Key Medical Services

Key Medical Services Clinician’s handbook

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Welcome

Thank you for partnering with Key Medical Services Limited to deliver medical services to our Primary Care clients.

You are receiving this handbook as you are about to start working at a client site on a Key Medical Services assignment, as a clinician representing Key Medical Services and we would like to tell you a bit more about who we are, what we offer and what we expect from our clinicians.

Before starting any assignment with Key Medical Services, please read this handbook. If you have any questions, please contact your Consultant.

Key Medical Services

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Introduction

About Key Medical Services

Key Medical Services Limited is part of the Celsus Group, which includes other companies including Medical Staffing Limited.

Key Medical Services provides clinician-led medical services to the primary care and integrated urgent care sector, working with professional clinicians to deliver care. It employs a Chief Medical Officer, a Chief Nurse and its clinicians operate within a quality framework that provides support, monitoring and feedback to target better clinical outcomes.

Key Medical Services' mission is to deliver professional service solutions for our clients and their patients by:

- Ensuring that every interaction our clients, clinicians and patients have with Key Medical Services is meaningful and seamless.
- Attracting and retaining a diverse community of quality clinicians who have good clinical judgement and are personable and flexible around our clients' needs.

We would like to ensure that all clinicians working with Key Medical Services, regardless of whether they are self-employed or providing services through their own company, are well supported and have access to learning opportunities whilst working with us.

The Key Medical Services team

CEO – James Stevenson

Chief Medical Officer (CMO) – Dr Caroline Rogers

Dr Caroline Rogers is Key Medical Services' Chief Medical Officer. Dr Rogers has 10 years of experience working as a Chief Medical Officer for several healthcare providers and is committed to supporting the Key Medical Services' team of doctors to deliver the best possible patient care. Dr Rogers does this by regular email updates of new guidelines, safety alerts, and lessons learnt from feedback, complaints, and adverse events. She is part of a team who support individual doctors in the various challenges they may face in their practice. Dr Rogers can be contacted at caroline.rogers@keymedicalservices.co.uk.

Group Head of Quality and Compliance – Clint Daniels

Clint has been operating in compliance within the healthcare sector for over 20 years. Gaining extensive experience in all types of compliance and compliance delivery.

Chief Nurse – Lorraine Gray

Lorraine Gray is our Chief Nurse and designated Safeguarding Lead, she has over 35 years of clinical and managerial experience in both Secondary and Primary Care. Lorraine oversees the complaints and feedback team and can support you with writing statements and reflective pieces, appraisal and revalidation.

Key Medical Services Consultants

Our experienced KMS consultants will be the people that you interact with most on a day-to-day basis. In most cases, they will be your first point of call. Their support will range from keeping you informed of suitable assignment opportunities to assistance in resolving queries related to assignments, timesheets, and compliance. For any questions that you have, our consultants are on hand to give you the help that you need.

Supporting documents

There are several documents or sources that should be used in conjunction with this document. Please check the Key Medical Services document repository on our website for the latest version of documents such as timesheets, terms and conditions and Assignment confirmation forms.

Key Medical Services standard terms and conditions for clinicians are available on our website here: https://www.keymedicalservices.co.uk/terms/clinicians or on request from your Consultant.

Local policies and procedures

Please refer to your Assignment confirmation for information on local policies if provided or if unavailable or not specified, please speak with the client.

Please also ensure that you familiarise yourself with the Key Medical Services client's local:

- Fire procedures

- Health and safety arrangements
- Infection control and clinical waste procedures

Other queries

If you have any other queries not addressed by the above, please contact your appointed Consultant.

Complaints and feedback about Key Medical Services staff, clients, or services

Please contact complaints@keymedicalservices.co.uk if you have any complaints. If you would like to leave us any feedback, to help us improve our services please contact feedback@keymedicalservices.co.uk.

Speaking up

If you develop concerns about a practice or organisation where you have been assigned, which could impact patient safety or negatively affect patient care, should raise the issue with senior staff at that organisation. If you feel you need to escalate this further, then you can go directly to the NHS England Freedom to Speak Up team at england.speakup1@nhs.net and/or the Care Quality Commission.

Privacy notice

Please refer to our website for Key Medical Services' privacy notice https://www.keymedicalservices.co.uk/privacy/.

Starting work as a Key Medical Service clinician

Checklist before you start work

Before you start working for Key Medical Services, you must make sure you read:

- Assignment confirmation (sent before starting a placement)
- Key Medical Services terms and conditions - https://www.keymedicalservices.co.uk/terms/clinicians/
- This handbook

Before you start work with Key Medical Services you need to provide valid:

- Photo ID and valid UK work visa if applicable
- Proof of adequate Medical indemnity insurance for your whole scope of work
- Disclosure and Barring Certificate (DBS)
- Professional registration number
- Evidence that you are on a GP Performer's list (for GPs)
- Two clinical references

Occupational health information and evidence

Please let us know if you have any health or medical issues requiring reasonable adjustments to your workplace or environment.

It is the responsibility of health care workers to be vaccinated against certain conditions to protect the healthcare worker and/or prevent these being transmitted to patients. You should have vaccinations against and/or immunity to, or a declaration of vaccination or previous infection to Hepatitis B, TB, Diphtheria, Polio, Tetanus, Measles, Mumps, Rubella and chickenpox. This list may vary with compliance requirement updates. You may be asked to provide evidence of this at any time. For details see section 'Clinicians' vaccination and immunity'

Mandatory training and certification

As a registered clinician you are aware that regular update training on certain subjects is mandatory and essential for patient safety and meeting your registered body's guidance. It is your responsibility to ensure that your training is kept up to date and you may be asked to provide evidence of this at any time. See CSTF-Eng-Subject-Guide-v1.1.pdf (skillsforhealth.org.uk)

All clinicians require:

- Basic Life Support for adults and children annually.
- Level 3 safeguarding children and safeguarding adults every 3 years

- Information governance and data security
- How to interact appropriately with people with a learning disability and autistic people (McGowan) – New 1st July 2022 - All CQC-registered providers to ensure their staff receive training on interacting with people with a learning disability and autistic people
- Fire safety
- Equality and diversity and human rights
- Moving and handling Level 1
- Infection prevention and control level two, every three years
- Mental Capacity Act and the Deprivation of Liberties
- Conflict resolution
- Health, Safety and welfare
- Preventing radicalisation ('Prevent' awareness)

Key Medical Services is pleased to have teamed up with the Healthier Business Group to help facilitate completion of the above. You will have free access to the necessary training modules and your certificates will automatically be uploaded to your Key Medical Services profile. If you wish to receive copies of your certificates for your own use, there is a modest annual fee which covers certificates for all the training you do through the Healthier Business Group. Please contact your consultant to obtain log in details.

Information governance

Data protection is **everyone's** responsibility. Key Medical Services expects all clinicians to understand their responsibilities regarding handling patient data and any personal details to which they may have access through Key Medical Services.

Clinicians are expected to undertake regular update training in Information Governance, Data Protection and GDPR (General Data Protection Regulations 2016) and may be asked to provide certification.

The following KMS policies are available on request:

- Privacy policy (also available via our website)
- Data protection policy

Any concerns related to data protection within KMS should be raised to the group Data Protection Officer; you can do this by emailing dpo@celsusgroup.co.uk

For more details about patient confidentiality see section on good practice policies and training requirements.

Professional interactions

Professional appearance and punctuality

As well as having good clinical judgement, we would like to work with clinicians who:

- Have a genuine appreciation and understanding of the needs of independent practices
- Are professional (e.g., turn up on time and avoid short notice cancellation)
- Handle patient and client communications professionally.
- Are approachable to clients and patients
- Are flexible – the services we provide can sometimes be unpredictable and we would like our clinicians to show understanding towards our clients when things change (within reason)

We expect Key Medical Services' clinicians

- To be punctual
- To dress in a professional manner appropriate to their role and follow any dress protocols required by individual practices. Arms should be bare below the elbow, with no jewellery to allow adequate handwashing and infection control.
- To endeavour to balance minimising patient waiting times, with providing adequate time to the patients they see

Interaction with practice managers and other members of the local team

Key Medical Services recognises the critical importance of its clinicians working as part of an integrated, multi-disciplinary and multi-organisational team for the best interests of the patients they care for. We expect all our clinicians to be courteous and helpful to practice managers and members of the local team. See: working with colleagues - ethical guidance - GMC (gmc-uk.org). https://www.nmc.org.uk/standards/code/

You may be working on other healthcare providers' premises, however, as a Key Medical Services' clinician, you will not be working under the control, direction, or supervision of any of the practice's team in relation to clinical judgement. Should the Practice Manager or any

other member of the local team try to provide excessive direction e.g., over clinical judgement, please notify your Consultant.

Timesheets and payment policy

On receipt of a properly completed and signed timesheet, Key Medical Services endeavours to pay our clinicians or their companies weekly in arrears. However, incomplete timesheets could result in payment being withheld until the issues are resolved. Grossly unsatisfactory performance could also result in non-payments or payments being withheld.

It is not legal to ‘work’ for two clients or employers at the same time, even when working remotely. Timesheets should not overlap, and you should be devoting each hour to one role only. You must not work for another provider during the hours that you are claiming.

For any concerns around payroll, or payment of invoices, please contact your Consultant.

Absences, holidays, sickness, and cancellations

At Key Medical Services we appreciate that sometimes emergencies happen, that lead to last minute absences, sickness, and cancellations, however this can have a direct impact on patient care and affect Key Medical Services reputation. We ask that you let Key Medical Services know with as much notice as possible so that Key Medical Services can endeavour to use its network to find a replacement clinician.

Working time regulations

The Working Time Regulations 1998 (WTR) require Celsus Group Limited to limit your average weekly working time to 48 hours unless you agree that the limit shall not apply to you. You are given the option to opt out during the registration process.

Celsus Group Limited must keep records relating to your working time.

If you have ‘opted out’ of the WTR when registering or subsequently then you have agreed that the 48-hour limit on average weekly time shall not apply to you. You may terminate the agreement at any time.

If you have opted out of WTR you may choose to work more than an average working time of 48 hours, but still have a professional responsibility to ensure that your workload does not have a negative impact on the quality of patient care that you provide. Key Medical Services’ limit on average working hours is set at 60 hours per week, with two uninterrupted rest periods each of not less than 24 hours in each 14-day period or one uninterrupted rest

period of not less than 48 hours in each 14-day period, and a daily rest period of not less than eleven consecutive hours in each 24-hour period. This is in line with The Working Time Regulations 1998.

Quality of care and performance policy

GMC Revalidation and appraisals

The Designated body for GPs is always your NHS England local Office. [Find your connection for revalidation - GMC (gmc-uk.org) here](). The GMC does not allow GPs to connect to Key Medical Services.

The Chief Nurse for KMS can support with revalidation and appraisal for non-GP clinicians

Complaints

Minimising the risk of complaints

Here are some suggestions for how clinicians can reduce the risk of a complaint being made against them:

- **At any new premises make sure you know before you start work:**
  - Where are the things you might need in a medical emergency?
    - Oxygen
    - Emergency bag or box
    - Defibrillator
    - Nebuliser

- **Make clear, accurate and complete notes.**
  Good record keeping is vital as it can reduce the likelihood of a complaint by communicating key information to other members of the team and can be vital in responding to a complaint. Poor note taking could lead to misunderstandings and errors with regards to patient care. Record your work clearly, accurately, and legibly.

- **Communicate effectively and respectfully with patients and colleagues**
  As a clinician you have a duty to perform your role in a professional manner regardless of how you are personally feeling at any given time

  Patients:
  - Listen & provide appropriate information.

- Treat patients as individuals, respect their dignity and privacy, and treat them fairly and respectfully.
- Be honest, polite, and considerate to the patient and those close to them.

Working collaboratively with colleagues

- You must work collaboratively with colleagues, respecting their skills and contributions.
- You must treat colleagues fairly and with respect.
- You must be aware of how your behaviour may influence others within and outside the team.

- **Avoid cancelling an assignment at short notice without good reason.**
Patient safety may be affected if there is not enough medical cover and complaints from clients can arise if clinicians are unreliable.

- **Check the expiry date of any medication that you give directly to patients.**

- **Ensure that you get the information that you need** at each assignment regarding local processes, such as how to request investigations and make referrals

Key medical services (KMS) complaint process

Key Medical Services is committed to delivering a quality service. If a complaint arises, it needs to be dealt with in a considerate, quick, and effective manner.

If you would like to make a complaint about Key Medical Services, its clients or service please contact complaints@keymedicalservices.co.uk, and the Key Medical Services team will take appropriate action.

You must inform Key Medical Services, using the email above, if you become aware of any complaint relating to you or the service provided by Key Medical Services. Clients are also invited to send complaints relating to our service, to clinicians' performance or behaviour, or a patient complaint relating to a Key Medical Services' clinician to complaints@keymedicalservices.co.uk.

Handling a complaint made against you

It is common to feel defensive, upset or even angry when you hear of a complaint against you, but you need to put your personal feelings aside and be professional, measured and sympathetic when responding to a complaint. Patients who complain about the care or treatment they have received have a right to expect **a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology**.

In the unfortunate event that a complaint is made against you while working in a KMS assignment, the complaint will be sent to the mailbox complaints@keymedicalservices.co.uk and logged on a confidential complaints and serious incident tracking spreadsheet. The KMS complaints team will ask the complainant for any additional information needed for a response, such as redacted patient notes. You'll then receive details of the complaint and will be asked to draft a response or statement.

Your consultant and other members of the KMS team will be there to support you and you will be given guidance on how to write a statement and kept fully up to date of information that Key Medical Services receives regarding progress.

The response should be returned to the complaints team at complaints@keymedicalservices.co.uk within 5 working days. If a full response is not possible in that time due to, for example, necessary communication with your indemnity provider, then you should send a 'holding response'. Your response will be checked by a member of the complaints team to ensure that it is professional, measured, and sympathetic, and once approved this will be returned to the complainant. Complaints from patients will normally be investigated by the client.

If a complaint is serious then you should of course contact your indemnity provider as soon as possible for advice.

Key Medical Services' Chief Medical Officer, Dr Caroline Rogers (cmo@keymedicalservices.co.uk) is available for GPs and Lorraine Gray Chief Nurse is available for all other clinicians who need additional support during a complaints process. They also may contact those who are subject to serious or multiple complaints to offer support and help with reflecting on complaints to identify possible training needs. Remember, for GPs that any complaints whether minor, serious, upheld or not, should be included in your annual GMC appraisal with reflection on what you have learned from the experience and measures to take to reduce the risk of a similar incident occurring again.

Depending on the nature of the complaint it will be investigated by either the client who you were assigned to at the time, or the Key Medical Services complaints team, or both.

Key Medical Services recording and reviewing complaints.

All complaints will be recorded and handled by Key Medical Services' Chief Nurse and Group Head of Quality and Compliance for Celsus. Complaints received will be reviewed at least every three months at Key Medical Services Senior Management Team meetings and any

suggestions for changes to practice discussed. Any serious complaints will be referred to the Senior management team and reviewed at their next meeting.

Significant event analysis

Significant events may be:

- Serious patient safety NHS England - Serious Incident framework such as
    - Unexpected or avoidable death
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, failure to safeguard against abuse.
    - A Never Event - http://www.england.nhs.uk/ourwork/patientsafety/never-events/
- Adverse events of a less serious nature, but that result in a risk to a patient or a failure to deliver a good service such as
    - an unsent referral letters.
    - a prescribing error.

Any event where reflection could lead to an improvement in patient care. Positive events can also be recorded as examples of good practice.

Key Medical Services reviews significant events to learn from them, and, in the case of all adverse events Key Medical Services is committed to implementing changes to reduce the risk of recurrence.

As a Key Medical Services clinician, you **must report** all serious incidents, as defined above, to Key Medical Services as part of your obligations to them, and your duty to uphold the principles of duty of candour. (Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk) – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.)

Key Medical Services also encourages clinicians to report to them **other significant events**, such as long waiting times, problems accessing services, communication limitations, problems with continuity of care, delays in obtaining pathology or imaging results or problems with referrals.

Key Medical Services will support clinicians in coping with serious patient safety incidents and will review all significant events to learn from them and implement changes to reduce

the risk of recurrence. Significant events will be reviewed at Senior Management meetings and any suggestions for changes to practice discussed. Any serious patient safety incidents will be referred to the board and reviewed at the next board meeting.

Feedback and performance

At Key Medical Services we care about providing a good experience for patients and clients. and want to make sure we continue to attract good clinicians and so welcome feedback from you, from patients and from clients.

Feedback from you

As part of this commitment to improving our services we welcome any feedback you may have about our services or clients, to enable us to improve the service delivered to patients. Please email us on feedback@keymedicalservices.co.uk or contact your Consultant.

Client and patient feedback

As part of this commitment to improving our services, at the end of each assignment, we will ask the client for feedback.

We may also ask GPs to share with Key Medical Services their GMC formal colleague and patient feedback, which is required every five years for revalidation. We encourage sharing of feedback from all our clinicians so that we can share good practice and support where required.

Clinicians’ performance and training

Clinicians’ performance will be assessed through feedback received from clients and patients, and through complaints and significant events reviews. Key Medical Services offers support with identifying and addressing your learning needs and you may be offered performance reviews. Key Medical Services may ask you to provide Key Medical Services with the summary of your appraisals.

Good practice policies and training requirements

Assignment location specific information

At your assignment location it is vital that you find out before you start work

- **Fire** - where to find Fire extinguishers and the fire exits, and the evacuation procedure and meeting point
- **Medical Emergencies** – where to find the oxygen and how to use it; where the defibrillator is kept; where to find the Emergency box or bag and what it contains; how to raise the alarm and call an ambulance.
- **Needle stick injury** – Post Exposure Prophylaxis against HIV (PEP) policy.
- **Medicines and Prescribing** – Local prescribing and dispensing policies.

The following policies and guidance are not location specific.

Patient confidentiality

Clinicians have a duty NOT to disclose the identity of, or any personal or medical details about any patient to anyone without the patient's consent, with a few exceptions including:

- Most patients understand and expect that relevant information must be shared within the direct care team to provide their care. You should share relevant information with those who provide or support direct care to a patient, unless the patient has objected.
- With regards to those close to the patient, you should establish with the patient what information they want you to share, with whom, and in what circumstances. You must treat information about patients as confidential. This includes after a patient has died.
- The only other time the confidentiality may be broken is if the clinician believes that the patient is at risk or a risk to others. A clinician should discuss any such decision with the appropriate person in the client's organisation and may wish to seek advice from the Key Medical Services compliance team and/or their indemnity insurance company.

Clinicians should not share the identity of their patients with Key Medical Services. When managing complaints and adverse events and reflecting on cases with Key Medical Services, this should be done with patient data anonymised / redacted.

See the GMC good practice in handling patient information for more details.

Confidentiality within the practice at which the clinician is working

All consultations must be conducted in consultation rooms designed for this purpose, with the door closed. Clinicians must be mindful of the need to avoid being overheard by others when talking to or about a patient about their care or treatment, including during phone calls.

Children

Children have a right to confidentiality. Clinicians can generally assume that they can freely discuss a child's care with a parent or guardian attending with them. However, they should consider whether the child may wish to share information with them without the parent or guardian's knowledge, particularly if a child is over the age of 12. Consideration should be given to this if there are any concerns relating to contraception or STIs or safeguarding issues. In these circumstances the clinicians should endeavour to spend some time with the young person without the parent or guardian, assess their 'Gillick' competence and, in the case of contraception or sexual health, apply the Fraser guidelines. (See section on Consent).

Police requests for information

In the event of a request by the police for the release of information, the clinician should require a written request detailing why and what information is requested. The clinician who saw the patient should discuss with the practice where the patient was seen and may wish to seek advice from their indemnity insurance company to decide as to whether a breach of confidentiality is justified and exactly what information is relevant.

Patient access to their medical records.

If a patient requests access to their medical records, clinicians should pass the request to the practice where the patient is seen, so the request can be dealt with according to their policies.

Consent policy

Professional Consent: patients and clinicians making decisions together

Including extracts from

Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care.

In so doing, you must:

- Listen to patients and respect their views about their health.
- Discuss with patients what their diagnosis, prognosis, treatment, and care involved.
- Share with patients the information they want or need to make decisions, including risks, complications, and alternatives.
- Maximise patients' opportunities, and their ability, to make decisions for themselves
- Respect patients' decisions.

For a relationship between clinician and patient to be effective, it should be a partnership based on openness, trust, and good communication.

Patients can give consent:

- Orally
- In writing
- Or they may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken.

In the case of minor or routine investigations or treatments, if you are satisfied that the patient understands what you propose to do and why, it is usually enough to have oral or implied consent. In cases that involve higher risk, it is important that you get the patient's written consent. This is so that everyone involved understands what was explained and agreed.

You must use the patient's medical records or a consent form to record the key elements of your discussion with the patient. This should include the information you discussed, any specific requests by the patient, any written, visual, or audio information given to the patient, and details of any decisions that were made.

Making decisions about investigations and treatment

You must give patients the information they want or need about:

- The diagnosis and prognosis
- Any uncertainties about the diagnosis or prognosis, including options for further investigations
- Options for treating or managing the condition, including the option not to treat
- The purpose of any proposed investigation or treatment and what it will involve
- The potential benefits, risks and burdens, and the likelihood of success, for each option; this should include information, if available, about whether the benefits or risks are affected by which organisation or clinician is chosen to provide care
- Whether a proposed investigation or treatment is part of a research programme or is an innovative treatment designed specifically for their benefit

Remember that patients can change their mind at any time. Consent must be treated as a process that continues throughout the duration of care and treatment, recognising that it may be **withheld and/or withdrawn** at any time. Clinicians must respect the patients' decisions, including refusal of consent or withdrawal of previously given consent.

A person's capacity to consent is NOT a one-off assessment. It will vary in time (depending for example on mental capacity or medication) and will depend on the complexity and seriousness of the decision to be made.

Learning disability - Assessing capacity in a patient with a learning disability - GMC (gmc-uk.org)

Involving families, carers and advocates

You should accommodate a patient's wishes if they want another person, such as a relative, partner, friend, carer, or advocate, to be involved in discussions or to help them make decisions.

Carers

More information about general ways of supporting carers can be found through the following links:

Supporting carers in general practice: a framework of quality markers

The quality markers ask a general practice to identify six things. How they:

- identify and register carers
- use the carer's register to support holistic carer health and wellbeing needs
- organise themselves to understand and respond to the needs of carers
- make it easier for carers to access services
- communicate with, involve, and inform carers
- promote a career-friendly culture

NHS England advice: carers' toolkit - Identify, assess, and support carers' needs

Commitment to Carers - reflects what carers say is important to them:

Checklist-for-Carers-updated.pdf (carersinfo.org.uk)

All professionals can access advice via their registered body

Consent in emergency situations

When an emergency arises in a clinical setting and it is not possible to find out a patient's wishes, you can treat them without their consent, provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition. The treatment you provide must be the least restrictive of the patient's future choices. For as long as the patient lacks capacity, you should provide ongoing care. If the patient regains capacity while in your care, you should tell them what has been done, and why as soon as they are sufficiently recovered to understand.

Respecting patient decisions

You must respect a patient's decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational. You should explain your concerns clearly to the patient and outline the possible consequences of their decision. You must not, however, put pressure on a patient to accept your advice. If you are unsure about the patient's capacity to make a decision, you must follow the guidance from your professional body

Children and young people

You should involve children and young people as much as possible in discussions about their care, even if they are not able to make decisions on their own. A young person's ability to make decisions depends more on their ability to understand and weigh up options, in accordance with Gillick competence assessment, than on their age.

When assessing a young person's capacity to make decisions, you should bear in mind that:

- A young person under 16 may have capacity to make decisions, depending on their maturity and ability to understand what is involved
- At 16 a young person can be presumed to have the capacity to make most decisions about their treatment and care.

If you judge a young person to have capacity to give consent, you should accommodate their wishes if they want another person, such as a relative, partner, friend, carer, or advocate, to be involved in discussions or to help them make decisions.

If you judge a young person or child to lack capacity, then you must follow the guidance in 0–18 years: guidance for all clinicians, and in particular the section Making decisions (paragraphs 22–41).

Young people: contraception, abortion and STI advice

You can provide contraceptive, abortion and STI advice and treatment, without parental knowledge or consent, to young people under 16 provided you follow the Fraser Guidelines:

- They understand all aspects of the advice and its implications
- You cannot persuade the young person to tell their parents or to allow you to tell them
- In relation to contraception and STIs, the young person is very likely to have sex with or without such treatment
- Their physical or mental health is likely to suffer unless they receive such advice or treatment
- It is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent

You should keep consultations confidential even if you decide not to provide advice or treatment (for example, if your patient does not understand your advice or the implications of treatment), other than in the exceptional circumstances outlined in GMC guidance.

A child under 13 years (= 12 years or younger) cannot legally consent to sex and it is obligatory to report to the Local Child Safeguarding Team if you become aware of a young person in this situation.

Mental Capacity Act 2005 and DoLs (Deprivation of liberties safeguards) amendment 2019

Key Medical Services clinicians must have knowledge and understanding of the Mental Capacity Act 2005 and be able to assess the capacity of patients and know what to do if they feel a patient lacks capacity to consent to medical examination, investigation, or treatment. They must also Clinicians must undertake regular training updates.

Principles of the act

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing capacity

You must start from the presumption that every adult patient has capacity to make decisions about their treatment care. You must not assume a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), beliefs, their apparent inability to communicate, or because they choose an option that you consider unwise.

A person has capacity if they can do all the following:

a. understand information relevant to the decision in question
b. retain that information
c. use the information to make their decision
d. communicate a decision.

Providers must make every reasonable effort to provide opportunities to involve people in making decisions about their care and treatment and support them to do this. This includes physical, psychological, or emotional support, or support to get information in **an accessible format or to understand the content**. It may include involving people in discussions, inviting them to meetings and encouraging them to ask questions and providing suggestions.

People using the service and/or those lawfully acting on their behalf must be actively encouraged and supported to be involved in making decisions about their care or treatment as much or as little as they wish to be. This includes **taking all steps to maximise a person's mental capacity in different ways to make as many of their own choices as possible**.

- Regulation 9: Person-centred care | Care Quality Commission (cqc.org.uk)
- GMC Decision making and consent, paragraphs 81 and 83

If in doubt, assess your patient's capacity in line with the relevant national law and GMC guidance.

Always assess a patient's capacity **to make a particular decision at the time it needs to be made**. Don't assume that because a patient lacks capacity to make a decision on a particular occasion, they lack capacity to make any decisions at all now or in the future. Requirements can differ from country to country but by following the principles in the GMC Decision making and consent guidance or your professional code guidance you'll always be in line with the law. Always record your actions and decision clearly.

Deprivation of liberties

The deprivation of liberty safeguards (DoLS) protect people who do not have the mental capacity to consent to treatment.
They apply to people who lack mental capacity who live in a:

- care home
- hospital
- supported living environment

Deprivation of liberty safeguards make it clear that a person may only be deprived of their liberty:
- In their own best interests to protect them from harm
- If it is a proportionate response to the likelihood and seriousness of the harm
- If there is no less restrictive alternative.

See the CQC Nigel's surgery 10 for more information on:

- Appointing an Independent Mental Capacity Advocate (IMCA)
- Lasting powers of attorney (LPA)
- Court of Protection
- Deprivation of liberties

Basic life support

Key Medical Services clinicians must

1. **Training** - Undertake **annual training in Basic Life Support** for adults and children and be able to provide Key Medical Services with appropriate up to date certification on request. They should have the knowledge and skills to manage cardiac or respiratory arrest and choking. 2021 Resuscitation Guidelines | Resuscitation Council UK.
2. **Emergency equipment** - Familiarise themselves with the **type of emergency equipment and where to find it,** including the defibrillator; emergency bag or box; and oxygen, on arrival at a new assignment location. They must ensure that they keep up to date with how to use an AED, oxygen, and the contents of the available emergency bag.
3. **Summoning help** - Familiarise themselves with the local arrangements for **summoning help**.

Healthcare professionals can access guidelines on the go with Resuscitation Council UK's **iResus app**

BLS/ AED sequence of steps:

Danger – check surroundings

Response – Gently shake the shoulders and ask loudly 'Are you all right?'

Airway – Patient on their back, head tilt, chin lift

Breathing – Look, listen and feel for breathing for no more than 10 seconds

999 – Call for help & dial 999 or get someone else to do this while you start CPR

AED – send for (do not leave patient if on your own)

Circulation ADULTS – start **C**hest **C**ompressions 100-120 per minute 5-6 cm depth

Count to 30.

(CHILDREN 5 rescue breaths first then chest compressions 100-120 per min 1/3 depth of chest)

2 Rescue Breaths – then continue CPR 30:2 chest compressions to rescue breaths.

AED – attach and turn on **AED** continuing CPR if more than one rescuer. Follow instructions.

Anaphylaxis

Key Medical Services clinicians must have the knowledge and skills to recognise and manage anaphylaxis and must undertake regular training updates. See the resuscitation council guidance updated information for use in any vaccination setting updated in 2021 and Guidance: Anaphylaxis | Resuscitation Council UK

Recognising anaphylaxis

- reaction.pdf (resus.org.uk)

Anaphylaxis characteristics

- Sudden onset and rapid progression of symptoms
- Life-threatening airway and/or breathing and/or circulation problems
  e.g., Swollen lips, hands or feet / lightheaded or faint/ swollen mouth, throat or tongue affecting breathing / wheezing/ abdominal pain, nausea & vomiting / collapse
- Skin and/or mucosal changes (flushing, urticaria, angioedema) in some casualties.

Action

- Call for an Ambulance
- Lie patient flat with or without legs elevated
  - Alternatively, a sitting position may optimize respiratory distress
  - If pregnant lie on left side.

Adrenaline

The following doses of adrenaline 1/1,000 are recommended:

Age	Dose
Over 12 years	0.5 mg IM (0.5ml 1:1000 solution)
6 - 12 years	0.3 mg IM (0.3ml 1:1000 solution)
6 months - 6 years	0.15 mg IM (0.15ml 1:1000 solution)
Under 6 months	0.01mg/kg IM (0.01ml/kg 1:1000 solution)

Repeat the IM adrenaline dose if there is no improvement in the patient's condition. Further doses can be given at about 5-minute intervals according to the patient's response.

Further action

- Establish airway
- Give high dose oxygen
- Apply monitoring: Pulse oximetry, ECD, Blood pressure

Sepsis

Key Medical Services clinicians must have the knowledge and skills to recognise and manage sepsis and must undertake regular training updates.

NICE' Sepsis: recognition, diagnosis and early management guidance.

Think 'could this be sepsis?' if a person presents with signs or symptoms that indicate possible infection.

- Consider that people with sepsis may have non-specific, non-localised presentations, for example feeling very unwell, and may not have a high temperature.
- Pay particular attention to concerns expressed by the person and their family or carers, for example changes from usual behaviour.
- Assess people who might have sepsis with extra care if they cannot give a good history (for example, people with English as a second language or people with communication problems).
- Assess people with any suspected infection to identify:
  - possible source of infection
  - factors that increase risk of sepsis (see section 1.2)
  - any indications of clinical concern, such as new onset abnormalities of behaviour, circulation, or respiration.
- Identify factors that increase risk of sepsis (see section 1.2) or indications of clinical concern such as new onset abnormalities of behaviour, circulation or respiration when deciding during a remote assessment whether to offer a face-to-face-assessment and if so, on the urgency of face-to-face assessment.
- Use a structured set of observations (see section 1.3) to assess people in a face-to-face setting to stratify risk (see section 1.4) if sepsis is suspected.

- Consider using an early warning score (NEWS2 has been endorsed by NHS England) to assess people with suspected sepsis in acute hospital settings.
- Suspect neutropenic sepsis in patients having anticancer treatment who become unwell. (This recommendation is from NICE's guideline on neutropenic sepsis.)
- Refer patients with suspected neutropenic sepsis immediately for assessment in secondary or tertiary care. (This recommendation is from NICE's guideline on neutropenic sepsis.)
- Treat people with neutropenic sepsis in line with NICE's guideline on neutropenic sepsis.

Face-to-face assessment of people with suspected sepsis

1. Assess temperature, heart rate, respiratory rate, blood pressure, level of consciousness and oxygen saturation in young people and adults with suspected sepsis.
2. Assess temperature, heart rate, respiratory rate, level of consciousness, oxygen saturation and capillary refill time in children under 12 years with suspected sepsis. (This recommendation is adapted from NICE's guideline on fever in under 5s.)
3. Measure blood pressure of children under 5 years if heart rate or capillary refill time is abnormal and facilities to measure blood pressure, including a correctly sized blood pressure cuff, are available. (This recommendation is adapted NICE's guideline on fever in under 5s.)
4. Measure blood pressure of children aged 5 to 11 years who might have sepsis if facilities to measure blood pressure, including a correctly sized cuff, are available.
5. Only measure blood pressure in children under 12 years in community settings if facilities to measure blood pressure, including a correctly sized cuff, are available and taking a measurement does not cause a delay in assessment or treatment.
6. Measure oxygen saturation in community settings if equipment is available and taking a measurement does not cause a delay in assessment or treatment.
7. Examine people with suspected sepsis for mottled or ashen appearance, cyanosis of the skin, lips or tongue, non-blanching rash of the skin, any breach of skin integrity (for example, cuts, burns or skin infections) or other rash indicating potential infection.
8. Ask the person, parent, or carer about frequency of urination in the past 18 hours

Action

If there is a high risk of sepsis (or a moderate to high risk where there is no definitive condition which be diagnosed and treated in an out of hospital setting)

Send patient urgently for emergency care to a setting with resuscitation facilities

Safeguarding policy (includes FGM, modern slavery and radicalisation)

Checks and training

All Key Medical Services clinicians must have an enhanced DBS (Disclosure and Barring service) check prior to seeing patients.

Key Medical Services clinicians MUST complete the following training every 3 years and provide Key Medical Services with updated certifications of completed training when requested.

- Safeguarding Children level 3
- Safeguarding Adults' level 3. In addition, if not included in the level 3 safeguarding training they must have completed training in
- Modern day slavery, sex slavery and people trafficking
- Female genital mutilation (FGM)
- Radicalisation

Intimate examinations and chaperones - maintaining dignity

To ensure the personal dignity of patients, they must be seen in private consultation rooms where the doors are closed throughout the consultation, (unless on a home visit). If an intimate examination is to be performed clinicians must ensure that the door is locked in a way that prevents others from entering the room.

Clinicians should allow patients who need to undress for examination to do so behind screens, out of sight of the clinician, and provide the patient with a gown where available and / or something to cover themselves, only exposing, for the minimum time possible, the part of the body being examined.

Extract from Intimate examinations and chaperones - professional standards - GMC (gmc-uk.org).

Whenever you examine a patient, you should be sensitive to what they may think of as intimate and make clear the steps that will be carried out as part of the examination, before it begins

- Before conducting an intimate examination, you should:
  - explain to the patient why an examination is necessary and give the patient an opportunity to ask questions
  - consider and address any communication barriers that could impact on the patient's experience or understanding of an intimate examination
  - explain what the examination will involve in a way the patient can understand, so that they have a clear idea of what to expect, including any pain or discomfort
  - explain to the patient that they can ask at any time for the examination to stop
  - offer the patient a chaperone (see paragraphs 16– 22) and explain what the chaperone's role would be during the examination.
  -
- You must obtain the patient's consent or have other valid authority before the examination and record that the patient has given it (see *Decision making and consent* for more information)
- If an adult patient lacks capacity, you should follow the guidance in paragraphs 76 – 91 of *Decision making and consent*.
- If the patient is a child or young person:
  - you must assess their capacity to consent to the examination
  - if they lack the capacity to consent, you should seek their parent's consent or make sure you have other valid authority (see *0–18 years: guidance for all doctors* for more information).
- You should give the patient privacy to undress and dress and keep them covered as much as possible to maintain their dignity. Do not help the patient to remove clothing unless they have asked you to, or you have checked with them that they want you to help.

During the examination

- During the examination, you must follow the guidance in *Decision making and consent*. In particular you should:

- explain what you are going to do before you do it and, if this differs from what you have told the patient before, explain why and seek the patient's permission
- be alert to the patient showing signs of discomfort or distress
- check whether the patient has questions, wants to stop the examination or agrees for the examination to continue
- stop the examination if the patient asks you to
- keep your comments professional and relevant to the clinical examination. Unnecessary personal comments may cause distress or offence.

Chaperones

When you carry out an intimate examination, you should, wherever possible, offer the patient the option of having a chaperone who can act as an impartial observer. You should explain what the chaperone's role would be during the examination.

- A chaperone should usually be a health professional and their role are to be:
  - sensitive and respect the patient's dignity and confidentiality
  - alert to the patient showing signs of distress or discomfort
  - aware of the most appropriate route to raise concerns and do so if they are concerned about the medical professional's behaviour or actions.
- You must be satisfied that a chaperone is:
  - trained for the role they are undertaking
  - familiar with the procedures involved in the proposed examination or briefed in advance
  - able to stay for the whole examination and be able to see what you are doing, as much as practical without obstructing the examination or interfering with the patient's dignity.
- A chaperone should also be given the chance to ask questions if anything about their role is not clear to them prior to the examination.
- A relative or friend of the patient is not a trained impartial observer and so would not usually be a suitable chaperone. However, the presence of a chaperone does not override a patient's wish to be supported by a relative, friend or advocate. You should comply with a reasonable request from the patient to have such a person present as well as a chaperone
- You should not assume that the patient doesn't want a chaperone. If no suitable chaperone is available, or if either of you is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a suitable

chaperone will be available, as long as the delay would not adversely affect the patient's health.

- If you wish to examine the patient with a chaperone present but the patient has said no to having one, you must explain clearly why you want a chaperone present. If the patient wishes to proceed without a chaperone but you remain uncomfortable with this, you may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as the delay would not adversely affect the patient's health. If you feel your personal safety is at risk you should follow the guidance in *Maintaining personal and professional boundaries* or *Ending a professional relationship with a patient*.
- You should record the detail and outcome of any discussion about chaperones in the patient's medical record. If a chaperone is present during an examination, you should record that fact and make a note of their identity and role. If the patient does not want a chaperone, you should record that the offer was made and declined.

Reporting concerns about persons at risk

Clinicians have a duty of care to inform the safeguarding lead at the practice where the person or child is seen if they have any suspicion that the person or child may be at risk. If anyone suspects **immediate risk**, they should **call 999**.

If it is believed that there is no immediate risk the clinician must discuss their concerns with **members of the practice** where the patient was seen at the earliest opportunity and report their concern to the **safeguarding lead** at the practice.

The Children and Families Assessment Team or **Adult Safeguarding Team for the county council** where the person lives should be informed where deemed appropriate by the team at the practice. The practice should have the relevant numbers in their practice safeguarding policy.

Managing communication where you suspect risk

All patients (except young children) should be seen without the person who brought them, for part of the consultation, and asked if there is anything that they would like to tell you while the other person is not present. Ask the accompanying person to leave for part of the appointment e.g., while you examine the patient.

Further advice on handling situations where you suspect risk will be found in your mandatory training.

Specific groups who may be vulnerable

Nigel’s surgery provides references to specific groups who may be particularly vulnerable. For more information see the following links

- Nigel's surgery 29: Looking after homeless patients in General Practice | Care Quality Commission (cqc.org.uk)
- Nigel's surgery 36: Registration and treatment of asylum seekers, refugees and other migrants
- Nigel's surgery 53: Care of people with a learning disability in GP practices
- Nigel's surgery 93: Caring for veterans and their families | Care Quality Commission (cqc.org.uk)

Possible domestic abuse

Staff should encourage patients to seek help from the police or through the domestic abuse helpline **0808 2000 247**.

- See Domestic Violence Support | National Domestic Violence Hotline (thehotline.org)
- Offer to help them to report abuse
- Offer support as far as possible within your role
- Discuss your concerns with colleagues and safeguarding lead and seek further professional advice when needed

Modern slavery, sex slavery and people trafficking

Options if you have concerns:

- Call the Modern Slavery Helpline on 08000 121 700
- Contact the Gangmasters and Labour Abuse Authority to report concerns about the mistreatment of workers on 0800 432 0804, or by email intelligence@glaa.gsi.gov.uk
- Contact Crime stoppers on 0800 555 111
- Contact the Police

Modern slavery is a global crime and affects thousands of men, women, and children here in the UK. Defined in the Modern Slavery Act 2015, it encompasses various types of exploitation, including but not limited to:

- Forced labour
- Sexual exploitation
- Domestic servitude
- Criminal exploitation
- Forced marriage
- Organ harvesting

By recognising the signs of modern slavery and sharing information, you can help the most vulnerable people within our community and prevent this crime from happening.

There are several common signs that someone is being exploited:

- Acting as if they are being forced or coerced to carry out specific activities
- Showing signs of physical or psychological abuse or has untreated medical conditions
- Seeming to be bonded by debt or has money deducted from their salary
- Having little or no contact with family or loved ones
- Being distrustful of authorities
- Having threats made against themselves or family members
- Not being in possession of their own legal documents

If you have any concerns, gather as much information as possible, particularly contact information to enable you to get back in touch with the person if unable to take immediate action.

- Discuss with the safeguarding lead
- Call the helpline above to discuss concerns

Female genital mutilation (FGM)

Extracts from Nigel's surgery 80: Female genital mutilation (FGM) | Care Quality Commission (cqc.org.uk) 2021.

Serious Crime Act 2015

FGM has been illegal in the UK since 1985. In November 2015 the Serious Crime Act strengthened legislation by adding extra requirements for health care professionals to report FGM.

The Act:

- Granted lifelong anonymity to alleged FGM victims.
- Made it an offence for parents to fail to protect their child from FGM.

- Introduced FGM Protection Orders, which can prevent potential victims from travelling abroad.
- Created a mandatory reporting duty for nurses, midwives, doctors, social workers, and teachers to report to the police whenever they observe physical signs of FGM on a person under the age of 18, or where a girl tells them it has been carried out on her.
- Made it an offence for FGM to be committed abroad against UK residents.

Identifying FGM

A variety of presentations may prompt a clinician working in primary care to suspect a woman or child has been subjected to FGM. This includes repeated urinary tract or vaginal infections, urinary incontinence, dysmenorrhea, and difficulty becoming pregnant.
The Department of Health FGM safeguarding pathway, which is relevant for all primary care staff, gives guidance on how to proceed. This includes initially asking the woman whether she comes from a community where cutting or circumcision is practised.
Daughters of women who have undergone FGM are at risk of being taken abroad to undergo FGM. Nurses in general practice who provide pre-travel consultations for patients requesting vaccinations should be alert to patients travelling to destinations where FGM may be practised.

Requirements on clinicians to report FGM

In addition to the requirements of the Serious Crime Act, it is now mandatory for all GP practices and Acute and Mental Health Trusts to submit FGM data to NHS Digital. Specific read codes have been produced for GPs and nurses to document FGM in patient records. Under 18s who may be at risk of FGM should be referred using standard existing safeguarding procedures, usually to children’s services.

Resources

- Department of Health FGM guidance for healthcare staff
- Multi-agency statutory guidance on female genital mutilation
- Royal College of General Practitioners FGM resources

Login to MyRCN and search FGM Action if FGM uncovered, or risk suspected

- Ensure you have as much information to facilitate future contact with the patient, a parent, or a guardian – phone number, email, address, school, place of work, GP, etc.
- Inform the safeguarding lead at the practice where the person was seen as soon possible.

- Contact local safeguarding services
- Link for GMC training in FGM for Clinicians: https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare
- Free training module 2018: https://rcpsg.ac.uk/elearning/product/female-genital-mutilation

As of **31/10/2015** all clinicians in England and Wales have **a mandatory duty** to report FGM in under 18s. The target time for reporting is the end of the next working day from when the FGM was discovered or disclosed.

- FGM is a "serious crime" and a child protection issue
- GMC: "you **must** tell an appropriate agency (social services, child protection services) if you are concerned that a child or young person is **at risk or has sustained FGM"**

Failure to report actual cases or serious concerns may result in a clinician's registration to be put at risk

Radicalisation

Definition - the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups. The 'Prevent' campaign involves schools and child services.

If you are concerned about extremism in an organisation that works with children, or if you think a child might be at risk of extremism, contact the government's helpline.
020 7340 7264. Email counter.extremism@education.gov.uk

Infection prevention and control policy

All Key Medical Services clinicians must take appropriate measures at all times to prevent and control infections and complete training every 3 years and provide Key Medical Services with updated certifications of completed training on request.

Epidemics / pandemics

During an epidemic or pandemic, clinicians agree to comply with the advice issued by NHS England and PHE.

In addition, clinicians must not work if they have symptoms of a potentially infectious disease and must report to Key Medical Services if they develop symptoms within a few days of working.

Immunisation responsibilities

It is your responsibility to have the following immunisations or tests or meet the following criteria before seeing patients. See [Immunisation against infectious disease - GOV.UK (www.gov.uk)]

- Diphtheria / Tetanus /Whooping cough / Polio
  - Full childhood course
- Hepatitis B
  - 3 or more vaccines at appropriate intervals followed by a blood test more than one month after completion of the course showing titre levels of 100lu/l or above. You may be asked to provide your results at any time.
  - If your immunity test result is <100Iu/l then seek expert advice on whether to have further doses.
  - If you are a ‘non-responder’ (i.e. your blood test result does not reach adequate levels after additional doses recommended by an expert, please inform your KMS consultant. You are responsible for following appropriate measures for a non-responder in the event of a potential exposure.
- Tuberculosis
  - BCG vaccination. You may be asked to provide certification of the BCG scar check or proof of BCG vaccination

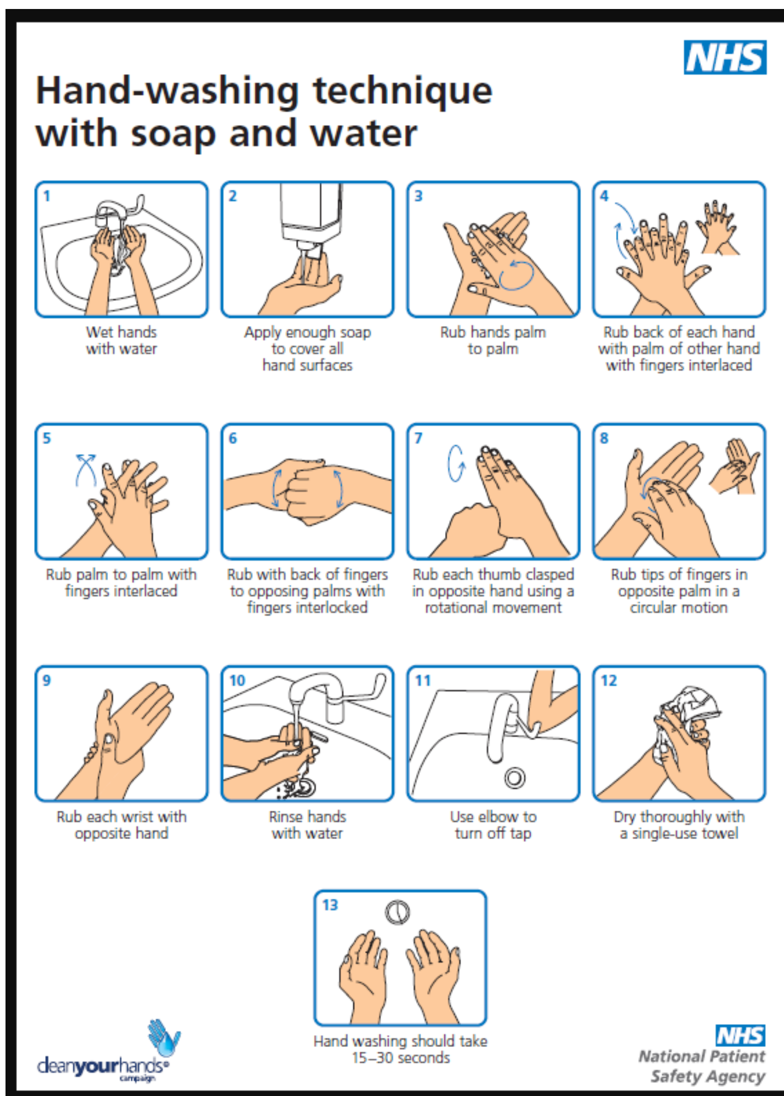
        - Any symptoms consistent with possible TB, regardless of BCG vaccination, must be investigated before seeing patients.
    - In addition, if you have previously lived outside the UK there is a requirement relating to certain countries for health care workers to have a skin test (Mantoux test) for TB or Interferon Gamma release Assay (IGRA) / Quantiferon 'gold' TB blood test before working in the UK.
    - If you have a positive skin test for TB at any time, then it is your responsibility to have an Interferon Gamma release Assay (IGRA) / Quantiferon 'gold' TB blood test. If this is also positive, then it is your responsibility to seek investigation for active TB and assessment for treatment of latent TB, and hence to ensure that you are clear of TB before seeing patients.

- Measles, Mumps and Rubella
    - Proof of two MMR vaccinations or proof of a positive antibody blood titre for Rubella and Measles.
- Varicella
    - If you have had Chickenpox or shingles infection, you may be asked to provide a written statement to confirm this.

If you have not had chickenpox or shingles, it is your responsibility to have a serology test which shows immunity, or to have 2 vaccinations against varicella to ensure that there is not a risk of you passing this infection to vulnerable patient

Clinicians' infection control responsibilities

- To wash their hands correctly with soap and water between patients and whenever else appropriate. You must report to the clinic in which you are working if you consider handwashing facilities to be inadequate.



- To wear gloves and / or a surgical mask where appropriate, and to follow infection control procedures of the location to which they are assigned.
- To take measures to prevent contact of bodily fluids with any part of the clinic or contents, or in the event of this occurring, ensure appropriate cleaning including bodily fluid spillages. If a spillage occurs as the client for the location of spillage packs.
- To dispose of sharps and clinical waste in the appropriate containers and take action to prevent them from becoming overfilled. If a clinical waste bin or sharps' bin is full to it's safe limit, then ensure it is changed before adding any further waste.
- Not to re-use equipment designed for single use marked by the symbol ②
- To ensure that equipment, such as your stethoscope, sphygmomanometers, otoscopes, etc. are clean. Clean equipment between use.

Report to the practice manager any concerns about the cleanliness of premises or infection control measures at the clinic where they are working, and, if unsatisfied with the response, discuss with Key Medical Services.

Needlestick injury policy

If a clinician suffers a needlestick injury, they should **irrigate** the injury under running water immediately and wash the wound with soap and water. In the event of bodily fluids coming into contact with mucous membranes, the mouth, eye, or nose should be irrigated.

The next priority is, where possible, to **ask the patient**, on whom the needle had been used prior to injury, or whose bodily fluids were involved, if they would be willing to undergo **testing for HIV and Hepatitis B and C**. If they consent, blood should be taken and sent for analysis, and if possible, a point of care test for HIV arranged. Ensure that adequate contact details for the patient have been recorded. If the patient is willing to answer personal questions to reassure the health professional and /or allow adequate risk assessment, then record where possible:

- If they have had any previous testing for HIV, Hepatitis B or Hepatitis C
- Their current HIV/Hepatitis B/Hepatitis C status (if known)
- Whether they have a regular sexual partner
- If they have had other partners – who, when and details if relevant
- Any history of injecting drugs/sharing needles

The clinician should follow the needlestick injury policy of the clinic at which they are working.

Antimicrobial stewardship

Clinicians must prescribe antibiotics appropriately to reduce resistance.

1 Recommendations | Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use | Guidance | NICE

Recommendations for prescribers

Antimicrobial prescribing – *points applicable in GP setting*

1.1.24. When prescribing antimicrobials, prescribers should follow local (where available) or national guidelines on:

- prescribing the shortest effective course
- the most appropriate dose
- route of administration.

1.1.25. When deciding whether to prescribe an antimicrobial, take into account the risk of antimicrobial resistance for individual patients and the population as a whole.

1.1.26. When prescribing any antimicrobial, undertake a clinical assessment and document the clinical diagnosis (including symptoms) in the patient's record and clinical management plan.

1.1.28. For patients in primary care who have recurrent or persistent infections, consider taking microbiological samples when prescribing an antimicrobial and review the prescription when the results are available.

1.1.29. For patients who have non-severe infections, consider taking microbiological samples before deciding about prescribing an antimicrobial, providing it is safe to withhold treatment until the results are available.

1.1.30. Consider point-of-care testing in primary care for patients with suspected lower respiratory tract infections as described in the NICE guideline on pneumonia in adults.

1.1.31. Prescribers should take time to discuss with the patient and/or their family members or carers (as appropriate):

- The likely nature of the condition
- Why prescribing an antimicrobial may not be the best option
- Alternative options to prescribing an antimicrobial
- Their views on antimicrobials, considering their priorities or concerns for their current illness and whether they want or expect an antimicrobial
- The benefits and harms of immediate antimicrobial prescribing
- What they should do if their condition deteriorates (safety netting advice), or they have problems as a result of treatment
- Whether they need any written information about their medicines and any possible outcomes.

1.1.32. When an antimicrobial is a treatment option, document in the patient's records (electronically wherever possible):

- The reason for prescribing, or not prescribing, an antimicrobial
- The plan of care as discussed with the patient, their family member or carer (as appropriate), including the planned duration of any treatment.

1.1.33. Do not issue an immediate prescription for an antimicrobial to a patient who is likely to have a self-limiting condition.

1.1.34. If immediate antimicrobial prescribing is not the most appropriate option, discuss with the patient and/or their family members or carers (as appropriate) other options such as:

- Self-care with over-the-counter preparations
- Back-up (delayed) prescribing
- Other non-pharmacological interventions, for example, draining the site of infection.

1.1.35 When a decision to prescribe an antimicrobial has been made, consider the benefits and harms for an individual patient associated with the particular antimicrobial, including:

- Possible interactions with other medicines or any food and drink
- The patient's other illnesses, for example, the need for dose adjustment in a patient with renal impairment
- Any drug allergies (see the NICE guideline on drug allergy; these should be documented in the patient's record)
- The risk of selection for organisms causing healthcare-associated infections, for example, *C. difficile*.

1.1.36. When prescribing is outside local (where available) or national guidelines, document in the patient's records the reasons for the decision.

1.1.37. Do not issue repeat prescriptions for antimicrobials unless needed for a particular clinical condition or indication. Avoid issuing repeat prescriptions for longer than 6 months without review and ensure adequate monitoring for individual patients to reduce adverse drug reactions and to check whether continuing an antimicrobial is really needed.

Health and safety policy (fire, premises, devices and equipment, staff safety)

Key Medical Services clinicians must have adequate knowledge and skills in Health and Safety and must undertake regular training updates

Health and Safety responsibilities

Health and safety are the responsibility of **everyone**. Clinicians have a responsibility to report any health and safety concerns to the manager or health and safety officer at the site at which they are working, for example, blocked fire exit routes, trip hazards, electric items poorly maintained, plugs overloaded or workstations poorly set up.

Any accident or injury must be reported to the clinic manager or health and safety officer and be entered by them into the practice's Accident book and reported to Key Medical Services.

Fire

Checks at each new location

At your assignment location it is vital that you find out before you start work where to find **fire extinguishers and the fire exits**, and the **evacuation procedure and meeting point.**

Training

Clinicians must also undertake general fire training updates.

Fire action

- Raise the alarm
- Leave the building by the nearest exit
- Report to the assembly point
- Do not stop to collect personal belongings
- Do not return to the building until authorised to do so

Extinguishers - only if it is safe

Before using a fire extinguisher make sure the alarm has been raised and that you have a safe evacuation route, then use the **PASS** sequence

- **P**ull the pin
- **A**im low at base of the fire (Do not touch the horn on a CO2 extinguisher as it gets very cold)
- **S**queeze the handle
- **S**weep from side to side at the base of the fire until the fire is out

Fire Extinguisher Colours - explained in a simple guide (surreyfire.co.uk)

Type (Fire / Extinguisher)	CLASS A Combustible materials (e.g. paper & wood)	CLASS B Flammable liquids (e.g. paint & petrol)	CLASS C Flammable gases (e.g. butane and methane)	CLASS D Flammable metals (e.g. lithium & potassium)	Electrical Electrical equipment (e.g. computers & generators)	CLASS F Deep fat fryers (e.g. chip pans)	Comments
Water	✓	✗	✗	✗	✗	✗	Do not use on liquid or electric fires
Foam	✓	✓	✗	✗	✗	✗	Not suited to domestic use
Dry Powder	✓	✓	✓	✓	✓	✗	Can be used safely up to 1000 volts
CO2	✗	✓	✗	✗	✓	✗	Safe on both high and low voltage
Wet Chemical	✓	✗	✗	✗	✗	✓	Use on extremely high temperatures

Health and safety - premises

Slips, trips, falls and falling objects.

All staff are responsible for keeping themselves, their colleagues, and patients safe by minimising the risks of slips, trips, falls and falling objects.

- If you see slip and trip risks, try to sort them out or inform the client
- Keep place of work including floors and work surfaces clear of obstacles
- Remove rubbish as soon as possible
- Remove clutter from doorways and stairs.
- Help to keep floors clean and dry
- Clear up spillages straight away

- Cover cables and wires and don't leave them trailing
- Make sure doors and drawers are closed.
- Ensure areas are well lit and report faulty lighting ASAP
- If you think of ways of preventing trip or slip hazards (water, oils, cardboard, waste etc) from getting onto the floor, suggest them to the client
- Report near misses and accidents promptly to the client

Scalding and burning

Report to the client if you notice that hot water in washing facilities or the temperature of radiators or hot pipes feel unacceptably hot.
All staff are responsible for ensuring that any additional portable heaters are used in a way that is safe to themselves, their colleagues and service users. They should be positioned to minimise the risk of direct contact with people.
Managers must ensure that hot water and radiators are kept below 44 degrees C.

Accidents and injury at work and first aid

Medical practices have staff and resources to deal with most first aid needs, accidents, and injuries. Ensure that you report any accidents or injuries to the clinic manager for them to record the event in the practice's Accident Book.

Check to see if the accident falls into the categories requiring reporting to RIDDOR for the national database and whether it needs reporting to the CQC and fills these reports where necessary.

- http://www.hse.gov.uk/pubns/indg453.pdf
- http://www.hse.gov.uk/riddor/index.htm

Electrical equipment

http://www.hse.gov.uk/healthservices/equipment-safety.htm

- Report any concerns about wear and tear, damage, frayed, broken or bare wires, smells of burning, sparks, hot plugs or sockets etc. to the client and disconnect the device immediately and take it out of service.
- Do not attempt to repair any electrical device yourself.
- Ensure that leads are not trip hazards.
- Do not overload electrical sockets and avoid extension leads whenever possible.

Health and safety - medical equipment

Clinicians will have received training in the use of most equipment available to them at assignment locations in their basic professional training. On arrival at new location check that you are familiar with the equipment provided and ask for training if you are unsure. Do not use equipment if you are not trained to do so.

Check that equipment is fit for purpose, reporting any faults or ‘wear and tear’ to the client, and clean equipment before and after use in accordance with local guidelines.

Do not reuse single use equipment. This is marked

Report any concerns about vaccine fridge temperatures or daily recording to the client.

Health and safety – staff safety

Your own safety

- Please report to the client and Key Medical Services any concerns that you have for your personal safety at an assignment or arriving or leaving the premises
- Clinicians should familiarise themselves with the location of panic buttons or alternatives within the first day of arriving at the assignment location
- Discuss with Key Medical Services any adjustments that you may need for your safety due to, for example, disability or pregnancy.
- Clinicians should ensure that their workstation is set up correctly and request amendments to chairs, screen height, wrist rests, etc. that they need to avoid injury. ck1.pdf (hse.gov.uk) (see below for more details.

Your health and wellbeing

For your well-being the following should be provided at your assignment location

- Toilets and hand basins, with soap and towels or a hand-dryer.
- Drinking water.
- A place to store clothing (and somewhere to change if special clothing is worn for work).
- Somewhere to rest and eat meals.
- Good ventilation – a supply of fresh, clean air drawn from outside or a ventilation system.

- A reasonable working temperature (usually at least 16°C, or 13°C for strenuous work, unless other laws require lower temperatures).
- Lighting suitable for the work being carried out.
- Enough room space and suitable workstations and seating.
- A clean workplace with appropriate waste containers.
- Any transparent (e.g., glass) doors or walls are protected or made of safety material.

To keep your workplace safe, you must:

- Properly maintain your premises and work equipment
- Keep floors and traffic routes free from obstruction

Personal safety; threatening and violent behaviour; work-related violence and lone working

Medical staff should consider strategies if they feel vulnerable, such as asking for someone else to join them in the room in the guise of a chaperone or second opinion. They should use the phone to attract help if they feel threatened.

If you feel threatened

- Put your own safety first above anything else
- Try to de-escalate the situation – see below
- Try to escape the situation / call for help / phone for help or the police.

Staff should talk to the client should they feel at risk and share any ideas they have for minimising risks.

All incidences where staff feel vulnerable should be reported to the client and Key Medical Services for review and reflection on how to reduce risks.

Lone working

Lone workers – your health and safety responsibilities (hse.gov.uk)

What you must do

Like any worker, you must take care of your own health and safety and that of others who may be harmed by your actions at work.

[Home - NHS Employers](#) > [HSWPG-Lone-Workers-staff-guide-210218-FINAL.pdf (nhsemployers.org)](#) 2018.

Things that you can do to protect your safety and that of your colleagues when working alone, for example when making home visits to patients.

- **Your client's policy and procedures**
  Make sure you are acquainted with and follow the local procedures put in place to protect your safety and the safety of others. Ensure that you know who your point of contact is, their contact details, and confirm that they will be available for the whole time that you are working alone. Find out if there are local code words that will be recognised if you feel threatened.
- **Report incidents**
  Incidents and 'near misses' provide details about violent individuals, unsafe environments and other important information on the risks faced. You can help your manager and your trust take steps to address these risks to you and your colleagues by reporting incidents.
- **Undertake training**
  Complete an online training module in Lone Working such as the Healthier Business Group module. You can obtain a log in through your consultant
- **Assess the risks to your personal safety**
  Then you are going to be working alone, you should assess any immediate and unfolding risks to your safety. This is called dynamic risk assessment. If you feel in serious or imminent danger, you should withdraw to a place of safety.
- **Make use of your lone worker device**
  There is now a wide range of technology that can support lone workers as they go about their work. Some devices are integrated into mobile phones, and some are stand-alone units, such as SIM cards within ID badge holders. If you are supplied with a lone worker device, make sure it is well maintained, charged, and is carried with you in line with local procedures

De-escalating conflict

Patients, and sometimes their careers, become challenging, difficult, uncooperative or aggressive for a number of reasons:

- Being unwell or in pain.
- Alcohol/substance misuse.
- Fear, anxiety or distress.
- Communication or language difficulties.
- Unrealistic expectations.

- Previous poor experience.
- Frustration.
- Guilt that they didn't bring a sick relative in earlier.

Dealing with an aggressive person takes care, judgement and self-control.

- **Remain calm**, listen to what they are saying, ask open-ended questions.
- Reassure them and acknowledge their grievances.
- Provide them with an opportunity to explain what has angered them. Understanding the source of their frustration may help you find a solution.
- **Maintain eye contact**, but not prolonged.

If you feel the person may become physically violent

- **Keep an adequate distance** from the patient but keep away from corners. It is helpful if the furniture in your room is arranged in such a way that you can easily leave, but the patient doesn't feel trapped.
- If the patient has a weapon, ask them to put it down. Don't ask them to hand it over.
- Use the panic button or **call for help**.
- **Leave the room** and call security or the police.
- If possible, **move the patient to an area away from public view**.

Copied from https://www.themdu.com/guidance-and-advice/guides/guide-to-dealing-with-challenging-patients

Violence reduction policy

Ask the client for their policy

- Be aware of your client's violence reduction policy and take up any training
- Report incidences to the client and Key Medical Services and fill out an incident reporting form
- Report any incidences involving physical attack or serious cases of threatening or verbal abuse to the police, including any details about when it happened, who was involved and any other relevant
- Take up wellbeing support offers and encourage colleagues to do the same
- Suggest additional measures to the client and Key Medical Services which might help to prevent and manage the risk of violence

Working with display screen equipment (DSE):

What are the health risks with DSE?

Some workers may experience fatigue, eye strain, upper limb problems and backache from overuse or improper use of DSE. These problems can also be experienced from poorly designed workstations or work environments. The causes may not always be obvious and can be due to a combination of factors.

Request screen dimmers, footrests, wrist rests, screen lifts if you need them.

All DSE users are encouraged to complete a workstation self-assessment form to establish that their station matches all UK guidelines and is fit for purpose, http://www.hse.gov.uk/pubns/ck1.pdf.

Extracts from http://www.hse.gov.uk/pubns/indg36.pdf

Getting comfortable:

The following may help users:

- Forearms should be approximately horizontal, and the user's eyes should be the same height as the top of the screen
- Make sure there is enough workspace to accommodate all documents or other equipment. A document holder may help avoid awkward neck and eye movements
- Arrange the desk and screen to avoid glare, or bright reflections. This is often easiest if the screen is not directly facing windows or bright lights
- Adjust curtains or blinds to prevent intrusive light
- Make sure there is space under the desk to move legs
- Avoid excess pressure from the edge of seats on the backs of legs and knees. A footrest may be helpful, particularly for smaller users

Well-designed workstation:

Keyboards and keying in (typing)

- A space in front of the keyboard can help you rest your hands and wrists when not keying.
- Try to keep wrists straight when keying.

- Good keyboard technique is important – you can do this by keeping a soft touch on the keys and not overstretching the fingers.

Using a mouse

- Position the mouse within easy reach, so it can be used with a straight wrist.
- Sit upright and close to the desk to reduce working with the mouse arm stretched.
- Move the keyboard out of the way if it is not being used.
- Support the forearm on the desk, and don't grip the mouse too tightly.
- Rest fingers lightly on the buttons and do not press them hard.

Reading the screen

- Make sure individual characters on the screen are sharp, in focus and don't flicker or move. If they do, the DSE may need servicing or adjustment.
- Adjust the brightness and contrast controls on the screen to suit lighting conditions in the room.
- Make sure the screen surface is clean.
- When setting up software, choose text that is large enough to read easily on screen when sitting in a normal comfortable working position.
- Select colours that are easy on the eye (avoid red text on a blue background, or vice versa).

Changes in activity

Breaking up long spells of DSE work helps prevent fatigue, eye strain, upper limb problems and backache. As the employer you need to plan, so users can interrupt prolonged use of DSE with changes of activity. Organised or scheduled rest breaks may sometimes be a solution.

The following may help users:

- Stretch and change position.
- Look into the distance from time to time, and blink often.
- Change activity before users get tired, rather than to recover.
- Short, frequent breaks are better than longer, infrequent ones.

Timing and length of changes in activity or breaks for DSE use is not set down in law and arrangements will vary depending on a particular situation. Employers are not responsible for providing breaks for the self-employed.

Portable computers:

These same controls will also reduce the DSE risks associated with portable computers. However, the following may also help reduce manual handling, fatigue, and postural problems:

- Consider potential risks from manual handling if users must carry heavy equipment and papers
- Whenever possible, users should be encouraged to use a docking station or firm surface and a full-sized keyboard and mouse.
- The height and position of the portable's screen should be angled so that the user is sitting comfortably, and reflection is minimised (raiser blocks are commonly used to help with screen height).
- More changes in activity may be needed if the user cannot minimise the risks of prolonged use and awkward postures to suitable levels.
- While portable systems not in prolonged use are excluded from the regulations some jobs will use such devices intermittently and to support the main tasks. The degree and intensity of use may vary. Any employer who provides such equipment still must risk assess and take steps to reduce residual risks.

Moving and handling

Clinicians should **avoid** moving, handling, and lifting as much as possible, but there are occasions when equipment needs to be moved or where patients need assistance. Clinicians must take care to minimise the risk of strain or injury and only lift what they can reasonably manage. If there is any doubt about the safety of the move, discuss with your colleagues whether more than one person should lift and how to minimise risks and do not attempt to lift objects above your head. Clinicians should have regular training updates.

Guidance

- Do not move or lift things if you cannot find a way in which you feel you can do this safely
- If possible, push or pull the object in a straight line

- Think before you lift, plan your route, and have a safe path. Make sure you will be able to see over the load
- Bend at the knees, not the waist, to pick up the load
- Stand with feet shoulder width apart in a balanced and stable position and lift with proper posture without flexing your back. Your hips and shoulders should be facing the same direction. Avoid twisting or leaning sideways
- Use your leg muscle to lift and not your lower back
- Check your feet are pointing in the direction of travel
- Keep the item close to the body, preferable at waist height with the elbows bent and close to the body
- Use two hands and get a firm and constant grip
- Do not change your grip without supporting the object first
- Keep your head raised
- Walk smoothly
- Put the load down just as carefully as you picked it up
- Bend your knees and keep the load close to your body as you put it down
- Mind your fingers do not get trapped as you put it down
- Rest the weight of the object and then push it into place

Assisting patients

Should a patient need assistance in moving around the building or moving into a suitable position for examination, offer help and discuss with the patient the best way in which you may be able to help them. At the same time assess possible risk and think of ways to minimise this. If assisting a patient by lifting, pulling, or pushing, please follow the guidelines above.

Ethics and good clinical practice

The GMC gives advice on professional standards and medical ethics, and sets out the professional values, knowledge, skills and behaviours expected of all doctors working in the UK. GMC good medical practice describes what it means to be a good doctor. Good medical practice - professional standards - GMC (gmc-uk.org) **updated 2024**. All professional bodies give advice via their websites on good practice.

Within the professional codes of conduct there is advice and standards, there are statements about how clinicians should behave professionally, respectfully, and always treat people in a caring and compassionate way, highlighting principles which all clinicians should aspire to.

Domain 2 Patients partnership and communication - GMC (gmc-uk.org)
Good Medical Practice Guidelines headings are:

- Treating patients fairly and respecting their rights
- Treating patients with kindness courtesy and respect
- Supporting patients to make decisions about treatment and care
- Sharing information with patients
- Communicating with those close to a patient
- Caring for the whole patient
- Safeguarding children and adults who are at risk of harm
- Helping in emergencies
- Making sure patients who pose a risk of harm to others can access appropriate care
- Being open if things go wrong

This is also included in the CQC Key lines of enquiry:
- C.1. People should be treated with kindness, respect, and compassion, and given emotional support when needed.
- C.3. Staff should respond in a compassionate, timely and appropriate way when people experience physical pain, discomfort, or emotional distress.

Communication challenges

People whose **first language is not English**
- Ensure at your assignment location that you check where to find written information in various languages and formats for the visually impaired.

- Nigel's surgery 20: Making information accessible - Care Quality Commission (cqc.org.uk)

Communicating with people with learning disability
What do patients with a learning disability want from their clinicians and surgery staff? – Taken from We want you to remember-best practice sheet MENCAP.doc (rcgp.org.uk)

1. We would like you to smile and ask, “What can I do for you?”
2. We would like you to look at us, and to sit facing us.
3. We would like you to talk to us, not to our relative or supporter.
4. We would like you to show interest in what we are saying.
5. We would like you to say what you think is wrong with us.
6. We would like you to say how you are going to treat us.
7. We would like you to tell us how to take our medication and make sure we are ‘clear’ about how to take it.
8. We would like you to explain things clearly, making sure we understand.
9. We would like you to realise that we sometimes worry and get anxious if we cannot do things as planned (for example, if we cannot keep to agreed times for appointments)
10. We would like you to make it easier for us to see our ‘own’ Doctor (s/he will know us and understand our needs and how we communicate).

Dignity and respect

Establish and maintain partnerships with patients:

You must be **polite and considerate**.

People using the service should **be addressed** in the way they prefer.

You must treat patients as individuals and **respect their dignity and privacy**.

- To ensure the personal dignity of patients, they must be seen in private consultation rooms where the doors are closed throughout the consultation, (unless on a home visit)
- Clinicians should allow patients who need to undress for examination to do so behind screens, out of sight of the clinician, and provide the patient with a gown where available
- See also Intimate examination and chaperones in the Safeguarding section

You must treat patients **fairly and with respect** whatever their life choices and beliefs.

You must work in partnership with patients, sharing with them the information they will need **to make decisions about their care**, any other information patients need if they are asked to agree to be involved in teaching or research.

You must support patients in caring for themselves to **empower them** to improve and maintain their health. This may, for example, include:

a. Advising patients on the effects of their life choices and lifestyle on their health and well-being
b. Supporting patients to make lifestyle changes where appropriate

You must explain to patients if you have a **conscientious objection** to a particular procedure. You must tell them about their right to see another doctor.

Show respect for patients

You must **not use your professional position** to pursue a sexual or improper emotional relationship with a patient or someone close to them.

You must not express your personal beliefs (including political, religious, and moral beliefs) to patients **in ways that exploit their vulnerability** or are likely to cause them **distress**.

You must be **open and honest** with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

a. Put matters right (if that is possible)
b. Offer an apology
c. Explain fully and promptly what has happened and the likely short-term and long-term effects

Treat patients and colleagues fairly and without discrimination

You must **not refuse or delay treatment because** you believe that a patient’s actions or lifestyle have contributed to their condition.

You must **not unfairly discriminate** against patients or colleagues ….

You must consider and respond to the needs of disabled patients and should make **reasonable adjustments** to your practice so they can receive care to meet their needs.

Act with honesty and integrity

You must make sure that your conduct justifies your patients' **trust** in you and the public's trust in the profession.

You must always be **honest** about your experience, qualifications, and current role.

Communicating information

You must be **honest and trustworthy** in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

Autonomy and independence

People using services must be offered support to maintain their **autonomy and independence** in line with their stated preferences. Regulation 10: Dignity and respect | Care Quality Commission (cqc.org.uk) 10(2)(B).

Clinicians and service providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. **Health and Social Care Act 2008** - Regulation 9: Person-centred care | Care Quality Commission (cqc.org.uk).

In some cases, people's preferences for their care or treatment may not meet their needs. Where this is the case, and people lack mental capacity or are detained under mental health legislation, providers must act in accordance with the Mental Capacity Act 2005 and/or the Mental Health Act 1983. See section on Mental Capacity Act 2005.

Patient independence in GP consultations.
If a service user attends with another person, the clinician should ensure that questions are directed at the patient themselves, even when an interpreter is needed. Clinicians should do everything they can to ensure that the patient themselves is making their own decisions and not being coerced.

Staff are trained to speak to children as well as their parents, and, if a patient has a limited capacity, to engage with that person as much as possible as well as with their carer.

Caring for people with Dementia.

Nigel's surgery 42: Caring for people with dementia | Care Quality Commission (cqc.org.uk)

Dementia Care Mapping™ is an established way to achieve and embed person-centred care for people with dementia. It is recognised by the National Institute for Health and Clinical Excellence.

Important considerations when caring for someone living with dementia are:

- Early diagnosis
- Care planning and
- Living well

GPs have a duty to recognise those at risk of dementia. They should provide timely diagnosis and refer to specialist services. NHS England has published a useful guide to support GPs:

- Dementia diagnosis and management: a brief pragmatic resource for general practitioners

Dementia UK has provided information on getting a diagnosis.

Alzheimer's UK provide information on the symptoms and diagnosis of dementia to help GPs/clinicians offer support post-diagnosis.

GPs/ACPs may refer patients to memory clinics. Clinics can offer further diagnosis, memory tests and more support to people living with dementia Find memory services - NHS (www.nhs.uk)

Care planning for people living with Dementia

Caring for people with dementia in primary care demands the same approach as other long-term conditions. The systematic follow-up of people with dementia should be integrated into primary care. This should also include their carers or care givers.

NHS England has produced dementia guidance and other resources on care planning. This is available to help with caring for people living with dementia.

The plan should be tailored to a person's individual needs. Consideration should be given to:

- Medicines management
- Talking therapies to help mood and behaviour
- Alternative therapies to support sleep and agitation

Many GP practices carry out social prescribing to support people living with dementia and their caregivers. Job titles can vary from care navigators to social prescribers. The role enables people to access other forms of support such as voluntary services and those local authorities offer. For example, memory cafes and carer support groups.

Support for caregivers

Caring for a person living with dementia often is a 24-hour commitment. It has a significant impact on the health and welfare of caregivers. GPs/ACPs are expected to actively identify caregivers. Practices should signpost caregivers to services which may be able to provide support.

Consideration should also be given to ethnicity of people living with dementia and their caregivers. It is important to recognise that some ethnic groups prefer to provide all care themselves. This may be part of their culture. GPs/ACPs need to respect this, while supporting caregivers effectively.

Covert administration of medicines

Before considering covert administration of medicines, you should test decisions and actions against the five key principles under the Mental Capacity Act 2005.

Nigel's surgery 96: Covert administration of medicines | Care Quality Commission (cqc.org.uk).

Safety netting

Safety netting | MDDUS

Safety netting is a diagnostic strategy or consultation technique to effect timely re-appraisal of a patient's condition.

What should safety net advice include?

- Explain uncertainty to the patient
- Highlight things to look out for
- Signpost further help
- Map out a timeline
- Check the patient has understood
- Keep accurate and detailed records

Equality

Key Medical Services values people's identity, individuality, privacy, and freedom to decide their health care. Key Medical Services offers a service which is open to everyone regardless of their age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave. Disability, race including colour, nationality, ethnic or national origin, religion or belief, sex, or sexual orientation. Equality Act 2010: guidance - GOV.UK (www.gov.uk).

Staff must understand and respect the personal, cultural, social, and religious needs of people and how these may relate to care needs. Clinicians must report any concerns they have to Key Medical Services.

Key Medical Services does not tolerate any harassment or discrimination against its patients or staff members, and harassment or bullying of others will result in disciplinary action.

Disabled people access to GP services and meeting communication needs

Clinicians must seek accessible ways to communicate with people including when their protected equality or other characteristics make adjustments necessary and identify and meet the information and communication needs of people with a disability or sensory loss.

Deafness and hearing loss communication tips: deafness and hearing loss toolkit (rcgp.org.uk).

1. Gain the person's attention before you begin to speak
2. Avoid speaking from another room. Place yourself at a reasonable distance so they can see your face and lips
3. Avoid having the conversation with a lot of background noise. Remember hearing aids will amplify all background noise, so speech can get lost.

4. Keep your face well lit. Do not stand with the light or a window behind you as your face will be in a shadow
5. Do not cover your face or your lip movements
6. Do not look away when talking
7. Do not shout! Speak clearly and not too fast or too slow
8. Repeat the sentence again (just once) if necessary, then rephrase
9. **Write down** important facts - times, dates, names, places, instructions
10. Be calm and patient and leave enough time for the consultation
11. Gestures and facial expressions will help augment your message

References:

1. RNID: Communication tips if you have hearing loss
2. RNID: Communication tips for people with hearing loss
3. UCL: Deaf Awareness - Online Courses for Health Professionals

Blind and partially sighted communication tips

Taken from RNIB Cymru EQUIP Top Ten tips.doc (rcgp.org.uk) - adapted

1. Many people with sight problems have some useful vision but still welcome assistance. Always ask a person if they require assistance, it is their choice
2. Moving around the premises
    a. Always Introduce yourself giving your name and title
    b. Ask if any assistance is required
    c. If necessary, guide your patients to a vacant seat or appropriate room
    d. If forms are required to be filled in offer assistance
    e. Inform the patients of the system for being called for their appointment
3. Offer information to take away in the patient's preferred format e.g., large print, audio tape, Braille, on disk or email. If printing material set your computer to default type face Arial font size 14. Have thick black markers available to write things down for the patient
4. Premises you are assigned to should be accessible to partially sighted people by using colour contrast, appropriate lighting, clear signage etc.

End of life care

People who may be approaching the end of their life should be supported to make informed choices about their care. https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-38-care-advanced-serious-illness-end-life

RCGP and Marie Curie report that peoples' top priorities at end-of-life are to be free from pain and to be with the people they love. They would also prefer to be cared for and die in familiar surroundings. People experience better care and death when their needs are identified early, and their care is properly coordinated - involving those important to them and regarding their personal care preferences.

The Leadership Alliance for the Care of Dying People, which included CQC, agreed five priorities for the care of the dying person:

1. The possibility that a person may die within the coming days or hours is **recognised and communicated** clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.
2. Sensitive **communication** takes place between staff and the person who is dying and those important to them. Training in communication, person centred approach and symptom control and services available is needed to improve care for all.
3. The dying person, and those identified as important to them, are **involved in decisions** about treatment and care. GPs should support people to make choices about their preferred place of death.
4. The **people important to the dying person are listened to** and their needs are respected.
5. **Care is tailored** to the individual and delivered with compassion – with an individual care plan in place. GPs should coordinate making and following an individualised care plan. Care plans should ideally be owned by the patient but recognised in all settings.

You may find the following organisations and guidelines useful to look at in more detail.

- Care of Dying Adults in the Last Days of Life (NICE Guideline)
- Dying Matters
- End of life care for adults (NICE Quality Standard)
- Gold Standards Framework: primary care training programme
- BJGP Editorial: New UK General Practice Core Standards for Advanced Serious Illness and End of Life Care

- GSF Frontrunners
- One chance to get it right (Leadership Alliance for the Care of Dying People)
- RCGP Palliative and End of Life Care Toolkit
- Treatment and care towards the end of life: good practice in decision making (GMC guidance)

Death of a patient

Verification and certification of death see: Nigel's surgery 13: Verification and certification of death | Care Quality Commission (cqc.org.uk).

Care after death

Working with the principles and decision-making models - cont - 2 - GMC (gmc-uk.org).

Your professional responsibility does not come to an end when a patient dies. For the patient's family and others close to them, their memories of the death, and of the person who has died, may be affected by the way in which you behave at this very difficult time. If you are involved with a patient around the time of their death, then it may be of comfort to those close to them to receive a call from you afterwards.

The wishes and needs of the bereaved

Death and bereavement affect different people in different ways, and an individual's response will be influenced by factors such as their beliefs, culture, religion, and values. You must show respect for and respond sensitively to the wishes and needs of the bereaved, considering what you know of the patient's wishes about what should happen after their death, including their views about sharing information. You should be prepared to offer support and assistance to the bereaved, for example, by explaining where they can get information about, and help with, the administrative practicalities following a death; or by involving other members of the team, such as nursing, chaplaincy, or bereavement care staff. Working with the principles and decision-making models - cont - 2 - GMC (gmc-uk.org)

Speaking up / whistleblowing

If you have a concern:

- Can you put it right? If you can, do it.
- Talk to colleagues to see if they share your concerns. Together, think about the bigger picture and any action you can take - potentially as a group.

- Understand and follow your organisation's internal policies and procedures.
- Consider whether to seek advice from someone independent of the situation early on.
- Keep a written record of your concerns and the actions you're taking.

Speak up

- If you're not able to fix the problem, find the right person to talk to. This might be your supervisor, the department or practice clinical lead, site manager or another named person in your local policy.
- Plan the best way to raise your concern to make sure you're listened to. It might sound obvious, but how, where and when you choose to speak up can make a big difference.
- Make your points as clearly as you can and stick to the facts. If possible, identify potential solutions.
- Agree next steps, timescales and how you'll keep in touch. Keep a written record.

Speaking up

If you develop concerns about a practice or organisation where you have been assigned, which could impact patient safety or negatively affect patient care, should raise the issue with senior staff at that organisation. If you feel you need to escalate this further, then you can go directly to the NHS England Freedom to Speak Up team at england.speakup1@nhs.net and/or the Care Quality Commission.

Medicines and prescribing policy

Key Medical Services does not handle any medicines. Responsibility for these lies with the client.

Emergency medicines

On starting an assignment, Key Medical Services' clinicians must make themselves familiar with the location of the emergency medicines, oxygen, and defibrillator, so that they can access them immediately when they become needed. They should also familiarise themselves with any other medicines kept at the practice or in a Clinician's bag for home or

off-site consultations. Medicines may vary slightly between practices and so they need to know exactly what they have emergency access to, the method of delivery and dosages. Clinicians must complete basic life support training for adults and children annually and ensure that they have adequate up to date knowledge of the use of all medicines available for emergencies and acute situations.

Practices are responsible for making regular checks on supplies of emergency and acute drugs and checks on expiry dates. If a clinician has any concerns about maintenance or storage of medicines or discovers anything to be out of date, they must report this immediately to the clinic manager, and should inform Key Medical Services if they feel systems at the practice are inadequate.

GP MythBusters 9: Emergency medicines for GP practices

Dispensing surgeries

The CQC guidance on prescribing in dispensing practices concludes that, 'where during a consultation, the GP/ACP sends a prescription to the dispensary for printing, which is then dispensed before it's signed', 'this is in keeping with modern good practice' and is 'safe'.

Vaccines

Clinicians must maintain up to date knowledge of the NHS vaccine schedule and of the individual vaccines on the schedule. They should use vaccines straight from the fridge, not leave them unattended once removed and not leave them at room temperature longer than necessary.

Clinicians should report to the clinic manager if they feel unhappy with vaccine management at a practice at which they are working and, if unhappy with the response, should inform Key Medical Services. Practices must keep vaccines, in their original packaging, in a fridge specifically designed for pharmaceutical products, and maintained at a temperature between +2 and +8°C, with a daily log of temperature checks. The fridge or room it is in must be kept locked; should be no more than half full to allow air circulation; and vaccines should not be stored alongside food or specimens.

GP MythBusters 17: Vaccine storage and fridges in GP practices

Prescribing

Clinicians should ensure that they have appropriate access to national and local prescribing formularies during the course of their work.

Note GMC prescribing guidelines have been updated in 2021 in response to increasing remote prescribing during the Covid-19 pandemic.

Refer to the various sections of good practice in prescribing and managing medicines and devices - GMC (gmc-uk.org).

- Keeping up to date and prescribing safely - GMC (gmc-uk.org)
- Deciding if it is safe to prescribe - GMC (gmc-uk.org)
- Controlled drugs and other medicines where additional safeguards are needed - GMC (gmc-uk.org)
- Shared care - GMC (gmc-uk.org)
- Raising concerns - GMC (gmc-uk.org)
- Reporting adverse drug reactions medical device incidents and other patient safety incidents - GMC (gmc-uk.org)
- Reviewing medicines - GMC (gmc-uk.org)
- Repeat prescribing and prescribing with repeats - GMC (gmc-uk.org)
- Prescribing unlicensed medicines - GMC (gmc-uk.org)
- Sports medicine - GMC (gmc-uk.org)
- 1 Recommendations | Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use | Guidance | NICE – see Infection Control Policy
- https://www.rcn.org.uk/get-help/rcn-advice/non-medical-prescribers

Security of blank prescription forms

- GP MythBusters 23: Security of blank prescription forms
- https://cfa.nhs.uk/fraud-prevention/fraud-guidance

The CQC expects GPs to be able to tell the CQC how the practice manages and secures blank prescription forms and paper. This should be in line with national guidance unless the practice can justify, with risk assessment and mitigation, why this is not the case. The CQC expects:

- Stock of blank prescription forms must be stored securely, at least in a locked cabinet within a lockable room or area
- Access to forms restricted to authorised individuals

- Records kept of prescription forms that are:
- Returned to stock
- Destroyed, and the reasons for destruction
- Clear storage system for prescribers using individualised forms:
- Kept in a locked space and not with patients' notes
- The serial number of the first remaining form is made at the end of each patient session
- Measures in place to keep forms secure. For example:
- Only authorised individuals have access to the lockable room or area where prescription form stocks are kept
- It is not advisable to leave the forms in printer trays when not in use or overnight. The new guidance says all prescriptions should be removed from printer trays and locked away when not in use or out of hours
- Consider at other times
- Using a lockable printer cover
- Storing a printer in a lockable drawer
- Storing forms in a lockable drawer and only placing them in a printer when needed
- Staff know what to do if they suspect that prescription forms have gone missing

The new guidance also includes information on:

- Destroying spoiled or duplicate prescriptions
- Sending prescriptions by post
- Access to prescriptions

Patient Group Directions (PGDs)

Some health professionals may supply and/or administer medicines under a PGD. They include registered nurses, paramedics, and pharmacists. Health professionals who will be using the PGD must be named and authorised before they use it to provide care. Practitioners should keep a copy of their individual authorisation and have the current authorised PGD available for reference.

- GP MythBusters 19: Patient Group Directions (PGDs)/Patient Specific Directions (PSDs)

Patient Specific Directions (PSDs)

See link above.

‘A PSD is the traditional written instruction, signed by a clinician for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.

A PSD must be written and signed by the prescriber - this can be by hand or electronically. A PSD is an instruction to administer/supply a medicine written in the patient’s notes. Careful consideration needs to be given to how the instruction is incorporated in the patient record to ensure the medicine is given safely and in a timely manner.

A PSD can also be an instruction to administer a medicine to a list of named patients where each patient on the list has been individually assessed by that prescriber. The prescriber must have knowledge of the patient's health and be satisfied that the medicine to be administered serves the individual needs of each patient on that list. For example, a healthcare assistant may be running an influenza immunisation clinic, so the prescriber reviews the patients planned to attend the clinic and produces a list of those that they authorise to be immunised.’

The following are examples that **do not** meet the requirements of a PSD and are therefore **not** a legal authority for the administration or supply of medicines:

- A Patient Group Direction (PGD) template that has been renamed a “PSD” and used to instruct healthcare staff
- A generic instruction to be applied to any patient who may be seen by a healthcare professional or who has an appointment on any day, for example, an instruction to administer a “flu vaccine” to any patient who fits the criteria attending clinics on a specific day
- A verbal instruction

The prescriber should include a start and finish date in the direction to ensure it is acted. The prescriber has a duty of care and is professionally and legally accountable for the care he/she provides, including tasks delegated to others.

The prescriber must be satisfied that the person to whom a task is delegated has the qualifications, experience, knowledge and skills to provide the care or treatment involved.’

What if a patient brings in prescribed medicines that have been dispensed for them elsewhere?

There may be some occasions when the practice issues a prescription to a patient for them to have the medicine dispensed to them at a pharmacy or dispensary which requires

administration at the practice. For example, the patient may obtain their Zoladex from their community pharmacy through an FP10 then return to the practice for it to be administered by the practice nurse. In these circumstances the accountabilities and responsibilities of the prescriber and the delegated member of staff administering the medicine will be same as above for PSDs.

Controlled drugs

Extracts taken from CQC guidance / Nigel's surgery / Controlled drugs and other medicines where additional safeguards are needed - GMC (gmc-uk.org).

Clinicians must comply with controlled drug regulations, and the policies in place at a practice at which they are working.

Controlled drug registers

'Any movement of a schedule 2 CD into and out of the practice must be recorded in a CD register. This should be done as soon as possible but must be done within 24 hours. It is recommended that two people do this together and check stock levels at the same time. Whilst the task of making the register entries can be delegated, the GP retains full responsibility.

In all CD registers, entries must

- Appear in chronological order
- Be made on the day of the transaction, or within 24 hours
- Be indelible
- Show the strength and form of the preparation at the top of each page
- If it is a dispensing practice, then there should also be a record of who the controlled drug has been supplied to when the prescription is collected'

Controlled drugs cupboards and keys

If a clinician needs access to controlled drugs for a patient, they must follow the practice's procedures for gaining access and locking the cupboard after use.

Controlled drugs in clinician's bags

'A clinician's bag, if locked, is considered a suitable receptacle for storing CDs. However, a locked car is not. A clinician's bag should be a lockable bag, box or case and it should always be kept locked except when in immediate use. The person in lawful possession of this bag (i.e., the GP) should always retain the keys to it. A digital combination lock would provide an acceptable alternative and removes the problem of lost keys. It is not recommended to leave a bag containing CDs in a car overnight or for long periods of time. When the clinician's bag is in the practice, it should be stored in a safe place away from patient areas.

A separate record book should be maintained for the CDs held within the bag and the GP is responsible for the receipt and supply of CDs from their bag.

If a GP makes a domiciliary visit and either administers a CD from the bag or issues a handwritten prescription for a CD, they should make a note of this in the patient's record as soon as possible after the event. It is good practice to write a prescription for the item administered, endorse it with the word 'administered' and date it.'

Prescribing controlled drugs (CDs)

'Prescriptions for schedules 2 and 3 CDs can be sent electronically via the Electronic Prescription Service (EPS) and signed with an Advanced Electronic Signature (AES) as well as handwritten.

Prescribers (both NHS and private) are strongly advised to limit the quantity of Schedule 2, 3 and 4 CDs prescribed to amounts that meet the patient's clinical need for up to 30 days' supply. In exceptional circumstances, where the prescriber considers more than 30 days is clinically indicated and would not pose an unacceptable risk to patient safety, a record of the reasons for deviating from the guidance should be made in the patient's record and the prescriber should be able to justify the decision, if challenged.

It is not illegal for a pharmacist to dispense a prescription for CDs for more than 30 days' supply, but they must satisfy themselves as to the clinical appropriateness of the prescription before doing so. The pharmacist may contact the prescriber for clarification. It is inappropriate for a prescriber to prescribe a CD for themselves, a family member, or a friend unless in a clinical emergency.'

Repeat prescriptions of controlled drugs

Consider:

- Frequency of review for further repeat prescriptions. Take the controlled drug and the person's individual circumstances into account
- Potential risk for misuse. Could a patient continue to request a prescription, even when they no longer need the controlled drug? They could make a request directly or via a friend or family member

Staff need to take steps to prevent issuing prescriptions once they are aware that the patient no longer needs the controlled drug. The practice repeat prescribing policy must include these steps.'

Prescription stationery for CDs

'Prescription stationery for CDs, including printer paper, must be stored securely to prevent theft and misuse to fraudulently obtain controlled drugs.'

Private prescribing of CDs

'Private prescriptions for all schedule 2 and 3 CDs, to be dispensed in the community, must either be written on standard forms (FP10(PCD)) designed to be similar to, but distinguishable from, the NHS prescription form or prescribed electronically via the EPS system. Prescribers need to apply for a private prescriber identification number via their NHS England CDAO team, before prescribing CDs privately.'

Record-keeping policy (including QOF)

Keeping clear records is essential for patient care, particularly for continuity of care, and for medico-legal purposes, often proving invaluable in the event of a complaint. We expect all Key Medical Services clinicians to keep records that are in line with the GMC's Good Medical Practice guidance:

Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

- You must keep records that contain personal information about patients, colleagues, or others securely, and in line with any data protection law requirements.
- Records must include tests, correspondence, and phone conversations
- Include consent
- Records must be accessible to authorised people as necessary
- They must be stored in accordance with national rules
    - Kept secure
    - Kept in accordance with the Data Protection Act

Assessment tools

Key Medical Services clinicians must have knowledge of and use readily available tools, and record assessment outcomes for conditions such as sepsis, depression, or anxiety. Key Medical Services will work with practices to audit record keeping.

Quality and Outcomes Framework (QOF)

Clinicians should allow about 10 minutes for each consultation, with some patients taking more or less time (excluding home visits).

We expect all Key Medical Services clinicians to use every consultation as an opportunity to ensure important lifestyle and other indicators are up to date for example

- Smoking and alcohol status
- BP
- BMI

- Frailty score
- Relevant family history

This will also help practices to fulfil contractual and QOF targets. From time to time, we will collaborate with clients to conduct audits of patient records to ensure that these important indicators are being assessed and appropriately recorded.

Handover / continuity of care / results policy

Extracts from GMC good practice guidelines and CQC Nigel's surgery. Clinicians have a duty to ensure the best possible continuity of care for their patients. This includes:

- Good **record keeping** providing subsequent medical staff with all the information they need
- Ensure adequate **hand over** of information to colleagues where your patient may need to be followed up by another practitioner
- **Prescribing** in accordance to national and local policies, and according to GMC good medical practice, for example in relation to repeat prescribing, delegating responsibility for administering or dispensing medicines, delegating responsibility for patient assessment of suitability for a medicine, prescribing at the recommendation of another clinician, nurse or other healthcare professional or recommending that a colleague, for example a junior general practitioner, prescribes a particular medicine for a patient
- Ensuring that **results** of any investigations that you authorise are managed appropriately. You must familiarise yourself with the results procedures where you are working and use the systems appropriately. The CQC expects 'to see that practices have an agreed and documented approach that every member of the practice team understands.'
- 'Contributing to the **safe transfer** of patients between healthcare providers and between health and social care providers' (GMC good practice guidelines), 'by sharing all relevant information with colleagues involved in your patient's care within and outside the team, including when you hand over care as you go off duty, when you delegate care or refer patients to other health or social care providers. This should include all relevant information about their current and recent use of other medicines, other conditions, allergies and previous adverse reactions to medicines.'
- It is essential for safe care that information about medicines accompanies patients (or quickly follows them, for example on emergency admission to hospital) when

they transfer between care settings. If you prescribe for a patient, but are not their general practitioner, you should check the completeness and accuracy of the information accompanying a referral.

Other key links

We expect all our clinicians to follow the guidance set out by the following key documents.

- The GMC's Good Medical Practice guide - Good medical practice - professional standards - GMC (gmc-uk.org)
- NICE guidelines: https://www.nice.org.uk/guidance
- 7 principles of public life by Lord Nolan https://www.gov.uk/government/publications/the-7-principles-of-public-life
- British National Formulary: https://bnf.nice.org.uk/
- CQC including Nigel's surgery: https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-tips-mythbusters-gp-practices
- https://www.nmc.org.uk/standards/code/
- Paramedics | (hcpc-uk.org)
- Standards | General Pharmaceutical Council (pharmacyregulation.org)

Document version control

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20 July, 2021	Version 4.0	Personnel update. Expansion of good practice policies.	New CEO. Consultant role. Expansion of good practice policies.
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Key Medical
Services

01582 394800

info@keymedicalservices.co.uk

keymedicalservices.co.uk

Suite B, Second Floor, 400 Capability Green, Luton, Bedfordshire, LU1 3LU

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