Essential Skills Handbook for All Staff

April 2020 - March 2021

Version 8
## Index

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Introduction

Welcome to the latest edition of the Essential Skills Handbook, which accompanies the annual e-Assessment. This method of refreshing training was first introduced to the Trust 7 years ago to reduce the amount of time staff had to spend in a classroom or undertaking separate e-Learning programmes, and we believe it has been successful in this aim.

In 2019 we carried out an Essential Skills Survey amongst staff to better understand the barriers to compliance and to gain feedback on the usefulness of the handbook and assessment. Acting on this feedback we have asked the trainers to ensure that their content reflects the current risks faced by the Trust and that answers to the accompanying questions can be found either in the booklet or by following links that they have provided to relevant documents. We have also redesigned the assessment to make it more meaningful; you will now be given 3 attempts to answer each section correctly. If you are not able to do this it will result in an overall failure of the assessment. If you cannot complete the assessment satisfactorily, or you feel that your knowledge and skills in any of the subjects needs improving, then it is your responsibility to access appropriate training, be that e-Learning or classroom.

As a reminder you will not be able to proceed with the assessment unless you confirm that you have received and read the Essential Skills Booklet.

Please be aware that some subjects require face-to-face or e-Learning updates and it is your responsibility to ensure that you complete these if required. These include:

- Basic Life Support
- Conflict Resolution Training
- Blood Awareness Training
- Fire Training (Clinical, Non-Clinical or Specialty Specific)
- MCA and DoLs Level 2
- Safeguarding Adults Level 2
- Safeguarding Children Level 3
- Mental Health – Level 1 and 2

All courses can be booked via ESR Employee Self-Service. You may find it useful to use the search icon alongside the essential skill displayed in your compliance matrix on the Learner Home Page.

Finally, all new starters must attend the Corporate Induction Programme, and complete the Induction e-Learning, as this booklet is only to be used to update yourself from year 2 of employment.

Debbie Knight | Head of Nursing & Midwifery Education
Essential Skills Handbook

User Guide
Please read this booklet before attempting to undertake the Essential Skills Assessment – by completing the assessment you will be confirming that you have read it. This booklet will enable you to update in the following subjects:

- Complaints Handling / Patient Advice and Liaison Service (PALS)
- Dementia Awareness and Delirium
- Equality and Diversity
- Fire Safety (theory only)
- Frailty
- Freedom to Speak Up
- Health and Safety at Work
- Infection Prevention and Control
- Information Governance / Cyber Security
- Legal Services
- Medicines Safety Update
- Moving and Handling Level 1
- Risk Management and Litigation
- Safeguarding Adults Level 1
- Safeguarding Children Level 1 and 2
- Security Awareness

There are two assessments available on ESR, the one you are required to do will depend on the staff group to which you belong.

192 Essential Skills Assessment 2020/21 (with Medicines Administration)

Please undertake this assessment if you are: a Doctor, Nurse, Midwife, Nursing Associate, Assistant Practitioner (Nursing), Healthcare Support Worker, Maternity Support Worker, Operating Department Practitioner or Pharmacist.

192 Essential Skills Assessment 2020/21 (without Medicines Administration)

Please undertake this assessment if you are: an Allied Health Professional (not including ODP), Healthcare Scientist, Admin and Clerical or Facilities Management
In order to answer the questions in this assessment you may need to refer to other sources outside of the booklet, for example policies, which are available on the intranet / internet. Hard copies are also available for reference in the library. However, they are all areas that you will have had training on previously.

You will need to pass each section in order to complete the assessment. You will be allowed 3 attempts at each section. If you cannot complete the assessment satisfactorily it is your responsibility to access appropriate training, be that e-Learning or classroom.

**Need Help?**

If you prefer to be away from your normal work place and are looking for a quieter environment in which to complete your e-Learning, you can access the Quiet Study Area on E Level (next to the Education Centre) or visit the Library who are based in the QuAD. The Library staff will also be able to help with any ESR / e-Learning issues that might be worrying you or causing a problem. If you would like to book a 1:1 session with the e-Learning team please contact them on Ext 1241.

**Access from Home**

If you would like to do the assessment from home you will first need to create an account through the ‘Manage Internet Access’ option on ESR whilst you are at work, using one of these two options:

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To access:

1. Log into ESR
2. Click onto the 'Learner Homepage' button under 'My e-Learning Enrolments'
3. In the search window enter 192%2020/21
4. Choose the appropriate course
Manual Work Login
- Login to ESR at work as normal
- Go to the menu on the left of the screen and click on the link to ‘Manage Internet Access’
- Click ‘Request Internet Access’
- Home access is then immediately granted
- You can then use your usual log in details to access ESR at home

Smartcard Work Login
- Login to ESR at work as normal
- Go to the menu on the left of the screen and click on the link to ‘Manage Internet Access’
- The screen will show you your User Name and allow you to set a password
- Click ‘Request Internet Access’
- Home access is then immediately granted
- You will then need to use the User Name and your new Password to log in to ESR at home
Basic Life Support
Key updates for 2020-21 from the Resuscitation Training Team

This is the correct End Tidal CO\textsuperscript{2} (ETCO\textsubscript{2}) adapter for the ZOLL R Series defibrillators

- The ETCO\textsubscript{2} adapter packet looks like this. Please ensure when using and restocking the cardiac arrest trolleys you have the right one.
- Cardiac Arrest trolleys must be stocked according to the current recommendations with no additional items.
- Go to Intranet \(
\xrightarrow[	ext{Departments}]{\text{Resuscitation Dept}} \xrightarrow{\text{Resuscitation Equipment Lists & Forms}}\)

There have been some never events in 2019 related to oxygen administration and a recurrent theme is patient transfers between departments.

Please note:

- Oxygen is a drug and therefore needs prescribing in all but emergency situations.
- Before commencing or reattaching oxygen the prescription chart and patients target oxygen saturation range should be checked.
- Patients requiring oxygen therapy whilst being transferred from one area to another should be accompanied by a registered health care professional wherever possible and the oxygen prescription chart must accompany the patient.
- In emergency situations oxygen can be given to the patient when required, and the prescription chart would be completed afterwards.

If you would like to know more about the CD O\textsuperscript{2} cylinder, BOC have a very good video which can be found on YouTube by searching for Integral Valve Oxygen Cylinder Operation.
Key learning points from 2019 DNACPR audit:
✓ DNACPR status can be handwritten on handover sheets
✓ DNACPR status must not be recorded electronically on BedView.
✓ For 1a decisions, patients should be informed and if they aren’t, a reason why must be documented
✓ DNACPR decisions should also be recorded in the notes with additional relevant details i.e. about communication, plan on discharge etc.
✓ DNACPR form must be stored at the front of the patients notes
✓ The notes of patients with a DNACPR decision in place should go with them if they go to another department, i.e. x-ray, in case the patient deteriorates

Key learning point from the July-Sept 2019 Sepsis Audit:
✓ Only 55% of in-patients get IV antibiotics within one hour of sepsis being recognised.
✓ IV antibiotics for sepsis are a time critical intervention. Please can all healthcare professionals aim to improve this in 2020/21

Key updates from the Time to ACT project team:
✓ The Deteriorating Patient Policy has been updated and there is a section for adult patients who do not require track and trigger monitoring as per NEWS2 protocol. See Page 12 Section 6.9 on when and how to use the limited or no monitoring function of VitalPAC
✓ Time to ACT project team will be working with the clinical staff to promote the use of the Deteriorating Patient pro forma from Jan 2020
Essential Skills Pick & Mix 2020

- Drop in sessions for BLS, Fire, MCA and DoLS, Blood Awareness and e-Leaning help
- Clinical Moving and Handling sessions available to book via ESR
- All training available on one day in the QuAD Centre, QAH
- More info can be found on the Resuscitation Department intranet site. Go to Intranet → Departments → Resuscitation Dept → Training Dates

For clinical staff to note

- Basic Life Support is a mandatory annual update for all clinical staff and includes cardiopulmonary resuscitation (CPR)
- There are a range of courses which all include Basic Life Support
- To select the right one for you go to the Resuscitation Department intranet site and look at the Additional Information on Resus Courses document which is in the Training Dates and Information section or Ring Ext: 6110
- Most training courses are booked via ESR
- The current Resuscitation Council (UK) Guidelines (2015) can be found on www.resus.org.uk
- The current PHT Cardiopulmonary Resuscitation and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policies can be found on the intranet in Clinical Policies Link to Clinical Policies on the Intranet
**Blood Awareness Training**

If this is not applicable to you, please move on to the next subject.

**Mandatory Training Requirements every 2 years**

There are a number of ways you can update your Blood Awareness on ESR....

- **Generic Blood Awareness Updates:** Book via ESR (Length: one hour)
  Suitable for all registered practitioners and unregistered staff and covers every aspect of the transfusion process

- **Department Specific Updates:** Book via Kay Heron (Length: time varies)
  Suitable for any department, minimum of 6 attendees, content specific to speciality and role

- **Laboratory Tour:** Book via Kay Heron (Length: time varies)
  For anyone interested in seeing what happens to patients samples.  
  *Suitable as an update for Consultants*
  All registered practitioners who administer transfusions must have a signed Blood Administration competency (Found on Learning and Development Intranet Page)

**Transfusion Top 3 Reminders**

- **Please** ensure you confirm a transfusion has taken place by completing and returning the appropriate label to the lab at the start of the transfusion.  This is a legal requirement and a Datix will be completed if the label is not returned, or the required information is incomplete

- Single unit red cell transfusions should be written up for stable non-bleeding patients (except those who are chronically transfusion dependent). Each unit of red cells should be a separate clinical decision based on Hb result or patient symptoms

- Suspected transfusion reactions or any other transfusion adverse event or near miss – please report via Datix. The Transfusion Practitioner will then follow up
***Activation of Massive Haemorrhage Protocol***

Call Ext 4444 to activate MHP
Direct line to Transfusion Laboratory

Give brief details of situation as prompted by lab staff then send a runner to lab to collect

We are now live with the new blood fridge access system (Blood360). All clinical staff who are required to collect blood components / products from the transfusion laboratory must attend training. Contact Kay Heron by e-Mail to make an appointment.

The Transfusion Team are available for advice and support –

**Contact the Blood Awareness Training Team**

**Clinical Lead** – Dr Gwynn Matthias

- 023 9228 6000 Ext 6311
- gwynn.matthias@porthosp.nhs.uk

**Transfusion Laboratory Operational Manager** – Alison Davies

- 023 9228 6000 Ext 1760
- alison.davies@porthosp.nhs.uk

**Transfusion Practitioner** - Kay Heron

- 023 9228 6000 Ext 1793 or Bleep 0120
- kay.heron@porthosp.nhs.uk

Or for non-urgent enquiries, please e-Mail the Transfusion Laboratory Group mailbox at Blood-Bank@porthosp.nhs.uk

Please be aware this e-Mail account is for non-urgent requests, advice and information as it is only monitored Monday to Friday 09:00 -17:00 (excluding Bank Holidays)
Complaints, Concerns, Comments and Compliments Patient Advice and Liaison Service (PALS)

The Trust encourages feedback from all patients, relatives and visitors. We recognise that, in order to improve the standard of care that our staff provide, we need to know what people think about their experience so that changes can be made in the areas where we are failing to meet expectations.

There are various ways to resolve concerns for patients, relatives and visitors including:

**DIRECT CONTACT WITH STAFF**
The Trust expects all staff to make every effort to resolve concerns that are brought to their attention at the time if possible, involving senior staff when necessary.

**PALS**
PALS is a support service to help address any concerns or provide advice and signposting. PALS will acknowledge all contacts received and pass the details to the staff at the Clinical Service Centre involved in the hope that things can be resolved within 5 working days.

e-Mail: PHT.PALS@porthosp.nhs.uk
When there is a need for a full investigation, PALS can take the details of formal complaints and ensure that this is acknowledged within 3 working days either verbally or in writing.

Serious complaints will be shared with the Trust’s Risk, Legal, and Safeguarding Teams.

If the Complaint is to be investigated as a Serious Incident Requiring Investigation (SIRI) then a Duty of Candour Lead will be responsible for investigating and providing the response to the complainant.

The Trust aims to provide a full written response from the Chief Executive to all formal complaints within 30 working days, or to organise a meeting with the complainant and senior staff.

Complainants will be offered the opportunity to contact us again if they are unhappy with the Trust’s response, but they also have the right to refer
the matter to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO will review how a complaint has been handled and whether there is a need to carry out an independent review of the case. This can lead to recommendations which the Trust should implement within a required timescale. However, due to the robust handling of the complaints process PHT have very few referrals to the PHSO.

The Trust requires that all staff have an understanding of the Complaints Policy, which can be found on the intranet under ‘Management Policies’. In addition, training is available for all staff at bi-monthly Complaints Handling and Customer Service Workshops. Please see contact details below on how to apply to attend one of the workshops.

A Complaints Handling Guide titled ‘We Care About People Not Just For People’ is also available on the Trust intranet site within the Complaints and PALS information.

Please note that staff should not document any information about a complaint in a patient’s medical records as this can be seen to cause discrimination at a later date.

It is also important that all staff recognise that discrimination of any sort will not be tolerated.

The 3 following concerns came within the top 5 subjects in 2019

1. Aspects of Clinical Treatment
2. Communication
3. Attitude of staff

In the majority of complaints an element of ‘breakdown in communication’ will have occurred, but both communication and attitude of staff are areas that can be improved by every member of staff. Everyone is responsible for their own actions and how they communicate with people not only with patients, relatives but also with their colleagues.

Staff are expected to try to prevent complaints happening by listening and responding to any concern in a helpful and professional manner. If a member of staff feels unable to do so, then they must refer the matter to a more senior member of staff as quickly as possible.

SOCIAL MEDIA:

The Care Quality Commission partner with social media websites as independent healthcare feedback platform services and use the
information to help them “build a better picture of the care people receive and decide when, where and what to inspect, spot problems in care and make decisions on whether a service should continue to provide care and more”. Therefore, it is important that PALS continue to monitor feedback received through social media sites, including Facebook, Twitter, Care Opinion and NHS Choices.

SMALL CLAIMS:

PALS also handle small claims on behalf of the Trust, which covers patients’ lost or damaged property (e.g. hearing aids, dentures, spectacles). Unfortunately, PALS are unable to assist with claims for staff lost property.

It is important for staff to ensure that they document the full details of each patients’ property on admission or transfer to another ward as this helps provide evidence when a claim for lost property is received. If the correct process for documentation has not been followed then it is likely that the claim will have to be upheld.

If a loss or damage to property is reported to staff, it is expected that a search be carried out as quickly as possible to try to find the missing item (to prevent a claim having to be made) and that this should be documented within the patient’s notes.

Please note that if a claim is agreed then the amount paid comes out of the budget for the area involved.

PLAUDITS

PALS also record plaudits alongside complaints, as this provides a balanced view of the feedback the Trust has received. Departments can also log plaudits directly on the Trust Datixweb system.

Contact either:

📞 Lisete Da Silva Ext 3812 or
📞 Sharon Mendoza Ext 3470

To attend the Complaints Handling and Customer Service Workshop
Dementia and Delirium

Dementia

There are over 100 types of dementia - the most common are Alzheimer's and Vascular dementia, and 850,000 people in the country, with a diagnosis of dementia. This number is expected to rise to ≥1 million by 2025.

1 in every 4 patients in our hospital will have a dementia. Patients with a dementia will probably have a length of stay longer than others, and those who become medically fit are more likely to have their discharge delayed.

There is an acknowledgement that older patients, and particularly those with dementia, can decondition whilst in our care; studies show that 10 days in hospital leads to the equivalent of 10 years of aging in the muscles for people over 80.

There has been a national campaign EndPJParalysis which encourages all patients to Getup, Get dressed and Keep Moving. We want this to be embedded at the hospital. Please ask nursing and therapy colleagues for further information.

Lack of mental stimulation for patients with dementia can also cause deconditioning and agitation. The Trust has been investing in Activity trolleys that contain games and reminiscence information to help you interact with your patients. These trolleys are available in many areas; however, please contact Linda Field, Dementia Lead if you need further information.

It is important to recognise the support that Carers of patients with dementia can provide and the Trust endorses Johns Campaign where carers are welcome to stay throughout the day. This is described in our Visitors policy.

John's Campaign

for the right to stay with people with dementia

for the right of people with dementia to be supported by their family carers
The Dementia Action Alliance published the Dementia Friendly Hospitals Charter (September 2018) which has been adopted by the CQC as best practice. The named domains are; staffing, partnership, assessments, care, environment, governance, volunteers, form part of the Trust Dementia work programme.

**Delirium?**

**What is delirium?**

Delirium is a state of mental confusion that can happen if a patient becomes medically unwell - also known as an ‘acute confusional state’.

Patients can be agitated, restless, upset and have hallucinations (hyperactive delirium) and / or slow and sleepy (hypoactive delirium)

Medical conditions, medications and surgery can all cause delirium.

20-30% of older patients will have delirium and up to 50% will also have an existing dementia.

For further support with patients with Delirium who also display challenging behaviour, please refer to the Trust Guidelines for the Diagnosis of Management of Older People with Delirium in a General Hospital Setting.


**Resources**

Dementia-Friendly Hospital Charter (Dementia Action Alliance)

[https://www.dementiaction.org.uk/assets/0001/8146/DAA_Dementia_Friendly_Hospital_Charter_Booklet_06-2015.pdf](https://www.dementiaction.org.uk/assets/0001/8146/DAA_Dementia_Friendly_Hospital_Charter_Booklet_06-2015.pdf)

Johns Campaign

[http://www.goldstandardsframework.org.uk/john-s-campaign-dementia](http://www.goldstandardsframework.org.uk/john-s-campaign-dementia)
Dementia and Delirium support in QA

- Frailty and Interface Team in ED and AMU
- Dementia Case worker(s) available via bleep 1549
- Medicine for Older People Care Group clinical teams
- Older Peoples Mental Health team

For further information on Dementia care, please contact:
Linda Field - Senior Lead Nurse for Dementia
📞 023 9228 6000 Ext 3615
✉️ linda.field@porthosp.nhs.uk
Equality and Diversity and Inclusion

Understanding Equality, Diversity and Inclusion

We are all different and those differences should be respected.

Equality, diversity and inclusion do not mean the same thing but are closely related. We need to make sure that we note and value the difference between people (their diversity) if we’re going to make sure everyone has equal rights and opportunities (equality).

Equality can mean different things to many different people but essentially it’s about making sure everyone is treated fairly.

Diversity is recognising, valuing and taking into account people’s different backgrounds, knowledge, skills, experiences, values and beliefs.

Inclusion is about making sure that people feel valued, respected, listened to and able to challenge.

Fundamentally, equality, diversity and inclusion is recognising and valuing the differences we each bring to the workplace and creating an environment where everyone has equal access to opportunities and resources and can contribute to the organisation’s success.

What is the law?

The Equality Act 2010 is a framework with clear law to better tackle disadvantage and discrimination with a purpose to address unfair treatment and help achieve equal opportunities in the workplace and wider society. We have a legal requirement under the Act to demonstrate due regard to the nine protected characteristics. The nine protected characteristics are:
We all have some protected characteristics and anyone can seek protection under the Act if they have been discriminated against due to the characteristics.

The Act allows employers to take positive action if they reasonably think that employees or job applicants who share protected characteristics suffer a disadvantage connected to that characteristic. Positive action is about taking specific steps to improve equality for example; including statements in job adverts to encourage applications from under-represented groups, such as ‘we welcome female applicants’ or favouring a candidate from an under-represented group, where two candidates are ‘as qualified as’ each other.

As a public sector organisation, we also have to pay due regard to the Public Sector Equality Duty (PSED). The PSED has three aims, and public sector organisations are required to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

**Why is Equality, Diversity and Inclusion Important?**

Equality, diversity and inclusion is important for many reasons.

**For employees, it is important because:**

- The opportunity to achieve their full potential
- Fair and equal access to jobs, training and promotion
- More choice about how they can contribute to the organisation
- A diverse workforce is better able to understand the needs of a wide range of patients

**For patients, it is important because:**

- Individuals receive appropriate services in relation to their needs
- Service users can access information about the Trust and the services it provides
- Service users are able to participate and contribute to the development of services

A quality service is one that recognises the needs and circumstances of each patient, carer, community and staff member, and ensures that services are accessible, appropriate and effective for all, and that workplaces are free from discrimination where staff can thrive and deliver.
What is discrimination?

Discrimination is the unfair treatment of one person or a group of people based on actual or perceived characteristics and is banned by the Equality Act 2010.

Discrimination may be deliberate, when we choose to exclude individuals or groups from employment or services, or make decisions that result in this happening. Discrimination can also occur unconsciously, for example when we have made assumptions about what individuals or groups might want or need without asking them, or when we make decisions without considering the impact.

There are five types of discrimination:

Direct: when someone is treated less favourably than another person because of a protected characteristic they are thought to have (discrimination by perception) or because they associate with someone who has a protected characteristic (discrimination by association).

Indirect: this can occur when you have a rule or policy that applies to everyone but disadvantages a person with a particular protected characteristic.

Harassment: unwanted conduct related to a relevant protected characteristic which has the purpose or effect of violating an individual’s dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual.

Victimisation: happens when a person is treated less favourably because they complain about discrimination or they witness it and give evidence about it.

Failure to make reasonable adjustments: if an employer fails to make reasonable adjustments this can lead to discrimination.

Would you like further information?

Contact the Equality Diversity and Inclusion Team

☎ 023 9228 6000 Ext 5071
✉ o.d@porthosp.nhs.uk

Further information can also be found in the Equality, Diversity and Inclusion Policy and the Equality, Diversity and Inclusion Intranet page
Fire Safety

Hospital fires do happen, they can cost the lives of the patients, visitors, staff and fire fighters.

A fire will also cause disruption to services which will deprive patients of treatment.

Fires have happened at QAH, but the prevention of a fire occurring in the first instance is something we will explore along with the evacuation of patients, visitors and staff.

Most of this advice is intended for staff at QAH but arrangements at other sites may be different. Make sure you understand the fire safety arrangements at all sites you work in.

Fire Prevention

It is better to prevent a fire starting and spreading, so here are some tips.

1. Use electrical equipment safely and check for damage
2. Close all doors to unoccupied rooms
3. Keep fire doors closed, and do not prop them open
4. Keep your area secure from arson
5. Store and use medical gases safely
6. Do not store combustible materials together with sources of ignition

The Fire alarm

A continuous sound means that there may be a fire in your area. The most senior member of staff present takes immediate control of the situation. The repeater panel will give instructions as to the exact location of the incident.

If a fire is discovered, the senior person “Fire Incident Manager” must consider evacuation of the area – follow their directions. When an intermittent (pulsing) alarm is sounding, this means the fire zone next to yours has activated. There may be a fire in a separate area nearby. Be
prepared to receive any evacuating patients, visitors and staff. Consider the following:

1. Check where the incident is (on the repeater panel)
2. Approach the affected department if safe to do so and find out what is happening
3. Have you cleared your corridor in order to receive beds, patients or visitors?
4. Close doors nearest to the fire zone to prevent smoke entering
5. Is everyone aware of the problem?
6. Stop everything except vital medical care, and assist
7. Consider evacuation of your department afterwards

If you discover a fire
- Shout “Fire” to summon colleagues and “Operate the manual call point”
- Call 2222 (or 999 away from QAH) – Confirm “It is a fire”. Give details of locations, what is happening, what / who is involved etc.
- QAH Switchboard will summon the Fire Brigade and dispatch the fire response team
- Remove any patients at immediate risk from the fire
- If possible, close the door to the room to contain the fire

If you can smell smoke
- Try to locate the source of the smell and if in doubt call 2222
- If a fire is located follow the process for discovering a fire
- Do not ring the Help Desk
Progressive Horizontal Evacuation

The hospital is designed for “progressive horizontal evacuation” of patients. This is achieved by evacuating through fire doors on the same floor, from one fire zone to another. Each zone provides protection to allow time to stabilize patients and prepare for further evacuation if needed. Evacuation of dependant patients down stairs is a last resort. Specialist equipment is provided in staircases where this type of evacuation may be needed. Avoid using nearby lifts. Only use lifts in other areas if allowed for in the fire response plan.

All staff in the affected department will be expected to assist in the evacuation of patients. This is achieved by working together and following instructions from the senior manager at the time, known as the Fire Incident Manager.

If you work in any location away from QAH, make sure you understand the fire safety and response arrangements at each site.

More information can be found on the Fire Safety pages of the Intranet.

Contact the Fire Officer

📞 Rob Burns 07946 177745
📞 Becca Ward 07917 557267
📧 robert.burns@porthosp.nhs.uk
📧 rebecca.ward@porthosp.nhs.uk


**Frailty**

**Definition**

- Frailty is a long term condition with a decrease in biological reserve (how a person's body reacts to a new problem) and reduced resistance to stressors (e.g. admission to hospital, infection). Frailty varies in severity from mild to severe.

- Frailty increases with increasing age, but **not everyone who is older has frailty** and there are some younger people living with frailty. It is not an inevitable part of ageing; it is a long term condition, similar to diabetes or Alzheimer's disease. (source BGS Fit for Frailty, 2014)

Small shocks can have a big impact on a person with frailty. Their ability to bounce back from these can be much more difficult and take longer to get back to their usual function. Sometimes a person may not recover their previous ability or function.


**How common is it?**

- About 50% of patients aged 75 years and over coming to hospital as an emergency will have some degree of frailty (mild to severe).

- On average every day about 35 patients aged 75 years and over with frailty will come to the Emergency Department (ED) and about 10 of them will have severe frailty.

**Where are older patients with frailty at Queen Alexandra Hospital?**

- Almost everywhere!

- Those with acute medical presentation, multiple complex needs and moderate-severe frailty and aged 75+ years or above, may be cared for by Older Persons’ Medicine (OPM) but many patients with frailty are looked after by other teams across the hospital, because their primary problem requires specialist input or they do not meet criteria for OPM.
Why is it important?

- Increased risk of adverse outcomes such as:
  - Worsening of physical function (reduced mobility, increased need to support with day to day function)
  - Worsening of mental wellbeing (increased risk of delirium and deterioration in mental health)
  - Longer length of stay in hospital
  - Increased re-admissions to hospital
  - Increased mortality rate
  - Increased discharge to residential or nursing care homes

- The frailty state for an individual is not static; it can be made better and worse - recognition and appropriate management in hospital can help prevent or reduce adverse outcomes for those with frailty

- To help patients and clinical teams identify appropriate management and what matters most to those with severe frailty

How do we recognise Frailty?

More likely to present with frailty syndromes rather than the typical symptoms for the primary acute problem they have.

1. Falls (e.g. collapse, legs gave way, ‘found lying on floor’).
2. Immobility (e.g. sudden change in mobility, ‘gone off legs’ ‘stuck in toilet’).
3. Delirium (e.g. acute confusion, ‘muddled’, sudden worsening of confusion in someone with previous dementia or known memory loss).
4. Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
5. Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).
**Frailty screening at QAH and where to find it**

All patients aged 75+ or over in urgent care should be screened for frailty by admitting teams.

Emergency Department - screening done by triaging nurse and documented in Oceano notes.

Acute Medical Unit – Clinical Frailty Scale (CFS) in the clerking booklet.

Surgical Assessment Unit – Clinical Frailty Scale in the clerking booklet.

Bedview – flag for Frailty Positive Screen should be active if the patient is 75+ years and over and has presented with a frailty syndrome or has a USUAL CFS of 5 or more. A positive screen is NOT a definitive diagnosis or indicator of severity of frailty but should be used to identify that this person is at increased risk of adverse consequences and how they are cared for can alter their outcome.

Clinical Frailty Scale (CFS) - This is based on the patient's usual functional level not their acute function so information about this is needed to assess the CFS.

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**Applying clinical judgement – the Rockwood (Dalhousie) Clinical Frailty Scale**

1. **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. **Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. **Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. **Mildly Frail** – These people often have more evident slowing, and need help in higher order ADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (caring, standing) with dressing.

7. **Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so they seem stable and not at high risk of dying (within ~6 months).

8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** – Approaching the end of life. This category applies to people with a life expectancy <6 months who are not otherwise evidently frail.

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**Scoring frailty in people with dementia**

The degree of frailty corresponds to the degree of dementia.

Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.
What can we do for patients with frailty?

1. Diagnoses – be aware there are likely to be multiple active medical or surgical diagnoses that may need managing

2. Think about more than the primary diagnosis. All of the following should be considered throughout the hospital stay:
   a) Mind - cognition and mental health – e.g. delirium, supportive approach rather than challenging those with behavioural disturbance can make a difference to how patients respond
   b) Mobility – maintain wherever possible, you don’t need a physiotherapist to say it’s ok to mobilise if you have had manual handling training and feel able to support the patient
   c) Medication – rationalise and be aware that additions can provoke new problems e.g. constipation or delirium with opioid analgesics
   d) Nutrition – what support is needed e.g. Red Tray, are they at risk of refeeding, do you need to consider dietician involvement / nutritional supplementation, eating sitting out wherever possible
   e) Continence – don’t assume incontinence is normal for the patient. Explain how to summon help if it’s needed, encourage toilet use rather than bed pan or commode wherever possible
   f) Multi-professional discussion and management approach e.g. at Board Rounds
   g) Communication – hello my name is, discussion about what matters most to the patient, and if appropriate, their next of kin. Do you need to use a hearing aid / amplifier to enable them to hear you?
   h) Discharge – follow up arrangements – are these feasible and clear to all that need to know? Would a conversation / referral to community teams improve communication and reduce risks of readmission

3. Look out for information from the Frailty and Interface Team (FIT) who are nurses, therapists and social workers, based in ED and AMU, and work alongside the medical team to provide a multidisciplinary approach for as many patients with frailty as possible, so you don’t need to duplicate this if they’ve done it already.
In ED this is documented on the Oceano notes (usually printed on orange paper).

In AMU this is documented on a specific **ORANGE** bordered A4 sheet as shown below

![FIT Initial Comprehensive Assessment Form](image)

4. Watch video about patient experience of older people with frailty available through ESR

**References**

https://www.bgs.org.uk/resources/frailty-what%E2%80%99s-it-all-about

http://www.clinmed.rcpjournal.org/content/11/1/72.long

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4392630/

**Contact the Frailty Team**

Claire Spice

📞 023 9228 6362 (Ext 6362)

✉️ claire.spice@porthosp.nhs.uk
Raising concerns in the workplace

The Trust is committed to providing high quality care to patients within a safe environment by appropriately qualified staff.

We all have a responsibility and a duty of care to speak up when we believe something at work is not right.

Speak Up – We will listen

Speaking up about any concern you have is really important. It is vital because it will help us to keep improving the services that we deliver to our patients and the working environment for staff.

You may be worried about raising a concern and we understand this. In accordance with our duty of candour, our Trust Board and Senior Managers are committed to an open and honest culture. We will look into the concerns you raise and ensure that you have access to the support you need.

What concerns can I raise?

You can raise a concern about anything that you feel is detrimental to the services that we deliver, for example:

- Unsafe patient care
- Unsafe working conditions
- Suspicion of fraud or corruption
- Lack of, or poor response to a reported safety incident
- Inappropriate behaviors or grievances
How do I raise a concern, and with who?

In most circumstances the easiest way to get your concerns resolved will be to raise it with your line manager or with the person in charge of your shift for that day. If this does not resolve the issue or you feel unable to resolve it with them you can contact the Freedom to Speak up Guardian, or one of the Trusts’ Freedom to Speak up Advocates, for confidential advice and support.

Further information about raising concerns in the workplace, and contact details of FTSU Advocates, can be found on the FTSU web page by clicking on the FTSU logo on the intranet home page

http://pht/Departments/raisingconcerns/SitePages/Home.aspx

Contact the Freedom to Speak Up Guardian

Jenny Michael

📞 023 9228 6000 Ext 3641
📞 07783 171071
📧 guardianforstaff@porthosp.nhs.uk

Freedom to Speak up concerns can also be raised via DATIX
Health and Safety at Work

Nobody expects to go to work and sustain an injury. Workplaces, by Law, are supposed to be safe places and yet despite this hundreds of workers every day sustain injuries or develop illnesses that were attributable to their working environment.

Across 2018 to 2019, the top 5 staff incidents reported to Datix was:

1. Inappropriate / Aggressive behavior towards staff by a patient  354
2. Contact with sharps (this includes clean sharps)  275
3. Contact / Collision with objects / animals (not sharps)  114
4. Lifting / Handling  97
5. Slips, Trips, Falls  73

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

The Reporting of Injuries, Disease and Dangerous Occurrence Regulations 2013 (RIDDOR) requires employers to report certain workplace incidents to the Health and Safety Executive, for example:

- When a person has had more than 7 days absent from work as a result of their incident
- They sustain a specified injury such as a fracture
- Certain sharps injuries
- Some of our patient falls

We had 38 RIDDOR reportable incidents 2018/19 of which:

- 5 were classed as specified injuries (broken bone)
- 25 lost time incidents (over 7 days absent)
- 8 sharps injuries from a known infected source

If you are unsure about whether or not an incident at work is RIDDOR reportable, it is important that the Trust Health and Safety Advisor is contacted at the earliest opportunity for advice.

Safe use and disposal of sharps

What are sharps?

‘Sharps’ are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin.
What is the risk of working with sharps?
Sharps injuries are a well-known risk in the health and social care sector. Sharps contaminated with an infected patient’s blood can transmit diseases. Because of this transmission risk, sharps injuries can cause worry and stress to the many thousands who receive them.

Safe use of sharps containers
- Ensure that the lid is secure to the container (colour of the lid must match the label)
- Complete the label (started by, date, hospital and area – Don’t forget to complete this when you close the container too!)
- Ensure temporary closure is in place when container is not in use
- Containers must never be left on the floor or at an unsuitable height
- Containers must never be overfilled or have items protruding
- Containers must be closed and disposed of every three months (even if not full)
- Containers must not be used for any other purpose than the disposal of sharps

Safe handling of sharps
- Sharp safe devices to be used as primary choice where available
- Sharps should not be passed directly from hand to hand and handling should be kept to a minimum
- Used needles must not be bent or broken before disposal and must not be recapped
- Used sharps must be discarded immediately by the person generating the waste sharps into a sharps container conforming to current standards
- Ensure sharps container available at point of use

If you do receive a sharps injury, allow the puncture site to bleed and wash the wound with soap and water.

Report Immediately
During working hours to Occupational Health on Ext. 3689
Out of Hours report to Emergency Department
Slips, Trips and Falls

Slips, trips and falls can be avoided by taking simple precautions such as:

- Watching where you are going
- Not using your phone whilst walking
- Wearing appropriate footwear and clothing
- Not running
- Protecting or better still, not having trailing leads or cables
- Cleaning up any spillages that you make or see
- Using appropriate warning signs to identify potential slip or trip hazards

Remember good health and safety practice is also about:

- Following procedures and guidelines
- Ensuring that you are familiar with all relevant Health and Safety policies
- Not putting yourself and others at risk
- Considering substances that are hazardous to health
- Wearing appropriate personal protective equipment
- Taking note of safety signs
- Reporting hazards and defects
- Maintaining a system that regularly checks vital equipment
- Ensuring that restricted areas are kept secure
- Using work equipment appropriately
- Assessing risks – And not taking them
- Remembering that you have a duty of care – Not just to yourself but also to others
- Reporting work related accidents and incidents including those you consider to be a ‘near miss’

Contact the Health and Safety at Work Team

023 9228 6000 Ext 3641 / 3333
jenny.michael@porthosp.nhs.uk
hayley.rance@porthosp.nhs.uk

Contact the Sharps Team Hotline
023 9228 6000 Ext 3689
Infection Prevention and Control

Each year, 300,000 patients in England get a healthcare-associated infection, costing the NHS over £1 billion. All staff have a duty to protect patients from harm and ensure colleagues, patients and visitors take infection prevention seriously.

Hand Hygiene

Hand hygiene is proven to prevent the spread of infection. There are 5 key moments when hand hygiene must be done, but cleaning of hands will be necessary at other times, for example after using the toilet or before eating food.

The 2 methods of hand hygiene are:

Soap & Water must be used for:
- patients with diarrhoea and / or vomiting
- Clostridium difficile carriage or infection

Gel can be used:
- a maximum of 5 times before soap and water hand washing is needed

Transmission Precautions

Everyone carries potentially harmful bacteria or viruses – standard transmission precautions must be applied to all patients without exception. Specific conditions e.g. influenza, Tuberculosis may require enhanced transmission precautions – consult the infection prevention team.
Airborne Precautions
- some pathogens are transmitted through the air as fine aerosols e.g. Influenza / Tuberculosis
- procedures that are likely to generate aerosol particles or droplets include physiotherapy
- inducing deep coughing, bronchoscopy, resuscitation, intubation
- Always wear the appropriate mask to protect yourself
  - Tuberculosis – wear an FFP3
  - Flu – refer to the flu policy

Cleaning and Decontamination
Keep the environment tidy and uncluttered. When cleaning, concentrate on:
- Touch points (door handles, sink taps, bed rails, telephones, keyboards)
- Flat surfaces (tables and lockers, bed mattresses, chair arms)

No equipment must be used between patients without being thoroughly cleaned:
- General cleaning – soap and water or soap wipes
- Infectious cleaning – chlorine with detergent

Indwelling Devices (cannulas, catheters & central lines)
- 64% of bloodstream infections are associated with a vascular device
- 43% of urinary tract infections are due to urinary catheters

Indwelling devices should only be inserted when there is proven clinical need. They must be reviewed daily and removed as soon as possible to reduce the risk of complications.

Cannula Insertion
**Clostridium difficile (C.diff)**

- transmitted by spores in faeces (formed or diarrhoea)
- patients with type 6 / 7 (refer to the Bristol Stool chart) diarrhoea with no other cause must be isolated within 2-4 hours
- send stool samples quickly
- spores last for years and continue to infect others
- always use chlorine to clean rooms / equipment when diarrhoea is present
- *C.diff* carriers may be as infectious as active *C.diff* patients

For more information visit:


**Staphylococcus Aureus (MRSA and MSSA)**

- can survive in dust for 3 months and is usually transmitted by touch
- screen all emergency admissions for MRSA (nose and groin)
- start suppression therapy as soon as possible
- remember – ‘once positive, always high risk’ any patient with a previous history of MRSA should be assumed to be colonised
- all inpatients should be screened every 7 days for MRSA
- The most common causes of Staph Aureus bloodstream infections are skin / soft tissue, and indwelling devices
- There is a 30% mortality associated with a Staph Aureus bloodstream infection

**Carbapenemase-Producing Enterobacteriaceae (CPE)**

CPE are bacteria that produce Carbapenemase enzymes resulting in resistant to all or almost all antibiotics.

**What do you need to do?**

- Risk assess every patient on admission, re-admission and transfer to PHT
Suspect CPE colonisation or infection if:

- Your patient has been transferred directly from a healthcare facility abroad, or has been in a hospital abroad or an out of area hospital in the last 12 months
- Any patient previously colonised or infected with CPE
- Any close contact of a person who is or previously has been colonised with CPE

Protect your patients:

- Risk assess every patient on admission, re-admission and transfer to PHT
- Immediately isolate patients with suspected CPE colonisation or infection
- Escalate to Infection Prevention urgently
- Refer to the CPE policy, for more information

Contact the Infection Prevention and Control Team

**Monday to Friday (9am - 5pm)**

- Infection Prevention  Bleep 0064
- Intravenous Access  Bleep 1494
- 023 9228 6000  Ext 6261
- Or via Switchboard  Dial 0

**Out of Hours on-call service (Infection Prevention and IV access)**

- Via Switchboard  Dial 0

**General Enquiries**

- Please e-Mail: infection.prevention@porthosp.nhs.uk
Information Governance (IG)

Everyone who uses health and care services should be able to trust that their personal confidential information is used appropriately and protected.

Types of Information

**Personal information / data**

Information about someone is 'personal' when it identifies an individual. It may be about living or deceased people, including patients, service users, members of staff and other individuals.

A person’s name and address are clearly personal information when presented together, but an unusual name may, by itself, enable an individual to be identified.

**Special Category Personal Information / data**

Information relating to particularly sensitive areas such as physical and mental health, gender, race, ethnicity, sexual orientation, genetics, biometrics and trade union status are considered more sensitive, and require additional safeguards.

**Confidential information**

Confidential information is information that patients and service users disclose in confidence to staff who are providing their health and care. This type of information is covered in the ‘Common law duty of confidentiality’ and most professional codes of practice.

**Pseudonymised information**

This is information in which an individual's identity is disguised by using a unique identifier (that is, a pseudonym). This does not reveal their ‘real world’ identity, but allows the linking of different data from several sources (hospital and GP).

**Anonymised information**

This information does not identify an individual and cannot reasonably be used to determine their identity. Anonymization requires the removal of name, address, full post code and any other detail or combination of details that might support identification, either by itself or when used with other available information.
Aggregate Data

Data combined from several sources and provided in a summarised format.

Common law duty of confidentiality

Confidential information should not be used or shared without the consent of the individual.

Exceptions to the requirement for consent are:

• A legal reason to disclose information, e.g. by Acts of Parliament or court orders;
• A public interest justification for breaching confidentiality such as a serious crime (DP2) or to protect the vital interests of a person

Decisions on whether or not to breach confidentiality should ideally be made by senior staff, for example your Head of Information Governance (IG), SIRO or Caldicott Guardian.

The Caldicott Principles

Before using confidential information, you should consider the Caldicott Principles:

Principle 1: Justify the purpose(s) for using this confidential information

Principle 2: Don’t use confidential information unless it is absolutely necessary

Principle 3: Use the minimum information required

Principle 4: Access to confidential information is on a strict need-to-know basis only

Principle 5: Everyone with access to confidential information should be aware of their responsibilities

Principle 6: Understand and comply with the law

Principle 7: The duty to share information can be as important as the duty to protect confidentiality
Data Protection and the Law

We all have a legal duty to respect the privacy of our patients and service users – and to use their personal information appropriately.

The Trust collects, processes and stores approximately 1.8 million patient and 7100+ staff personal and confidential records.

Our patients and staff have the right to know what information we collect, why we need this information, how it will be used, who we will share this information with and how long and where it will be stored. (see the Trust’s Privacy Notice on the website)

To collect, process, share and store personal information, the Trust must ensure that there is a legal basis for this under Data Protection Legislation.

Sharing information for non-care

In many cases, you should obtain consent if you want to use someone's personal information for non-care purposes such as service planning or research.

Normally, if the individual objects to any proposed information sharing, you must respect their objection even if it undermines or prevents care provision. Your Caldicott Guardian or Head of IG will be able to advise on what to do in these circumstances.

In England, a ‘National Opt Out’ has been implemented, which allows patients to opt out, at a national level, of their personal information being used for research and service planning.

Data Protection Act 2018

This Act provides people with a number of rights, the most relevant of which, in a health and care setting, are:

- The right to be informed about what their personal information is being used for and who it may be shared with (fair processing or Privacy Notice)
- To have their objection to the use and sharing of information acknowledge and have those objections respected
- To see and have a copy of their information (subject access)
- To have objections to their information being used or shared
considered where they claim they are suffering unwarranted distress or damage as a result

- To prevent processing for direct marketing
- To object to decisions being taken by automated means
- Have inaccuracies corrected
- Have information erased (does not include health records)

Data Protection – Good Practice

Certain simple actions can ensure that you comply with the principles of the Data Protection Act.

- Ensure that you only access personal and confidential information as part of your work
- Keep all personal & confidential information safe
- Share information only if there is a legal basis to do so or the patient has given consent
- Dispose of information appropriately and safely

Remember – under the Data Protection Act 2018, individuals have a right to see information recorded about them. So make sure that what you record is clear, accurate, legible, and remain at all times professional

Breaches

Confidentiality is about privacy and ensuring information is only accessible to those with a proven need to see it.

Integrity is about information being consistent and accurate

Availability is about information being there when it’s needed to support care

In the Trust some common forms of breaches include:

- Discharge letters / TTO’s given to the wrong individual
- Using unsecure e-Mail to send personal information
- Lost paperwork / handover sheets
- Letters posted to the incorrect person or address
- Accessing information on friends, family and colleagues
Consequences of breaches and incidents

Patient
• Physical safety put at risk
• Fraud
• Reputational damage
• Loss of Trust
• Embarrassment
• Misdiagnosis or treatment provided to wrong individual

Trust / Employee
• Reputational damage
• Breakdown in patient / professional relationship
• Enforcement notices
• Fines up to 4% of annual turnover
• Personal Prosecutions

Reporting incidents
• Complete a Safety Learning Event on Datix If you know or suspect that an incident has taken place
• Notify your manager and the IG / IT Department as soon as possible, so they can assess how serious the incident is, start an investigation and reduce harm to the data subject
• Report ‘near misses’. Lessons can often be learned from them and they can be closed or withdrawn when the full facts are known
• Incidents which may involve some level of harm may need to be reported to the ICO within 72 hours, so do not delay reporting

Freedom of information
As the Trust is a public authority (receives public money) it must be open and transparent with regard to our finances, decision making and ratings. All requests for information about the Trust should be forwarded to the FOI Team as soon as possible. The Trust must respond to all requests within 20 working days.

Contact the Trust Information Governance Team
☎ 023 9228 6000 Ext 3708
✉ emile.armour@porthosp.nhs.uk
Cyber Security Threats

Cyber threats have the potential to seriously affect patient care as proven by the ‘WannaCry’ cyber attack in 2017. However, it is also worth remembering that the threats described below are just as valid in your personal lives as they are in the workplace. It is not only patients that are at risk, but also you, your colleagues, families and your friends.

Social Engineering

Those who want to steal data may use tricks such as spoofing, to manipulate people to provide access to sensitive and valuable information. This is called social engineering and it is very difficult for the Trust to mitigate this threat without staff working together to raise awareness.

The most common forms of social engineering include fake e-Mail (Phishing), phone / voice calls (Vishing) and even text messages.

IT Scams

A recognised scam is for criminals to set up call centres that make calls to health organisations or social care providers.

They may ask you to disclose your username, password, e-Mail address or other details about where you work. They may also try to get you to click on a malicious website or e-Mail link.

The IT Department already knows a lot about you and will never ask these types of questions. If you have suspicions about any call or e-Mail you have received, then contact the IT Department immediately.

What You Can Do

Always be vigilant, at work, using the phone, when receiving unsolicited e-Mails, using social media and around the workplace.

Don’t be afraid to challenge suspicious behaviour and request proof of identification, if it’s safe to do so.

Social engineering tries to get you to react, rather than pause and think things through. Tricks include trying to play on your emotions.

Fear – The message warns you something bad will happen if you don’t do as it says

Urgency – “You must respond now!”

Curiosity – “Thought you would like this”, “This is a great video”

Greed – “Unbelievable discounts”
Phishing

Phishing is by far the biggest and easiest form of social engineering and is used to trick staff into disclosing sensitive information on a mass scale.

Phishing Email Awareness

Warning Signs

- The e-Mail has attachments or links you weren’t expecting to receive
- The links lead to an unfamiliar website (hover over the link to check but don’t click – is it a valid / recognised address?)
- There is a request for sensitive data or for you to login to a system (potentially capturing your credentials)
- The sender does not address you by name (e.g. Dear Sir or Madam) or by the correct job role
- The e-Mail is poorly written with bad grammar or punctuation

How to Stay Safe

- Never click on any links or attachments unless you are completely sure of their authenticity
- Call the sender to verify any requests for sensitive data, even if it appears to come from someone you know or trust
- When in doubt call, the IT service desk or raise an incident on MyCall

Reducing the Risk of Being Phished

Malicious actors can prepare Social Engineering attacks, including phishing, by finding the Trust’s phone list, organisation chart or by researching employees on social networking sites like LinkedIn or Facebook.

Be careful what information you put on social media as those with malicious intent can use this information to impersonate you. The Trust regularly receives phishing e-Mails, including those attempting to trick staff into changing bank details. The more information you put on the Internet, the more these e-Mails can be made to look convincing.

Don’t use your work e-Mail address on non-work related websites. Websites can be hacked and the addresses then used to send phishing e-Mails. A number of websites external to the Trust have been hacked and been found to contain “@porthosp.nhs.uk” addresses.
Reporting Suspicious e-Mail

Remember, if you think an e-Mail is suspicious then please report it to the IT Department for it to be investigated, either via the Service Desk – 7701 2333 Option 1, or on MyCall - https://mycall.

Password Hygiene

It is important to use strong passwords on all your devices to prevent unauthorised access. It is good practise to use different passwords for each different account you access, especially given how frequently external websites are being breached.

Creating strong passwords doesn’t need to be a daunting task if you follow these simple guidelines. Rather than thinking up something particularly complex and difficult to remember, use pass phrases made up of a series of words to increase password length including upper and lower case letters and adding in the odd number and symbol. The longer the password, the more difficult it is for a hacker to crack (discovering the password using a malicious computer program).

Remember, do not use common characteristics such as your name, username, DOB or mobile number and change your password in accordance with Trust policy.

Locking Devices

You should always lock your device as soon as you stop using it. ALL mobile phones, laptops, PCs and tablets, whether personal or not, should have a passcode set. If you see a colleague’s device open and unlocked, lock it for them and gently remind them to do so in future.

Use the ID badge “tap out” feature of iDesktop to ensure your data is secure or if this feature is not available, select the Windows Key + L on your keyboard to quickly lock your laptop or PC.

Connecting Devices to your Computer

Please DO NOT connect any device to your computer without the prior approval of the IT department. Log a call on MyCall or speak to the Service Desk beforehand. One of the leading causes of cyber incidents in the Trust are from staff connecting devices that have malicious software (malware) on them, including computer viruses.

These typically originate from suppliers or partners that we share data with. Do not allow anyone from outside the Trust to plug devices into machines as they may have picked up a virus infection from elsewhere.
Device disposal

Many serious data breaches occur through the incorrect disposal of equipment. Most devices have the ability to store data, including mobile phones, medical equipment and even printers. Deleting data does not remove data permanently and therefore extreme care must be taken when disposing or re-using equipment.

For medical equipment the disposal process must be agreed with clinical engineering. For all other equipment it should be agreed with the IT department before disposal.

Need help?

Read the Trust’s Internet usage and social media policies to avoid any issues. Remember, you are expected to comply with the safe working practices laid out in Trust IT policies and guidelines. Failure to do so could results in disciplinary action against you.

If you have any questions, or you are concerned about IT / Cyber Security in general, please contact the Cyber Awareness Team by e-Mail on cyber.awareness@porthosp.nhs.uk
Legal Services

What do we do?

- Handle and investigate clinical negligence, employer liability and public liability claims brought against the Trust, acting as the primary contact for our risk pooling insurers, NHS Resolution
- Represent the Trust and support those staff required to give evidence at inquests
- Provide some advice about legal and ethical issues, referring to our solicitors as appropriate
- Work closely with the risk, complaints and patient safety teams as needed

What do you need to know about claims?

- Claims related to patient treatment are brought against the Trust and NOT individuals
- Most claims do not go to trial and are either settled or withdrawn beforehand
- Approximately 170 -180 potential claims are intimated against the Trust each year
- Early and open engagement in the process is key to successfully defending unmeritorious claims

What do you need to know about inquests?

- Inquests are held when a patient dies in certain specified circumstances and approximately 140 -150 are held each year relating to patients who die at QAH
- The remit of an inquest is normally to establish only who died, when, where and how
- An inquest is a fact finding process and does not seek to attribute blame
- An inquest can be used to identify whether there are practices and processes that can be improved (regulation 28 of the Coroners (Investigations) regulations 2013)
What do you need to know about seeking legal advice?

- If you have a patient related legal issue, in office hours you should contact the Legal Services Department in the first instance. If formal legal advice is required they will instruct the Trust’s Solicitors, Mills and Reeve.

- If out of hours legal advice is required the Duty Manager should contact Mills and Reeve on the out of hours telephone number 01384 679023 and executive approval should be obtained.

Contact Legal Services Team

📞 Monday to Friday (8am - 5pm)

- Head of Legal Services: Jacqueline Haines ☎️ Ext 6527
  jacqueline.haines@porthosp.nhs.uk

- Litigation Manager: Letitia Barrable ☎️ Ext 3479
  letitia.barrable@porthosp.nhs.uk
Medication Safety Update 2020

Anticoagulants
Direct Oral Anticoagulants (DOACs or NOACs) include apixaban, rivaroxaban, edoxaban, dabigatran. NOAC/DOACs must not be prescribed with enoxaparin or warfarin. Query any prescription where both are prescribed. Learning from reported Safety Learning Events have included when starting a DOAC, any enoxaparin should be crossed off to avoid duplication of anticoagulation.

IV Drug Library
The IV syringe drivers and volumetric pumps have an IV drug library for many drugs, listing standard infusion rate settings. Please use the library settings to increase safety. To help review any safety learning events involving infusions, please isolate any pump involved for Clinical Engineering Dept so that the pump data can be downloaded to enable the administration timeline to be reviewed and identify if drug library updates are needed.

Oxygen
Oxygen is a medication that needs to be prescribed, documenting the patient’s target oxygen saturation. National NHSI alerts have highlighted the risks with Oxygen Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders.


Ensure the first step to pull the tear ring and remove wheel cover is not forgotten.

Unintentional connection of a patient requiring oxygen to an air flowmeter is classed as a Never Event.

Allergies & Anaphylaxis

Ensure the allergy and type of reaction is entered on the drug chart and checked before prescribing or administering any medication.

Ensure you know where your yellow anaphylaxis containers are located. They are kept under ‘A’ for anaphylaxis in the drug cupboard in a yellow linen bin and should contain adrenaline, hydrocortisone and chlorphenamine and the laminated treatment flowchart card.

Penicillin Allergy

The most common drugs reported to be given in error to penicillin allergic patients are Tazocin® (piperacillin / tazobactam) or Augmentin® (co-amoxiclav).

![Antibiotics in Penicillin Allergy](Image)

Methotrexate - ONCE a WEEK dosing

- Methotrexate is only given ONCE A WEEK.

- Methotrexate is ONLY to be administered AFTER the prescription has been checked by a pharmacist. Methotrexate is long acting and it is safer to delay until the dose has been checked.

- QA Pharmacy will only dispense one weekly dose at a time and patient’s own supplies are not to be used for administration while an inpatient.

FY1 prescribers are not permitted to prescribe Methotrexate.

Self-administration of Medication

If patients are to administer their own medication it is essential that the PHT Self Administration of Medication Policy is followed. Patients are only permitted to self-administer after a formal assessment.
Opioids and Naloxone

- Whilst reversal of opioids with naloxone can be life-saving in respiratory depression and respiratory arrest, the use of naloxone in patients where it is not indicated, or in larger than recommended doses, can cause a rapid reversal, leading to intense pain and distress and potentially serious acute withdrawal syndrome and has been the subject of a NHSI Patient Safety Alert.

https://www.england.nhs.uk/2015/10/psa-naloxone-2/

- See the PHT Naloxone Drug Therapy Guideline for dosing information. If naloxone is needed to treat an inpatient, use a PHT Naloxone Guidance Sticker to record indication and guide dosing. Complete a Safety Learning Event Form on Datix to enable review, feedback and learning.

Insulin

NEVER abbreviate units to ‘u’ or ‘iu’ when prescribing or recording insulin dosages. This can lead to dosing errors if the ‘u’ is misread e.g. as a 0, 4 or 10.

Do not miss insulin doses – this can lead to hyperglycaemia and diabetic ketoacidosis (DKA). For patients with type 1 diabetes, long acting insulins must always be administered and continued even if the patient is on an IV insulin infusion or not eating. Doses may need to be adjusted but patients with Type 1 diabetes always need some background insulin on board.

Blood Glucose Monitoring

Remember that the current PHT glucose meter readings only display a result up to 27.8mmol/L. Any glucose results higher than 27.8mmol/L will only display as ‘>27.8mmol/L’ but could be MUCH higher (e.g. 40 or 50mmol/L) so an urgent lab value will be needed to check the actual level. Escalate to a senior as urgent action is needed.

Check insulin chart to identify if any doses have been missed.
CONCENTRATED INSULIN

• The strength of standard insulins is 100 units/ml, however insulin of higher strengths e.g. 200 or 300 units/ml have recently started to become available (e.g. Tresiba, Toujeo brands). See the PHT Concentrated Insulin Drug Therapy Guideline or contact the diabetes team or pharmacist for advice.

Insulin Safe Administration

Insulin must ALWAYS be administered using an insulin syringe and vial, or original pen device. NEVER withdraw insulin from insulin pen devices or insulin cartridges. An NHSI Safety Alert was issued to warn of the risks. An overdose of insulin due to withdrawing insulin from an insulin pen or pen refill is listed as a DoH Never Event.

Patient’s Own Drugs (PODs) and Locker Storage

Make sure that the POD locker is ALWAYS emptied and medication sent on when patients are transferred to reduce risk of errors and missed doses.

Discharging Patients:

The medication list on the discharge summary will list which medication has been dispensed by PHT Pharmacy, which patient’s own drugs (PODs) are already on the ward, or which the patient has a supply of at home.

Multiple issues have been reported as Safety Learning Events where patients have been given incorrectly labelled / other patient’s medication or medication/ fridge items missed on discharge.

Check through all the medication being given on discharge one-by-one against the discharge summary to check all the items are still required and labelled with the correct patient name and directions.

Do not send patients home with stock medications or those that have been labelled ‘FOR INPATIENT USE ONLY’ as these do not include directions for administration.
Contact the Medication Safety Team

☎ 023 9228 6000 Ext 5284
✉ Medication Safety - Group Mailbox
   mso@porthosp.nhs.uk

Twitter: @PHTMedsSafety
**Moving and Handling – Inanimate Loads**

**Manual Handling - lifting, lowering, pushing, pulling, moving or carrying of the load by hand or bodily force**

An inanimate load is a discrete, movable object

Have you ever:

- Lifted a load, and then realized the object is heavy?
- Carried a load over distance, to then realize the object is too heavy to carry over distance and then struggle for the rest of the journey?
- Carried multiple bags / boxes / patient notes to undertake the task in one trip?

The above questions are examples of poor manual handling errors or near misses, but we have all at some point in our life undertaken poor manual handling. The true error is one we have not learnt from.

**Duties**

The employer has a duty to look after the employee’s wellbeing, so far as is reasonably practicable.

All employees have a responsibility to follow safe systems such as policies, guidelines and risk assessments in the aim of creating a safer working environment for all.

The employee should:

- Avoid any manual handling that may cause harm to themselves or others
- Report near misses and incidents to their line manager and via the Trust incident reporting system
- Use handling equipment in accordance with training and instructions given to them
- Use functional equipment that is fit for purpose and appropriate for the task. Label / isolate faulty equipment and report faulty equipment
- Undergo appropriate training for their job role / tasks
- Wear appropriate clothing that allows good posture, hand and foot grip etc. and personal protective equipment (PPE) for the task
When undertaking manual handling static (still) postures, repetitiously bending, stooping, over reaching and sudden shock (trauma) could potentially cause short to long term musculoskeletal disorders (such as back pain) that could impact on work life and also home life. Musculoskeletal disorders can have an affect on the whole of the person by potentially affecting psychological and social wellbeing, as well as their physical wellbeing. In addition, this can work in reverse, for example a person experiencing stress can then develop musculoskeletal symptoms such as back pain.

**MANUAL HANDLING DECISION PROCESS**

**Avoid-Assess-Reduce**

**Avoid** hazardous manual handling operations so far as is reasonably practicable;

Do you need to move the load?

**Assess** any hazardous manual handling operations that cannot be avoided;

Assess the task to create a safe system of work

Is there a written weight on the load? If not, can you open the load to give you an idea of the weight? Can you lift an edge, to help assess the weight of the load?

**Reduce** the risk of injury so far as is reasonably practicable

Automate or mechanizing the task if reasonably practicable

Risk reductions for moving a loaded box on the floor that you have assessed to be slightly too heavy for a 1 person lift could include …

Sliding the load over a short distance - taking some objects out of the box to make the load lighter - ask for assistance and undertake the task as a 2 person lift.

N.B. when undertaking a two person lift it is advisable to use the commands READY-STEADY-LIFT.

N.B. when moving objects such as trollies it is generally better for your posture to push the trolley rather than pull (unless the manufacture states otherwise). When moving a trolley through doors generally it is better to back through the door as this reduces poor posture.

Request training where applicable

Review the task if risks change.
When undertaking a risk assessment use the acronym TILEO

**T** Assess factors about the **T**ask – such as what, when, how, duration, frequency or repetition

**I** Assess factors about the **I**ndividuals – capability, knowledge, wellbeing, skill level, ability to be able to apply safer biomechanical principles of:

- ✓ stable base
- ✓ soft knees
- ✓ spine in an upright neutral position (no bending, twisting, over-reaching)
- ✓ keep close to the load
- ✓ keep your head upright

N.B. when picking a load up from ground level you will have a slight bend in your back

**L** Assess factors about the **L**oad – is it heavy, awkward, unwieldy, difficult to grasp, unstable?

**E** Assess factors about the **E**nvironment – is it spacious, obstacle free, uneven ground and will slopes need to be considered?

**O** Assess any **O**ther factors about the task that could affect the handling

All hazardous manual handling operations that cannot be avoided must have a suitable and sufficient risk assessment.

Complex risk assessments - The Moving and Handling Team are very happy to assist you with risk assessments for moving and handling in general, and in complex situations.

**Staff referrals**

The Moving and Handling Advisory Team can support and advise staff members with musculoskeletal disorders. Staff should be referred to Occupational Health in the first instance for advice and support.
Have there been any recent changes relevant to manual handling?

There are no significant changes to legislation relating to Moving and Handling


Trust Changes - Managers are advised to input the load handling risk assessments onto the Datix reporting system.

TRAINING

Inanimate Load Handling

If the loads you handle are inanimate (i.e. boxes) then you need to attend a ‘face-to-face’ training course at least every 3 years. This applies if you handle loads frequently and they are heavy, difficult to manage or unwieldy. Speak to your manager to see if a ‘face-to-face’ session is required.

Inanimate load handling (generic) sessions are offered by the Moving and Handling Advisory Team throughout the year and they are advertised via the link. Please book on via ESR.

If your area would like an area specific inanimate load handling session this can be arranged via the Moving and Handling Team.

Patient Handling Training

If you handle patients you must attend a ‘face-to-face’ session every 3 years. Please book via ESR.

Additional training can be provided on patient handling techniques or equipment in the form of a workshop for an individual or a group (preferably.)

Do you want more information?

Contact the Moving and Handling Advisory Team (MHAT)

Occupational Health Building

023 9228 6000 Ext 3642

See Moving and Handling website

Access the Manual Handling Operations of Inanimate Loads Policy

Access the Patient Moving and Handling Policy
Risk Management

The management of risk is key to ensuring patient and staff safety.

Datix Reporting

There are regular drop-in training sessions you can attend – dates can be found on the Datix Homepage on the intranet. Training for staff with reviewer responsibilities, for groups of 5 or more, can be booked by contacting the Risk Management team.

Risk Register

There are guides to reporting a risk available within the Datix module and on the Risk Management homepage on the intranet.

Risk

We use risk assessments to anticipate, identify, document and manage all risks. All clinical / non clinical risks identified in the Trust are held in risk registers with the Datix reporting system where actions to mitigate the risk are regularly reviewed and updated.

Risks are scored using 5 x 5 matrix guided by examples to ensure a consistent approach for all categories of risk:


All risks are reviewed by the Divisional Governance leads and Risk Management to ensure risks are described and scored correctly before approval.

The Board Assurance Framework holds high level strategic risks, aligned to the Trust's strategic aims with documented action plans to reduce the risk. The Corporate Risk Register holds details of the most serious operational and clinical risks, which require corporate oversight. Both of these documents are monitored by the Trust Board.

It is important to be familiar with the Trust Risk Management Strategy, risks within your area / Division and those affecting the whole Trust. To access the Strategy, current Trust Risk Register and Board Assurance Framework please use the link to the Risk Management homepage Home - Risk Management Department

Risk Management training is provided as part of the Passport to Manage programme and as individual sessions to book through ESR.
Contact the Risk Management Team

Head of Risk Management
Annie Green  ☏ Ext 3476  annie.green@porthosp.nhs.uk

Senior Risk Advisor/Datix Manager
Kerry Harding  ☏ Ext 3478  kerry.harding@porthosp.nhs.uk

Datix Support Officer
Ellen Huskinson  ☏ Ext 3480  ellen.huskinson@porthosp.nhs.uk

Quality Support Officer
Abigail Mahoney  ☏ Ext 3479  abigail.mahoney@porthosp.nhs.uk
**Safeguarding Services**

Update in this booklet covers:

- Safeguarding Children Training at Levels 1 and 2 for non-registered and registered staff
- Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards update and changes
- Learning Disability update

The Safeguarding Service works as an integrated children and adult service and are located in Southwick Lodge. Specialist advice and support can be accessed via our single point of contact on ext. 6058 or via email on:

- Safeguarding.ChildrenTeam@porthosp.nhs.uk
- Safeguarding.Adults@porthosp.nhs.uk

Safeguarding advice, supervision and support can be sought locally, from senior colleagues within your area. Each Division has several Safeguarding Operational Leads who can be contacted for guidance about a child or adult concern. In addition, information can be found on the Safeguarding intranet site and within Trust policies.

**LEARNING FROM PRACTICE**

The Trust has a responsibility to ensure that we learn from practice. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm.

This year’s update contains examples of some local good practice initiatives that have come about through learning from cases and is based upon learning over the last year within PHT.

**CONTEXTUAL SAFEGUARDING** – Children and young people experience harm beyond their homes and families. The different relationships that young people form in their neighbourhoods, schools and online, can feature violence and abuse. Parents and carers have little influence over these contexts, and young people’s experiences of extra-familial abuse can undermine parent-child relationships. More information about how contextual safeguarding should inform your practice can be found here [https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding](https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding)

**CHILD CRIMINAL EXPLOITATION – COUNTY LINES** - Child Criminal Exploitation is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control,
manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual.

Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology. Criminal exploitation of children is broader than just county lines, and includes, for instance, children forced to work on cannabis farms or to commit theft. More information can be found here: https://www.hampshirescp.org.uk/professionals/child-exploitation/criminal-exploitation/

ICON ABUSIVE HEAD TRAUMA INTERVENTION - ICON is a programme of intervention based around coping with crying. The programme requires the same messages being shared with parents and carers at different stages by different professionals. More information about ICON can be found here https://www.hampshirescp.org.uk/toolkits/abusive-head-trauma/
SAFE SLEEP

Since April 2016 14 babies have died in Portsmouth and Hampshire where unsafe sleep was a presenting factor. Professionals have a responsibility to ensure that consistent evidence based advice is given to parents and carers to reduce the number of babies dying in these circumstances.

More information can be found at: https://www.hampshirescp.org.uk/toolkits/every-sleep-counts-toolkit/ or https://www.lullabytrust.org.uk/safer-sleep-advice/

RESTRAINT

There is an increasing focus on the use of preventative approaches and de-escalation for managing behaviour that services may find challenging. During 2019 the use restrictive practice was reviewed with the result that the use of mechanical restraint has ceased Trust wide. The new policy can be found here


Highlights of the new way of working include:

- Every incident of restraint must be recorded as a Safety Learning Event on Datix
- All restraint incidents must be clinically led
- If staff are ‘in fear of their life’ they must ring 999 and request police attendance using these words
- The standard restraint incident review template (SWARM) must be used following any restraint incident
- Any member of staff who has concerns about inappropriate use of restraint should discuss these with the Safeguarding Service

DISCRIMINATORY ABUSE / ORGANISATIONAL ABUSE /ACTS OF OMISSION

People who have a disability / vulnerability often experience poorer access to healthcare than the general population and are at a higher risk of abuse or neglect. The particular features recognised as learning themes includes, but is not exhaustive, to:
• Hearing impairment • Learning Disability • Mental Illness • Cognitive Impairment • Substance misuse / Alcohol

Every Patient should have an individualised care plan that takes account of their particular needs and ensures appropriate adjustments are made to enable them to experience safe and compassionate care. When this basic standard is not met, patients are at risk of abuse or neglect. Staff have a responsibility to listen to their patients and their carers and to include them in care planning and decision making wherever possible. When safeguarding adult patients, making safeguarding personal to them is critical – this supports them in making choices and having control about how they live.

LEARNING DISABILITY

People with learning disabilities, autism or both, and their families and carers should be able to expect high quality care across all services provided by the NHS. They should receive treatment, care and support that are safe and personalised; and have the same access to services and outcomes as their non-disabled peers. People with a Learning Disability are at an increased risk of developing health needs and when they do, they are less likely to get successful outcomes.

We support patients with a Learning Disability in the following ways:

• Ensure all patients with a Learning Disability have a hospital passport (a booklet describing how the patient wishes to lead their life and their likes and dislikes) and that this is used to provide the patient with an individualised care plan

• Ensure all ‘reasonable adjustments’ are made to ensure the patient has a safe and secure patient experience. Examples of reasonable adjustments are ensuring carers have access to a Z-bed if they wish to stay over with their relative, the environment is conducive to care, funding agreements are discussed so that known carers maintain care whilst in hospital and ensure patients are accompanied to procedures and waiting times adjusted if appropriate.

LIBERTY PROTECTION SAFEGUARDS

The new Liberty Protection Safeguards (LPS) is due to come into force in October 2020 via the Mental Capacity (Amendment) Act 2019. The LPS
will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty.

Under the LPS, the Trust will become the ‘responsible body’ who authorise the Deprivation of Liberty. This will include organising reviews, assessments, authorisations, renewals and monitoring, with the added caveat that the person completing these assessments are independent of the day to day care of the patient. Unlike DoLS, LPS will include 16 and 17 year olds.

The Safeguarding Service will keep the Trust informed as these changes come into force. For more information https://www.scie.org.uk/mca/dols/practice/lps

MANAGING ALLEGATIONS

Despite all efforts to recruit safely there will be occasions when concerns arise about members of staff (including volunteers) who work with children or at risk adults. No staff, regardless of their position must act in any way that constitutes any of the following:

- Behaviour that harms or may harm a child young person or adult
- Behaviour that results in a criminal offence against or related to a child young person or adult
- Behaviour towards a child young person or adult that indicates she / he is unsuitable to work in a position of trust

The member of staff who is alleged to have abused a child or adult must report the allegation to their Line Manager or a member staff who has become aware or, or witnessed, abuse must report this to their Line Manager and the Safeguarding Service. Restriction of practice or suspension may be considered, depending on the nature of the abuse, whilst investigations are conducted. There should be close liaison between Police and the Safeguarding Service as to how much can be shared with the subject of the allegation. There must be a support system in place for the member of staff.

For full details of the management of allegations please refer to the Management of Allegation Policy.

Contact the Safeguarding Team (incorporating both Children and Adult Services)

Nicky Gough and Karen Price are based in Room A1162 on A Level at QA Hospital and are usually available Monday to Friday 08.30 -16.30.

023 9228 6000  Ext 5825

karen.price7@nhs.net  nickygough@nhs.net
SECURITY

Security is everybody’s responsibility with support and advice available from the Accredited Security Management Specialist (ASMS) and the Operational Security team, promoting an anti-crime culture.

EVERY staff member is responsible for:-

• their own personal security and property whilst at work
• displaying their Trust Photographic ID badge appropriately
• maintaining a secure environment for their fellow employees, patients and visitors
• security and protection of all property (personal, patient and Trust)
• ensuring all patient property is accounted for and recorded and double checked at every ward transfer (where this forms part of their duties).

See the Patient Property Policy for full details.

• ensuring doors, windows and computers are secured and locked, preventing any unauthorised access
• preventing unauthorised entry by others who ‘tailgate’ through secure doors. Pause for a moment to ensure the door is closed securely behind you before carrying on
• keeping keys and door codes secure at all times. Never write codes on the walls or door frames! This is criminal damage!
• making sure keys for drug cabinets / trollies are kept safe and on the premises at all times

The ASMS provides professional advice and guidance in support of staff and patients to reduce the incidences of violence and aggression. Assisting in implementing measures to ensure patients, staff and contractors feel safe, reducing fear of assault and incidences of theft and criminal damage.

The ASMS is responsible for ensuring all security related incidents are investigated and action is taken against perpetrators where appropriate.


Alternatively, find it in the resource centre - ‘Security & Management of Personal Safety’.

Reporting of Incidents

Please report incidences of:

• breaches of security
• thefts
• assaults on staff
• threatening or abusive behaviour
• anti-social behaviour
• vandalism, damage and arson
• suspicious activity including those not displaying appropriate ID
• doors left unsecure

 Whenever you encounter any of these, or something you feel is a risk or security threat, you can report it to your line manager and complete a ‘Safety Learning Event’ Reporting Form via the online DATIX system. Familiarise yourself with this form - it is important that all incidents are captured fully and accurately.

**Actions against perpetrators**

The Trust will take all reasonable action to ensure anyone who commits crime or behaves in an unacceptable manner is dealt with appropriately. Actions that can be taken include:

• unacceptable behaviour written warnings
• exclusion from premises
• acceptable behaviour agreements
• withholding treatment
• civil injunctions and anti-social behaviour orders
• criminal prosecutions

**Tailgating**

Tailgating is the most common way our security is breached. Access control measures i.e. card entry system, digi locks, are expensive and designed to ensure that only those staff authorised have access to areas they need to enter to do their job. They are only as good as the people who use them. Staff should not ‘lend’ access cards to anyone or wedge doors open and don’t let people tailgate you.

These are the most common causes of crime in NHS premises:

• Not locking cash / valuables away
• Not closing / locking doors properly
• Not challenging strangers in restricted areas
• Not checking who is following you through secure doors
By continuing to be vigilant and working together we can make our workplace safe and secure for all staff and patients. On those occasions where you are suspicious or challenge individuals, it is OK to act and ask. If people are genuine, no harm will have been done.

The operational security officers maintain a 24/7 security presence at QA Hospital to deal with security emergencies and requirements. They can be contacted on Ext. 6100 or in the event of an emergency via Ext. 2222.

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Contacting the Security Team

Accredited Security Management Specialist (Policy, Crime Reduction, Investigations)

023 9228 6000 Ext 5100

paultravers@nhs.net  (07771 814956)

Operational Security (Guards, Car Parks etc)

023 9228 6000 Ext 6100

portsmouthsecurity@porthosp.nhs.uk
**Essential Skills - Next Steps Summary**

**Step 1 – All staff**

All staff must read the booklet and then complete the single e-Assessment. This will update the following Essential Skills and no further action for these essential skills is needed until April 2020:

- Dementia Awareness
- Health, Safety and Welfare
- Infection Prevention and Control
- Information Governance
- Medicines Safety Update
- Moving and Handling – Inanimate Loads
- Patient Experience Department / Complaints
- Risk Management and Litigation
- Safeguarding Children and Young People Levels 1 and 2
- Safeguarding Vulnerable Adults (Adult at Risk) level 1

**Step 2 – All staff**

All staff working in non-clinical areas must attend a face-to-face Non-Clinical Fire Safety session at least every three years. If you need a face-to-face Fire Safety session then this can be arranged in your department or can be booked via ESR. Go to Departments / Fire Safety on the Intranet for more information.

*** Non-clinical staff you are now up to date for a year ***

**Step 3 – For all clinical staff only e.g. HCSW, RGN’s, Doctors, Radiographers, ODP’s**

Clinical staff must attend the following face-to-face sessions:

a) **Basic Life Support (BLS) training annually**

- There is a range of training courses available that include Basic Life Support
- More information on selecting the right course for you and your clinical role can be found on the Resuscitation Department Intranet Site or by contacting the Resuscitation Department Admin Team on Ext 6110, or by e-Mailing resus.reception@porthosp.nhs.uk
- Book your place via ESR for the two-hour classroom BLS training
b) Clinical Fire Safety every two years
   • This can be arranged in your department or can be booked via ESR. Go to Departments / Fire Safety on the Intranet for more information

c) Moving and Handling of Patients every two years
   • If you move or handle patients you must attend a practical Skills Update
   • Book your place via ESR

d) Blood Awareness every two years
   • For all clinical staff involved in the transfusion process. This is a face-to-face update to ensure you are fully aware of your roles and responsibilities
   • Book via ESR or contact the team (see page 11) to arrange departmental updates

e) Mental Capacity Act (MCA) Enhanced and Deprivation of Liberties (DOLs)
   • Available via your CSC Safeguarding Lead

Now you have read this booklet fully, you can complete your e-Assessment as per the guide on pages 4 to 5.