Administrative Safeguarding Lead*  In the absence of a clinician please revert to the Safeguarding Adults & Children’s Contact List to report any concerns. The list is in every consulting room, reception and staff board. **Be ALERT & VIGILANT and follow the 5R’s – Recognise, Respond, Report, Record and Refer -** if you see anything untoward then please report it immediately.  *You will find a safeguarding emergency contact list placed in reception and on the staff board. Please refer to this in case of potential safeguarding concerns you need to raise where there is no GP or PM available at that time.* | Non-clinical staff- Annually [Level 1& 2]  Clinicians –Level 3  Named GP / designated GP for safeguarding must complete levels 4 & 5 | |
| Safeguarding Children | This policy can be quite in-depth however the overview is that the policy sets out the statutory requirements for all healthcare professionals to discharge its appropriate accountability for Safeguarding children & young people of risk of harm or abuse.  The MAIN 5 types of child abuses are:  *Emotional*  *Neglect*  *Physical*  *Sexual*  *Domestic Violence*  The OTHER types of abuse are:  Bullying & Cyberbulling  Child Sexual Exploitation  Child Trafficking  Female Genital Mutilation  Grooming  Non-recent Abuse  Online Abuse  *Our Safeguarding Children’s lead is Dr Padma Gooty and Dr Dania Shoeb is our deputy*  *Pavani Malladi is our Operational and Administrative Safeguarding Lead*  In the absence of a clinician please revert to the Safeguarding Adults & Children’s Contact List to report any concerns. The list is in every consulting room, reception and staff board. **Be ALERT & VIGILANT and follow the 5R’s – Recognise, Respond, Report, Record and Refer -** if you see anything untoward then please report it immediately.  *You will find a safeguarding emergency contact list placed in reception and on the staff board. Please refer to this in case of potential safeguarding concerns you need to raise where there is no GP or PM available at that time.* | Non-clinical staff- Annually [Level 1& 2]  Clinicians –Level 3  Named GP / designated GP for safeguarding must complete levels 4 & 5 | |
| Mental Capacity | The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.  The Act establishes five “statutory principles”   1. Assumption of capacity: “a person must be assumed to have capacity unless it is established that he lacks capacity.” 2. Assisted decision-making: “a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.” 3. Unwise decisions: “a person is not to be treated as unable to make a decision merely because he makes an unwise decision.” 4. Best interests: “an act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.” 5. Least restrictive alternative: “before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.”   *Please ensure all staff have completed their Mental Capacity Training as required by CQC*  *You can speak to any of the GPs in the surgery regarding Mental Capacity* | 3 years | |
| Infection Control | Standard INFECTION PREVENTION CONTROL [IPC] procedures underpin:  Safe Practice, Reducing the Risk to Staff and Patients from healthcare related infections.  It is the requirement by the CQC that Infection Control Risk Assessments and audits are completed REGULARLY and shared with all staff that **MUST** also complete their mandatory training.  **The three methods of infection control are: Direct, Indirect & Airborne**  The surgery MUST also have a nominated lead in Infection Control and a deputy lead.  Standard infection control precautions/procedures: -   1. Hand hygiene 2. Cleaning & Disinfection 3. Handling of Specimens 4. Personal Protective Equipment 5. Needlestick & Sharp Injury Prevention 6. Inoculation injury 7. Communicable Disease 8. Decontamination 9. Spillage of Blood and Bodily Fluids 10. Waste Management Disposal 11. Clinical Waste   *Our Infection Control Lead is Bolanie Kolade [Practice Nurse]*  *Supported by Sherry Escala [Practice Nurse]*  *And Pavani Malladi [Practice Manager] is our non-clinical Infection Control*  *Dr Padma Gooty [Principal GP] is the responsible person* | Annually | |
| Health and Safety | Healthcare providers are required to carry out and regularly review risk assessments to identify hazards and existing control measures; it will prioritise, plan and complete any corrective actions required to reduce risk to an acceptable level. These assessments MUST be shared with the team.  Maintaining a safe environment reflects a level of compassion and vigilance for patient welfare that is as important as any other aspect of competent health care. Most important, improving the work environment may also improve the quality and safety of patient care.  **The three key reasons for managing Health & Safety are:**  Moral – The practice should not be letting employees become ill or injured in the workplace. We all know we have to provide a safe place to work, but once we have ticked the box, that doesn’t mean we can simply ignore it afterwards. We have to ensure everyone is on board with our safe working methods, getting them involved in policy making, risk management and developing safe working procedures will ensure they are fully engaged in our methods.  Financial –This can include training courses, newer and better work equipment or by simple information, instruction and supervision that doesn’t have to cost the earth can make a big difference to help towards working safely and efficiently in any healthcare environment.  Legal - We have to follow statute law, the Acts and Regulations derived by Parliament that are provided for us to set our own health and safety objectives and follow to ensure we are meeting the compliance needs of legislation and to avoid criminal and/or civil prosecutions and convictions.  The employer is legally responsible for welfare, health and safety in the workplace and we use the term, ‘so far as is reasonably practicable,’ which is why we can set our own objectives otherwise known as ‘goal-setting’ safety management, so as long as what we do is compliant, our workplaces should be safe places to work.  Healthcare providers will actively consult with their workforce and nurture an open attitude to health and safety issues, encouraging staff to identify and report hazards and suggest innovative solutions so that we can all contribute to creating and maintaining a safe working environment.  It is a requirement to complete regular Health and safety checklists and a LEGAL requirement to display the Health & Safety Law Poster, WHAT YOU NEED TO KNOW with the nominated individual.  *Our Health & Safety Lead is Pavani Malladi [Practice Manager]*  *Supported by Nimra, [Deputy Manager]*  *And the practice nurses [Bolanie & Sherry]*  *Dr Padma Gooty [Principal GP] is the responsible person* | Annually | |
| Caldicott | The role of the Caldicott Guardian is a senior person within our practice who makes sure that the personal information about our patients and staff is used legally, ethically and appropriately, and that confidentiality is maintained at all times.  Patient-identifiable information takes many forms. It can be stored on computers, transmitted across networks, printed or stored on paper, spoken or recorded, the practice will take all necessary steps to safeguard the integrity, confidentiality, and availability of sensitive information.  No staff member employed by the practice is allowed to share any patient-identifiable information to anyone including the police unless it has been specifically authorised and documented by the Caldicott Guardian in our practices.  The seven Caldicott principals are:  Principle 1 - Justify the purpose(s) for using confidential information  Principle 2 - Don't use personal confidential data unless it is absolutely necessary  Principle 3 - Use the minimum necessary personal confidential data  Principle 4 - Access to personal confidential data should be on a strict need-to-know basis  Principle 5 - Everyone with access to personal confidential data should be aware of their responsibilities  Principle 6 - Comply with the law  Principle 7 - The duty to share information can be as important as the duty to protect patient confidentiality  *Our nominated Caldicott Guardian is Dr Padma Gooty and Pavani in her absence* | 3 years | |
| Significant Events | Significant event analysis [SEA] is a way of formally analysing incidents that may have implications for patient care, staff or the premises.  Some examples of significant events ‘Near Misses & No Harm Incidents’ in general practice, which might trigger such an analysis, are:  *Example 1: An incident that does not reach to the patient because of formal and planned interventions*  *Example 2: An incident that does not reach to the patient because of chance or unplanned interventions*  *Example 3: An incident that does reach to the patient but does not cause harm because of early detection, interventions and treatment*  *Example 4: An incident that does reach to the patient but does not cause harm because of chance*  Learning from what went wrong or right should help improve our practice.  Actions and lessons learned to avoid a repeat of the incident  If you feel you need to raise a Significant Event please complete the form and hand it to the practice manager or the duty GP for investigation. The form can be found from the shared drive or the staff board.  There is no requirement to use staff or patients names when raising an incident. We want to learn from the incident to avoid a repeat.  The SEA will then be investigated and lessons learned shared with the team at meetings.  All significant events MUST be recorded as evidence.  Managers to complete the summary log that can be used in meetings  Significant Events are a requirement by the CQC and NHSE  Significant Events should also be shared with the CCG dependant on the severity of the incident usually clinical.  *Our Significant Events/ Incidents and Accidents lead is Pavani Malladi supported by Nimra Jamil*  *Dr Padma Gooty is the overall responsible person for all incidents raised in the surgery* | N/A | |
| Serious Untoward Incidents | **DEFINITION OF A SERIOUS UNTOWARD INCIDENT**  Any incident on an NHS site, or elsewhere, whilst in NHS-funded or NHS regulated care by the CQC involving the following:   * NHS registered patients / Carers / Relatives / Visitors * All Staff including students undertaking clinical or work experience * Contractors, Building Equipment and Property   **WHICH MEET ONE or MORE OF THE FOLLOWING CRITERIA**   * Causes death or serious injury or was life threatening. * Contributes to a pattern of sustained reduction in standards of care that the provider or commissioner identifies as being below agreed minimum safe standards. * Involves a hazard to public health, including major toxic contamination or radiation hazard   **ANY PATIENT WHO:**   * May cause death and/or serious injury on NHS funded property * May pose a significant risk to the public [other patients including staff] * May seriously disrupt service delivery * May generate significant negative publicity * May be a risk to themselves * Causes significant damage to the reputation of NHSE or its employees * Relates to fraud or suspected fraud   *These incidents rarely happen however we have to follow the correct procedures and protocols of reporting such incidents when they do occur.*  *We have a serious untoward incidents policy that explains this in greater detail and can be found on the shared drive and a copy in the complaints and significant folder and policies folder kept in the practice manager’s office.*  *Please speak with Pavani or the duty GP if you need to know more about serious untoward incidents.* | N/A | |
| Fire Safety | Everyone needs to be committed to providing a safe environment for its staff, patients and visitors. Part of the responsibility is the provision and management of fire safety systems and procedures.  The policy outlines the fire safety arrangements, procedures and responsibilities in place at the practice.  All staff [clinicians included], visitors, contractors, have a statutory responsibility in ensuring compliance with the law and compliance with the fire safety provisions defined within the policy.  The Fire Safety Policy and Fire Safety Guidance can be found on the shared drive and from the manager’s office.  We **must** complete a fire drill annually or when a new member of staff joins the surgery  Fire Marshall duties can also be found in reception as a guide  All staff members should complete the mandatory fire safety module online  Please revert to our Emergency Fire Equipment FLYERS placed in reception and on the staff board.  Main duties are:   * *To minimise risk from fire through thorough risk assessments* * *To ensure adequate staff/ fire marshal training has taken place* * *To produce an emergency plan and put up fire notices* * *To conduct fire drills* * *To check adequacy of fire equipment and its maintenance annually* * *To implement recommendations from the Fire Risk Assessment* * *To ensure Fire Safety Log Book is kept up to date and accessible* * *To ensure fire escape routes and fire exit doors/ passageways are unobstructed and doors operate correctly* * *To check fire detection and protection systems are maintained and tested and records kept*   Our Fire Marshalls are:  **PAVANI MALLADI & NIMRA JAMIL** | Annually | |
| Grievance | A Grievance is ‘A Concern, Problem or Complaint’ that the employee raises with their employer typically relating to their terms and conditions of employment.  **The steps in raising a grievance are:**  Bring the grievance to the attention of your immediate manager or supervisor  Escalate the complaint to the direct report of the supervisor  Consider mediation  Escalate the issue to a managing partner  If the above solutions fails then..  Consider appealing at a higher level  A grievance can include the following:   * The nature or range of duties * Working practices * Organisational change * Contractual terms and conditions of employment * Working environment * Management decisions * Working Relationships * The operation of jointly agreed policies / procedures * Handling of sickness absence management   The following items are specifically excluded from the grievance procedure, however a complaint can be raised:   * Disciplinary / performance management matters * Bullying & Harassment Issues * Conditions relating to the NHS Pension Scheme * Agenda for Change agreements * Whistle blowing / serious concerns relating to health and safety / patient care   A grievance can take up to 3 months to resolve  Your grievance will never be ignored and the practice has a duty to listen to any formal grievance  If you believe your grievance was ignored you would resign and claim constructive dismissal [Minimum 2 years service to claim]  You will not be dismissed for raising a genuine grievance about one of your statutory employment rights  (E.g. about discrimination or about querying whether you have got the right wages etc.)  If you believe | N/A | |
| Cold Chain | **Cold chain** is referred to the maintenance of refrigeration of items (esp. vaccines) from the point of their origin at the manufacturer, through their transportation, unloading, distribution, and cold storage at the practice where they will be used for administering to patients.  **Cold chain process**is the storage, transport, and preservation of vaccines that needs to be maintained at a specific temperature or within an acceptable temperature range. – Between 2 and 8 degrees Celsius  Vaccines are biological substances that may lose their effectiveness quickly or become potentially dangerous if they become too hot or too cold at any time, especially during transport and storage.  Maintaining the cold chain ensures that vaccines are transported and stored according to the manufacturer’s recommended temperature range of +2˚C to +8˚C  All vaccines must be refrigerated and protected from light.  They must not be frozen.  Our cold chain protocol can be found from the shared drive or the manager’s office in the risk logs folder ONE  Use of a vaccine that has not been stored correctly is likely to be outside of the licensed use of the vaccine and therefore it cannot be used under a PGD.  Clinicians who administer vaccines must use the PGD guidelines – Patient Group Directions that are signed by the Practice Nurse and authorised by the GP - -These are a requirement by the CQC and NHSE  *Our Cold Chain Lead is Bolanie Kolade, practice nurse supported by Sherry Escala [Practice Nurse]*  *Pavani Malladi is the responsible person to ensure cold chain protocols, refrigerator temps are monitored daily and any incidents reported and investigated. The cold chain lead will manage the supply of vaccines in the surgery.*  *Persons authorised to administer vaccines are Practice Nurses and the GPs* | FALLS UNDER INFECTION CONTROL [ANNUALLY] |
| Waste Management including Clinical Waste | Waste is anything, which is discarded by the surgery. The method of dealing with waste varies according to the nature of the waste itself, and the need to dispose of the class of waste in a safe manner, both for staff and the environment.  Hazardous waste is defined as waste having the potential to harm persons or the environment.  Clinical Waste can be defined as “Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with it; and any other waste arising from medical, nursing or similar practice, investigation, treatment, care or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.”  This includes other waste arising from the provision of treatment such as disposable clothing, towels, or any other waste, which may cause infection to any person coming into contact with it.  *Our clinical Waste lead is Bolanie Kolade and overall waste management lead is Pavani Malladi*  *Dr Padma Gooty is the responsible person in the surgery.*  We **MUST** in order to comply with the regulations:   * *Use suitable labelled containers* * *Produce written procedures for staff to follow in handling waste [HEP B vaccine must be administered to staff handling clinical waste]* * *Maintain a hazardous waste inventory of the premises* * *Examine hazardous waste containers weekly* * *Ensure contractors are authorised* * *Have a WTN [Waste Transfer Note] or consignment note for every waste collection* |  |

*Please ensure your mandatory training modules are all completed and up to date with certificates handed to the practice manager to be filed in your individual staff files.*

*Failure to complete mandatory training modules by any staff member can potentially fail us under ‘Welled’ in our CQC inspection.*

*We have revised over 50 of our practice policies so if there are any specific policies, protocols or procedures not mentioned in the list above then please feel free to ask Rehana and/or Marie or Vashish who will assist you. They are also saved in the ‘Shared Drive’*

*Please sign and date the ‘Statement of Understanding’ document upon receiving this Summary of Policies document to be filed in your staff files.*