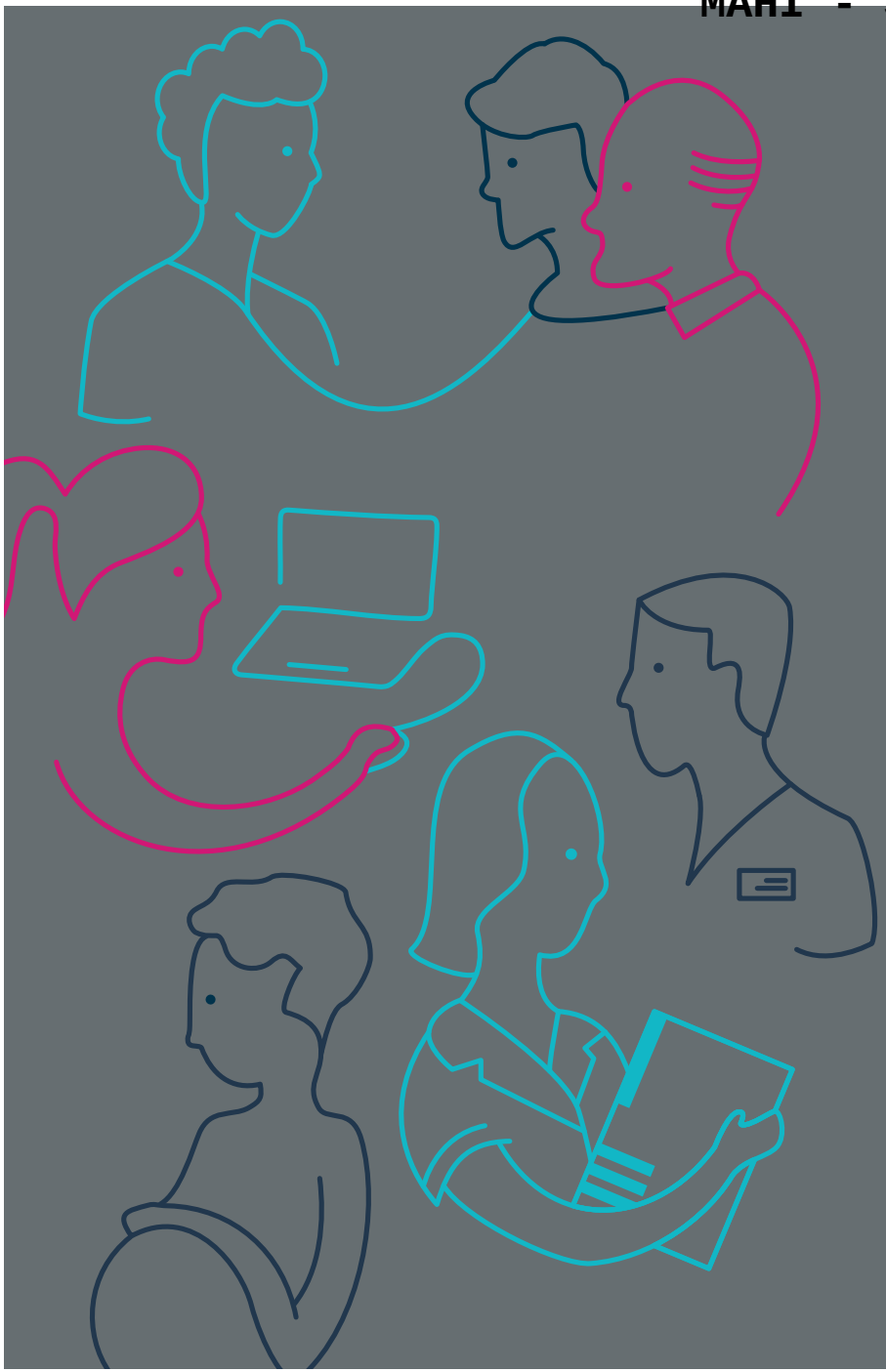


Nursing & Midwifery Council

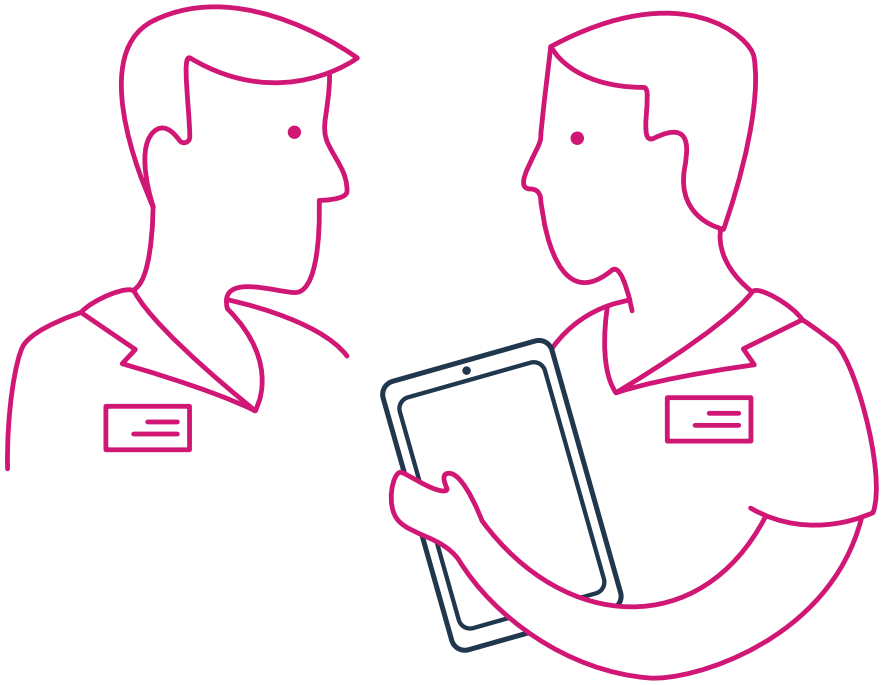
Realising professionalism:
Standards for education and training

Part 2: Standards for student supervision and assessment

Published 17 May 2018

About these standards

Realising professionalism: *Standards for education and training* includes the *Standards framework for nursing*[1] *and midwifery education*, *Standards for student supervision and assessment* and, programme standards specific to each approved programme.



Our *Standards for education and training* are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards

- Standards for pre-registration nursing education
- Standards for pre-registration nursing associate education
- Standards for prescribing programmes

These standards help nursing and midwifery students achieve the NMC proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of The Code, the professional standards of practice and behaviour that nurses, midwives and nursing associates are expected to uphold.

[1] We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

Introduction

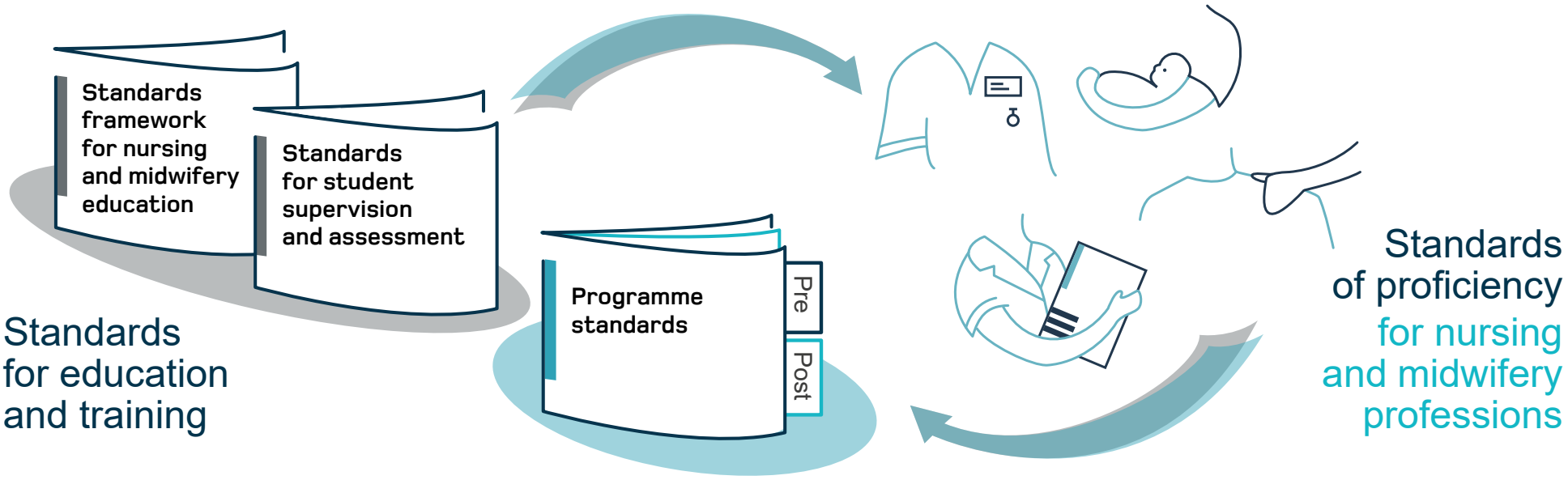
Our *Standards for student supervision and assessment* set out our expectations for the learning, support and supervision of students in the practice environment. They also set out how students are assessed for theory and practice.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The *Standards for student supervision and assessment* are established under the provision of Article 15(1) of the Order.

These standards aim to provide approved education institutions (AEIs) and practice learning partners with the flexibility to develop innovative approaches to nursing and midwifery education, while being accountable for the local delivery and management of approved programmes in line with our standards. Public safety is central to our standards.

Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

The *Standards for student supervision and assessment* apply to all NMC approved programmes and should be read with the NMC *Part 1: Standards framework for nursing and midwifery education* and the programme standards specific to the programme that is being delivered. There must be compliance with all these standards for an education institution to be approved and run NMC approved programmes.



Our *Standards for student supervision and assessment* are set out under the following three headings:

Effective practice learning (section 1)

These standards describe what needs to be in place to deliver safe and effective learning experiences for nursing and midwifery students in practice.

Supervision of students (sections 2 to 5)

Here we describe the principles of student supervision in the practice environment, and the role of the practice supervisor.

Assessment of students and confirmation of proficiency (sections 6 to 10)

In these standards we set out what we require from educators who are assessing and confirming students' practice and academic achievement. We describe the role and responsibilities of the practice assessor and the academic assessor.

Each of the described roles must be in place for education institutions and practice learning partners to meet our standards. Additional roles may be introduced in line with local or national requirements. Programme leaders will confirm the achievement of proficiencies by each student on a programme as set out in *Part 1: Standards framework for nursing and midwifery education* and the programme standards specific to the programme.

The *Standards for student supervision and assessment* are outcome-focused and allow for local innovation in programme delivery; they are designed to work across all programmes and in all settings. Student supervision and assessment can be flexible, provided the education institutions and practice learning partners meet our standards. Students in practice or work-placed learning must be supported to learn. This may include being supernumerary, meaning that they are not counted as part of the staffing required for safe and effective care in that setting. The decision on the level of supervision provided for students should be based on the needs of the individual student. The level of supervision can decrease with the student's increasing proficiency and confidence. Students must be provided with adjustments in accordance with relevant equalities and human rights legislation in all learning environments and for supervision and assessment.

Effective practice learning

All students are provided with safe, effective and inclusive learning experiences. Each learning environment has the governance and resources needed to deliver education and training. Students actively participate in their own education, learning from a range of people across a variety of settings.

1. Organisation of practice learning

Approved education institutions, together with practice learning partners, must ensure that:

1.1 practice learning complies with the NMC *Standards framework for nursing and midwifery education*

1.2 practice learning complies with specific programme standards

1.3 practice learning is designed to meet proficiencies and outcomes relevant to the programme

1.4 there are suitable systems, processes, resources and individuals in place to ensure safe and effective coordination of learning within practice learning environments

1.5 there is a nominated person for each practice setting to actively support students and address student concerns

1.6 students are made aware of the support and opportunities available to them within all learning environments

1.7 students are empowered to be proactive and to take responsibility for their learning

1.8 students have opportunities to learn from a range of relevant people in practice learning environments, including service users, registered and non-registered individuals, and other students as appropriate

1.9 learning experiences are inclusive and support the diverse needs of individual students

1.10 learning experiences are tailored to the student's stage of learning, proficiencies and programme outcomes, and

1.11 all nurses, midwives and nursing associates contribute to practice learning in accordance with *The Code*.

Supervision of students

Practice supervision enables students to learn and safely achieve proficiency and autonomy in their professional role. All NMC registered nurses, midwives and nursing associates are capable of supervising students, serving as role models for safe and effective practice. Students may be supervised by other registered health and social care professionals.

2. Expectations of practice supervision

Approved education institutions, together with practice learning partners, must ensure that:

2.1 all students on an NMC approved programme are supervised while learning in practice

2.2 there is support and oversight of practice supervision to ensure safe and effective learning

2.3 the level of supervision provided to students reflects their learning needs and stage of learning

2.4 practice supervision ensures safe and effective learning experiences that uphold public protection and the safety of people

2.5 there is sufficient coordination and continuity of support and supervision of students to ensure safe and effective learning experiences

2.6 practice supervision facilitates independent learning, and

2.7 all students on an NMC approved programme are supervised in practice by NMC registered nurses, midwives, nursing associates, and other registered health and social care professionals.

3. Practice supervisors: role and responsibilities

Approved education institutions, together with practice learning partners, must ensure that practice supervisors:

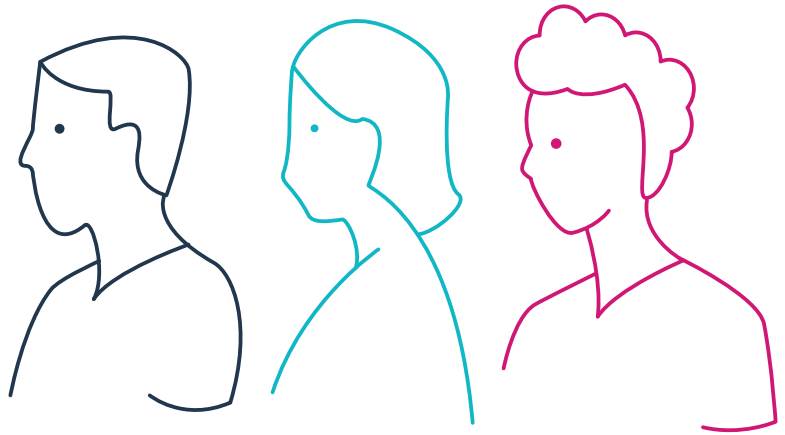
3.1 serve as role models for safe and effective practice in line with their code of conduct

3.2 support learning in line with their scope of practice to enable the student to meet their proficiencies and programme outcomes

3.3 support and supervise students, providing feedback on their progress towards, and achievement of, proficiencies and skills

3.4 have current knowledge and experience of the area in which they are providing support, supervision and feedback, and

3.5 receive ongoing support to participate in the practice learning of students.



4. Practice supervisors: contribution to assessment and progression

Approved education institutions, together with practice learning partners, must ensure that practice supervisors:

4.1 contribute to the student's record of achievement by periodically recording relevant observations on the conduct, proficiency and achievement of the students they are supervising

4.2 contribute to student assessments to inform decisions for progression

4.3 have sufficient opportunities to engage with practice assessors and academic assessors to share relevant observations on the conduct, proficiency and achievement of the students they are supervising, and

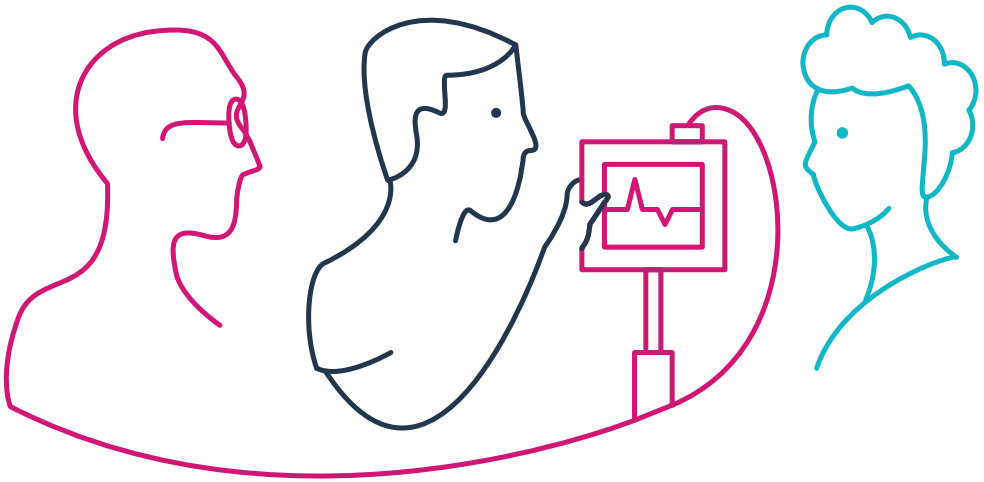
4.4 are expected to appropriately raise and respond to student conduct and competence concerns and are supported in doing so.

5. Practice supervisors: preparation

Approved education institutions, together with practice learning partners, must ensure that practice supervisors:

5.1 receive ongoing support to prepare, reflect and develop for effective supervision and contribution to, student learning and assessment, and

5.2 have understanding of the proficiencies and programme outcomes they are supporting students to achieve.



Assessment of students and confirmation of proficiency

Student assessments are evidence based, robust and objective. Assessments and confirmation of proficiency are based on an understanding of student achievements across theory and practice. Assessments and confirmation of proficiency are timely, providing assurance of student achievements and competence.

6. Assessor roles

Approved education institutions, together with practice learning partners, must ensure that:

6.1 all students on an NMC approved programme are assigned to a different nominated academic assessor for each part of the education programme

6.2 all students on an NMC approved programme are assigned to a nominated practice assessor for a practice placement or a series of practice placements, in line with local and national policies

6.3 nursing students are assigned to practice and academic assessors who are registered nurses with appropriate equivalent experience for the student's field of practice

6.4 midwifery students are assigned to practice and academic assessors who are registered midwives

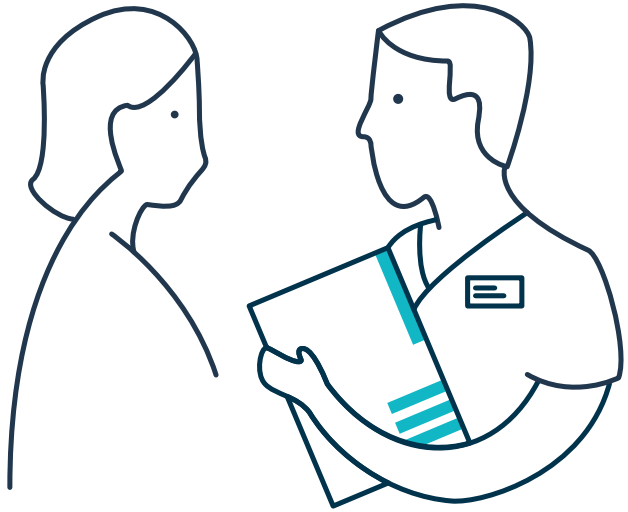
6.5 specialist community public health nurse (SCPHN) students are assigned to practice and academic assessors who are registered SCPHNs with appropriate equivalent experience for the student's field of practice

6.6 nursing associate students are assigned to practice and academic assessors who are either a registered nursing associate or a registered nurse

6.7 students studying for an NMC approved post-registration qualification are assigned to practice and academic assessors in accordance with relevant programme standards

6.8 practice and academic assessors receive ongoing support to fulfil their roles, and

6.9 practice and academic assessors are expected to appropriately raise and respond to concerns regarding student conduct, competence and achievement, and are supported in doing so.



7. Practice assessors: responsibilities

Approved education institutions, together with practice learning partners, must ensure that:

7.1 practice assessors conduct assessments to confirm student achievement of proficiencies and programme outcomes for practice learning

7.2 assessment decisions by practice assessors are informed by feedback sought and received from practice supervisors

7.3 practice assessors make and record objective, evidenced-based assessments on conduct, proficiency and achievement, drawing on student records, direct observations, student self-reflection, and other resources

7.4 practice assessors maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing

7.5 a nominated practice assessor works in partnership with the nominated academic assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies

7.6 there are sufficient opportunities for the practice assessor to periodically observe the student across environments in order to inform decisions for assessment and progression

7.7 there are sufficient opportunities for the practice assessor to gather and coordinate feedback from practice supervisors, any other practice assessors, and relevant people, in order to be assured about their decisions for assessment and progression

7.8 practice assessors have an understanding of the student's learning and achievement in theory

7.9 communication and collaboration between practice and academic assessors is scheduled for relevant points in programme structure and student progression

7.10 practice assessors are not simultaneously the practice supervisor and academic assessor for the same student, and

7.11 practice assessors for students on NMC approved prescribing programmes support learning in line with the NMC *Standards for prescribing programmes*.

8. Practice assessors: preparation

Approved education institutions, together with practice learning partners, must ensure that practice assessors:

8.1 undertake preparation or evidence prior learning and experience that enables them to demonstrate achievement of the following minimum outcomes:

- 8.1.1 interpersonal communication skills, relevant to student learning and assessment
- 8.1.2 conducting objective, evidence based assessments of students
- 8.1.3 providing constructive feedback to facilitate professional development in others, and
- 8.1.4 knowledge of the assessment process and their role within it

8.2 receive ongoing support and training to reflect and develop in their role

8.3 continue to proactively develop their professional practice and knowledge in order to fulfil their role, and

8.4 have an understanding of the proficiencies and programme outcomes that the student they assess is aiming to achieve.

9. Academic assessors: responsibilities

Approved education institutions, together with practice learning partners, must ensure that:

9.1 academic assessors collate and confirm student achievement of proficiencies and programme outcomes in the academic environment for each part of the programme

9.2 academic assessors make and record objective, evidence-based decisions on conduct, proficiency and achievement, and recommendations for progression, drawing on student records and other resources

9.3 academic assessors maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing and confirming

9.4 the nominated academic assessor works in partnership with a nominated practice assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies

9.5 academic assessors have an understanding of the student's learning and achievement in practice

9.6 communication and collaboration between academic and practice assessors is scheduled for relevant points in programme structure and student progression, and

9.7 academic assessors are not simultaneously the practice supervisor and practice assessor for the same student.

10. Academic assessors: preparation

Approved education institutions, together with practice learning partners, must ensure that academic assessors:

10.1 are working towards or hold relevant qualifications as required by their academic institution and local and national policies

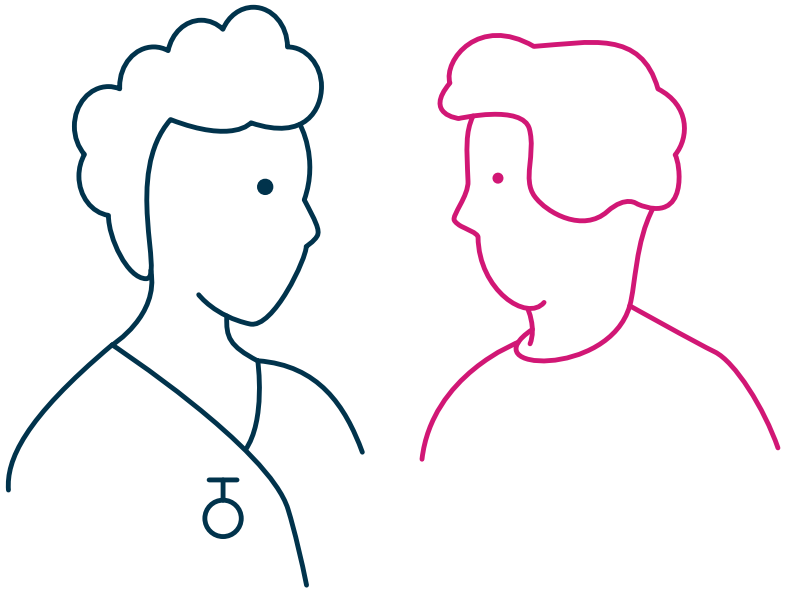
10.2 demonstrate that they have achieved the following minimum outcomes:

- 10.2.1 interpersonal communication skills, relevant to student learning and assessment
- 10.2.2 conducting objective, evidence based assessments of students
- 10.2.3 providing constructive feedback to facilitate professional development in others, and
- 10.2.4 knowledge of the assessment process and their role within it

10.3 receive ongoing support and training to reflect and develop in their role

10.4 continue to proactively develop their professional practice and knowledge in order to fulfil their role, and

10.5 have an understanding of the proficiencies and programme outcomes that the student they confirm is aiming to achieve.



The role of the Nursing and Midwifery Council

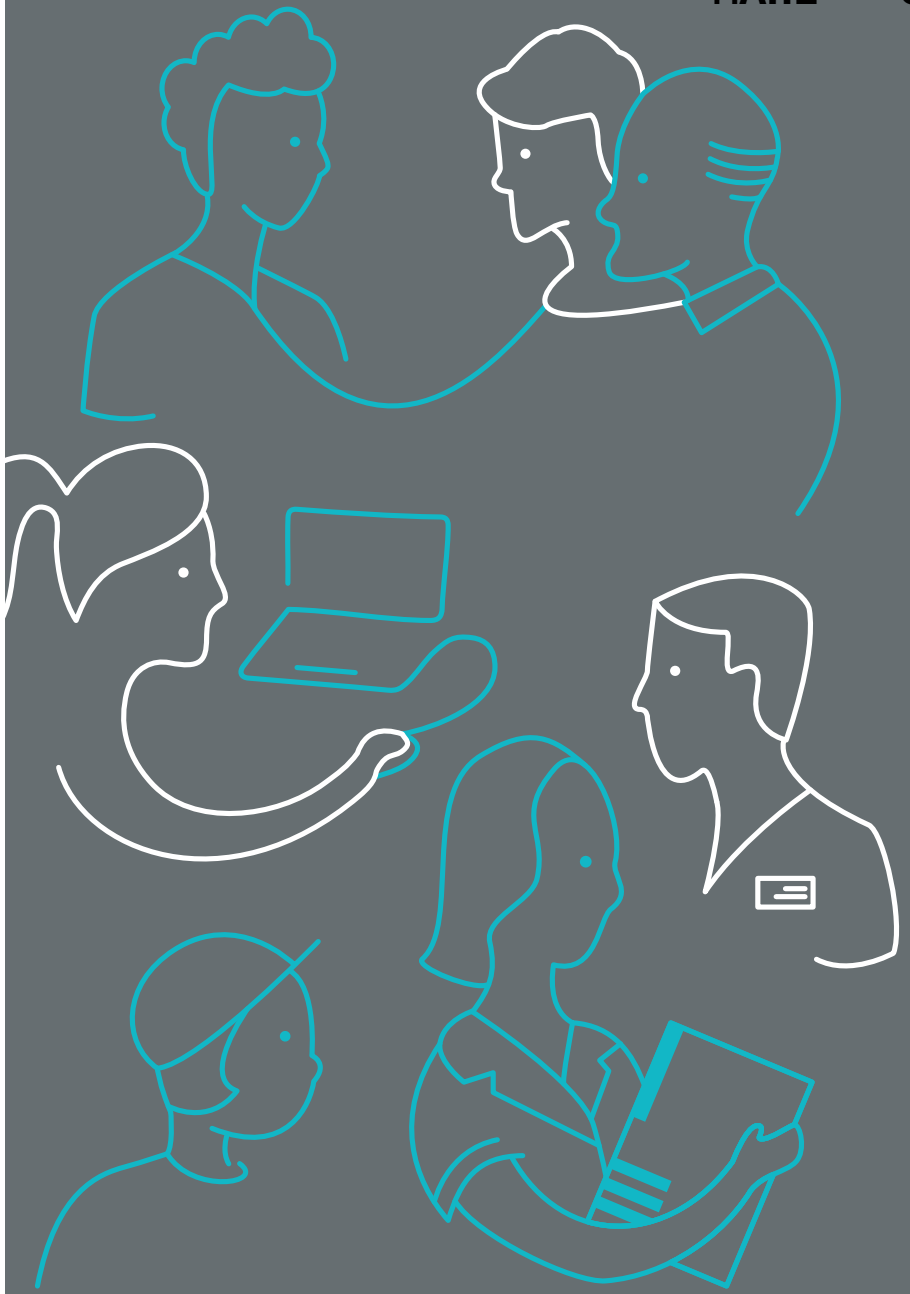
What we do

We regulate nurses, midwives and nursing associates in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses, midwives and nursing associates who fall short of our standards.

We maintain a register of nurses, midwives and nursing associates allowed to practise in the UK.

These standards were approved by Council at their meeting on 28 March 2018 and have been updated to include the regulation of pre-registration nursing associate programmes on 8 October 2018.



NMC Nursing & Midwifery Council

Realising professionalism:
Standards for education and training

Part 3: Standards for pre-registration nursing programmes

Published 17 May 2018

About these standards

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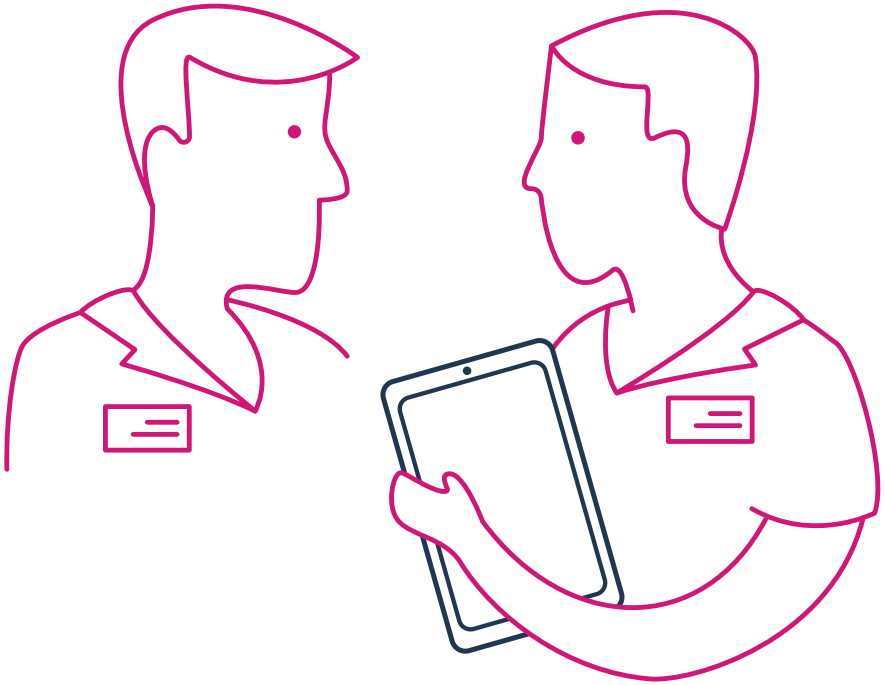

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[1] We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

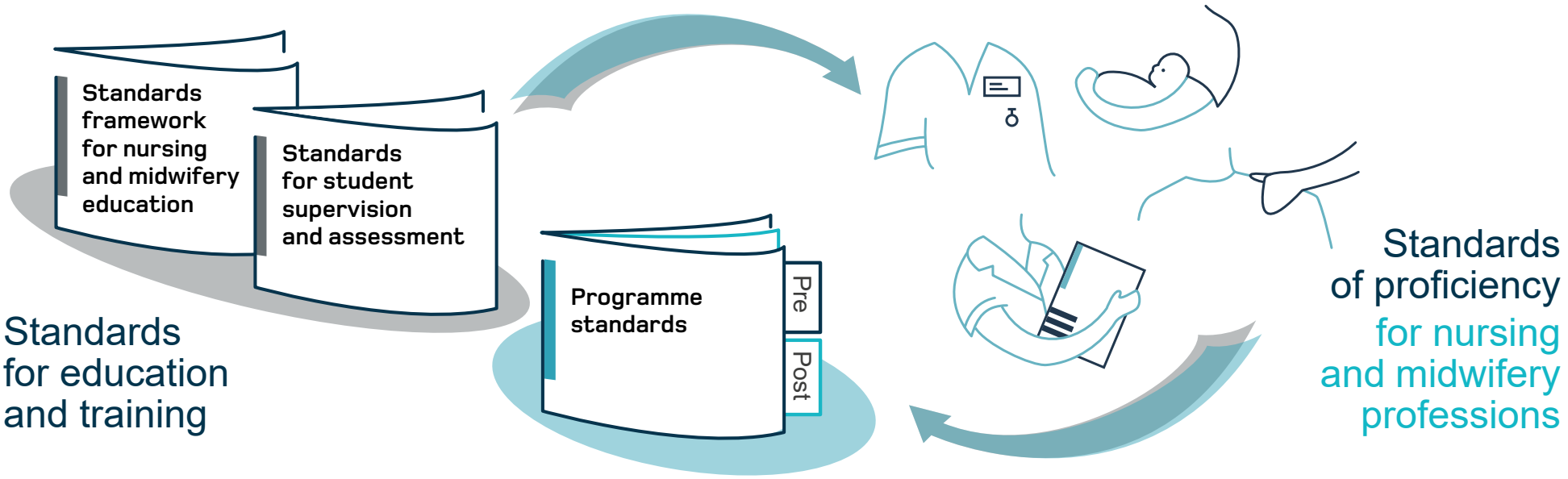
Introduction

Our *Standards for pre-registration nursing programmes* set out the legal requirements, entry requirements, availability of recognition of prior learning, length of programme, methods of assessment and information on the award for all pre-registration nursing education programmes.

Student nurses must successfully complete an NMC approved pre-registration programme in order to meet the *Standards of proficiency for registered nurses* and to be eligible to apply, and be entered onto, the NMC register.

Public safety is central to our standards. Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

These programme standards should be read with the NMC *Standards framework for nursing and midwifery education* and *Standards for student supervision and assessment* which apply to all NMC approved programmes. There must be compliance with all these standards for an education institution to be approved and to run any NMC approved programme.



Education providers structure their educational programmes to comply with our programme standards. They also design their curricula around the published proficiencies for a particular programme and students are assessed against these proficiencies to make sure they are capable of providing safe and effective care. Proficiencies are the knowledge, skills and behaviours that nurses and midwives need in order to practise. We publish standards of proficiency for the nursing and midwifery professions as well as proficiencies for NMC approved post-registration programmes.

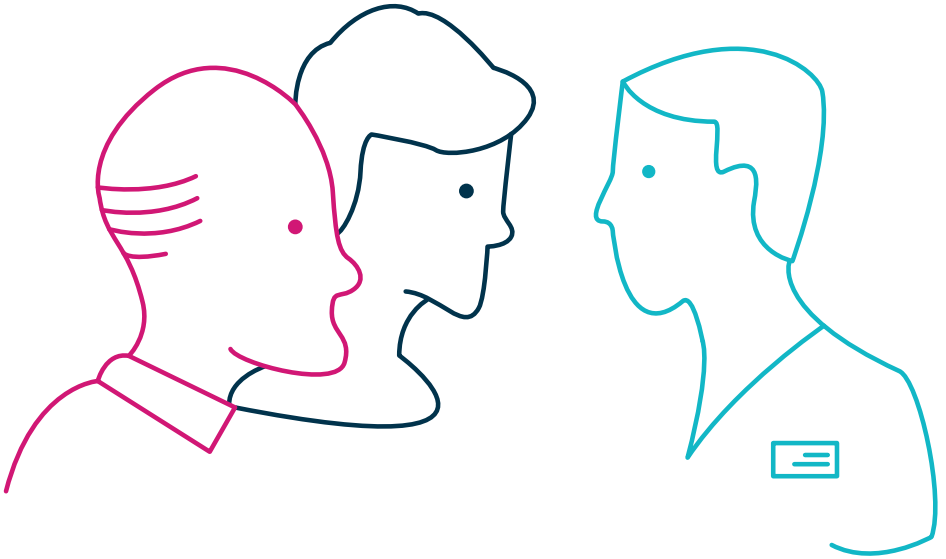
Through our quality assurance (QA) processes we check that education programmes meet all of our standards regarding the structure and delivery of educational programmes, that the programme outcomes relate to the expected proficiencies for particular qualifications and that the approved education institutions (AEIs) and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

Before any programme can be run, we make sure it meets our standards. We do this through an approvals process, in accordance with our *Quality assurance framework*.

Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for pre-registration nursing programmes are established under the provision of Article 15(1) of the Order.

Overall responsibility for the day-to-day management of the quality of any educational programme lies with an AEI in partnership with practice learning partners.



Four fields of nursing practice

In accordance with the Nurses & Midwives (Part and Entries in the Register) Order of Council 2004 (SI 2004/1765), which states that entries in the register are to include a registrant's field of practice, UK students that qualify in a specific field of practice as a level 1 nurse may apply to enter the NMC register as a nurse in one or more of the four fields of nursing practice: adult, children, learning disabilities and mental health.

AEIs and their practice learning partners have ownership and accountability for the development, delivery and management of pre-registration nursing programme curricula. Pre-registration nursing programmes may offer various routes to registration however, all programmes leading to registration must include routes within the programme specific to the relevant fields of nursing practice for which approval is being sought.

The *Standards framework for nursing and midwifery education* and these programme requirements give AEIs in partnership with practice partners the flexibility to design their own curriculum and the autonomy to decide on the proportion of generic and field specific hours provided. In designing curricula for dual award (that is, a programme of study that leads to registration in two fields of nursing practice) the NMC expects the AEI to design and deliver a programme of suitable length that ensures the student is proficient in delivering safe and effective care in both fields of nursing.

Programme curricula must cover the outcomes set out in platforms 1-7 of *Standards of proficiency for registered nurses* and the communication and relationship management skills and nursing procedures set out in the Annexes to that document. All nursing students across all fields of nursing must have the necessary learning supervision and assessment in preparation for professional practice as a registered nurse. The adult nursing field must also include the content and competencies specified in relevant EU legislation.

We believe that involving our service users and members of the public in the planning and delivery of curricula will promote public confidence in the education of future nurses. We encourage the use of supportive evidence and engagement from people who have experienced care by adult, children's, learning disabilities or mental health nurses to inform programme design and delivery for all fields of nursing practice.

Nursing students will learn and be assessed in theory, simulation and practice environments. AEIs and practice placement partners must ensure that students meet the proficiencies relevant to their anticipated field(s) of nursing practice by the end of the programme. On successful completion of a programme students will be registered by the NMC as qualifying in one or more field of nursing practice.

The student journey

Standards for pre-registration nursing programmes follow the student journey and are grouped under the following five headings:

1. Selection, admission and progression

Standards about an applicant's suitability and continued participation in a pre-registration nursing programme

2. Curriculum

Standards for the content, delivery and evaluation of the pre-registration nursing programme

3. Practice learning

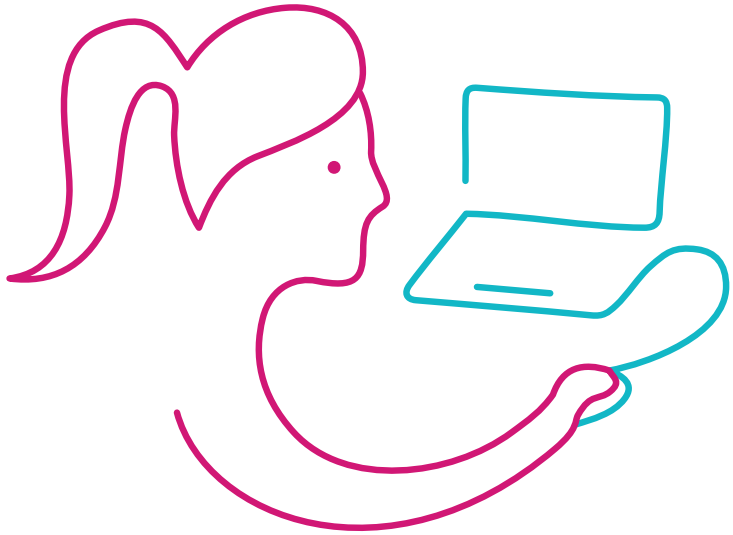
Standards specific to pre-registration learning for nurses that takes place in practice settings

4. Supervision and assessment

Standards for safe and effective supervision and assessment for pre-registration nursing programmes

5. Qualification to be awarded

Standards which state the award and information for the NMC register.



1 Selection, admission and progression

Approved education institutions, together with practice learning partners, must:

1.1 Confirm on entry to the programme that students:

1.1.1 are suitable for their intended field of nursing practice: adult, mental health, learning disabilities and children's nursing

1.1.2 demonstrate values in accordance with the Code

1.1.3 have capability to learn behaviours in accordance with the Code

1.1.4 have capability to develop numeracy skills required to meet programme outcomes

1.1.5 can demonstrate proficiency in English language

1.1.6 have capability in literacy to meet programme outcomes

1.1.7 have capability for digital and technological literacy to meet programme outcomes.

1.2 ensure students' health and character are sufficient to enable safe and effective practice on entering the programme, throughout the programme and when submitting the supporting declaration of health and character in line with the NMC's health and character decision-making guidance. This includes satisfactory occupational health assessment and criminal record checks

1.3 ensure students are fully informed of the requirement to declare immediately any cautions or convictions, pending charges[2] or adverse determinations made by other regulators, professional bodies and educational establishments, and that any declarations are dealt with promptly, fairly and lawfully

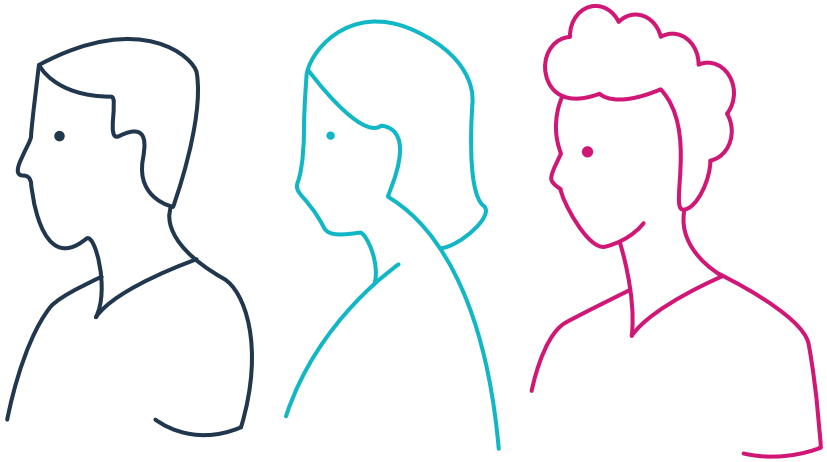
1.4 ensure the registered nurse responsible for directing the educational programme or their designated registered nurse substitute is able to provide supporting declarations of health and character for students who have completed a pre-registration nursing programme[3]

1.5 permit recognition of prior learning that is capable of being mapped to the *Standards of proficiency for registered nurses* and programme outcomes, up to a maximum of 50 percent of the programme and comply with Article 31(3) of Directive 2005/36/EC (included in Annexe 1 of this document)

1.6 for NMC registered nurses permit recognition of prior learning that is capable of being mapped to the *Standards of proficiency for registered nurses* and programme outcomes that may be more than 50 percent of the programme

1.7 support students throughout the programme in continuously developing their abilities in numeracy, literacy, digital and technological literacy to meet programme outcomes, and

1.8 ensure that all those enrolled on pre-registration nursing programmes are compliant with Article 31(1) of Directive 2005/36/EC regarding general education length as outlined in Annexe 1 of this document.



[2] By 'pending charge' we mean police charge pending conclusion of the criminal proceedings in line with the NMC's guidance on health and character.

[3] Rule 6(1)(a)(i) of the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (SI 2004/1767).

2 Curriculum

Approved education institutions, together with practice learning partners, must:

2.1 ensure that programmes comply with the NMC *Standards framework for nursing and midwifery education*

2.2 comply with the NMC *Standards for student supervision and assessment*

2.3 ensure that programme learning outcomes reflect the *Standards of proficiency for registered nurses* and each of the four fields of nursing practice: adult, mental health, learning disabilities and children's nursing

2.4 design and deliver a programme that supports students and provides exposure across all four fields of nursing practice: adult, mental health, learning disabilities and children's nursing

2.5 state routes within their pre-registration nursing programme that allows students to enter the register in one or more of the specific fields of nursing practice: adult, mental health, learning disabilities or children's nursing

2.6 set out the general and professional content necessary to meet the *Standards of proficiency for registered nurses* and programme outcomes

2.7 set out the content necessary to meet the programme outcomes for each field of nursing practice: adult, mental health, learning disabilities and children's nursing

2.8 ensure that field-specific content in relation to the law, safeguarding, consent, pharmacology and medicines administration and optimisation is included for entry to the register in one or more fields of nursing practice

2.9 ensure the curriculum provides an equal balance of theory and practice learning using a range of learning and teaching strategies

2.10 ensure that programmes delivered in Wales comply with legislation which supports use of the Welsh language

2.11 ensure pre-registration nursing programmes leading to registration in the adult field of practice are mapped to the content for nurses responsible for general care as set out in Annexe V.2 point 5.2.1 of Directive 2005/36/EC (included in Annexe 1 of this document)

2.12 ensure that all pre-registration nursing programmes meet the equivalent of minimum programme length for nurses responsible for general care in Article 31(3) of Directive 2005/36/EC (included in Annexe 1 of this document)

2.13 ensure programmes leading to registration in two fields of nursing practice are of suitable length to ensure proficiency in both fields of nursing, and

2.14 ensure programmes leading to nursing registration and registration in another profession, are of suitable length and nursing proficiencies and outcomes are achieved in a nursing context.

3 Practice learning

Approved education institutions, together with practice learning partners, must:

3.1 provide practice learning opportunities that allow students to develop and meet the *Standards of proficiency for registered nurses* to deliver safe and effective care to a diverse range of people across the four fields of nursing practice: adult, mental health, learning disabilities and children's nursing

3.2 ensure that students experience the variety of practice expected of registered nurses to meet the holistic needs of people of all ages

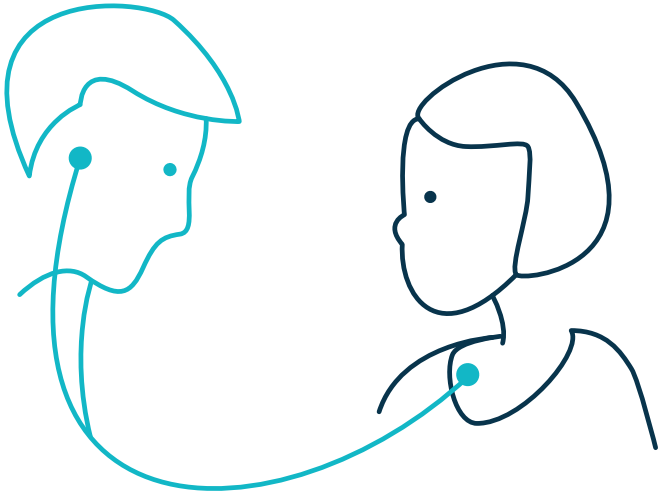
3.3 provide practice learning opportunities that allow students to meet the communication and relationship management skills and nursing procedures, as set out in *Standards of proficiency for registered nurses*, within their selected fields of nursing practice: adult, mental health, learning disabilities and children's nursing

3.4 ensure technology enhanced and simulation-based learning opportunities are used effectively and proportionately to support learning and assessment and pre-registration nursing programmes leading to registration in the adult field of practice comply with Article 31(5) of Directive 2005/36/EC (included in Annexe 1 of this document)

3.5 take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities

3.6 ensure students experience the range of hours expected of registered nurses, and

3.7 ensure that students are supernumerary.



4 Supervision and assessment

Approved education institutions, together with practice learning partners, must:

4.1 ensure that support, supervision, learning and assessment provided complies with the NMC *Standards framework for nursing and midwifery education*

4.2 ensure that support, supervision, learning and assessment provided complies with the NMC *Standards for student supervision and assessment*

4.3 ensure they inform the NMC of the name of the registered nurse responsible for directing the education programme

4.4 provide students with feedback throughout the programme to support their development

4.5 ensure throughout the programme that students meet the *Standards of proficiency for registered nurses* and programme outcomes for their fields of nursing practice: adult, mental health, learning disabilities and children's nursing

4.6 ensure that all programmes include a health numeracy assessment related to nursing proficiencies and calculation of medicines which must be passed with a score of 100%

4.7 ensure that students meet all communication and relationship management skills and nursing procedures within their fields of nursing practice: adult, mental health, learning disabilities and children's nursing

4.8 assess students to confirm proficiency in preparation for professional practice as a registered nurse

4.9 ensure that there is equal weighting in the assessment of theory and practice

4.10 ensure that all proficiencies are recorded in an ongoing record of achievement which must demonstrate the achievement of proficiencies and skills set out in *Standards of proficiency for registered nurses*, and

4.11 ensure the knowledge and skills for nurses responsible for general care set out in Article 31(6) and the competencies for nurses responsible for general care set out in Article 31(7) of Directive 2005/36/EC for pre-registration nursing programmes leading to registration in the adult field of practice have been met. (Annexe 1 of this document).

5 Qualification to be awarded

Approved education institutions, together with practice learning partners, must:

5.1 ensure that the minimum award for a pre-registration nursing programme is a bachelor's degree, and

5.2 notify students during and before completion of the programme that they have five years to register their award with the NMC. In the event of a student failing to register their qualification within five years they will have to undertake additional education and training or gain such experience as specified in our standards.

Annexe 1

DIRECTIVE 2005/36/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the recognition of professional qualifications (as amended by Directive 2013/55/EU)

Article 31

Training of nurses responsible for general care

1. Admission to training for nurses responsible for general care shall be contingent upon either:

   a completion of general education of 12 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or a certificate attesting success in an examination of an equivalent level and giving access to universities or to higher education institutions of a level recognised as equivalent; or

   b completion of general education of at least 10 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or a certificate attesting success in an examination of an equivalent level and giving access to a vocational school or vocational training programme for nursing.

2. Training of nurses responsible for general care shall be given on a full-time basis and shall include at least the programme described in Annex V.2, point 5.2.1.

   The Commission shall be empowered to adopt delegated acts in accordance with Article 57c concerning amendments to the list set out in point 5.2.1 of Annex V.2 with a view to adapting it to scientific and technical progress.

   The amendments referred to in the second subparagraph shall not entail an amendment of existing essential legislative principles in Member States regarding the structure of professions as regards training and conditions of access by natural persons. Such amendments shall respect the responsibility of the Member States for the organisation of education systems, as set out in Article 165(1) TFEU.

3. The training of nurses responsible for general care shall comprise a total of at least three years of study, which may in addition be expressed with the equivalent ECTS credits, and shall consist of at least 4,600 hours of theoretical and clinical training, the duration of the theoretical training representing at least one third and the duration of the clinical training at least one half of the minimum duration of the training. Member States may grant partial exemptions to professionals who have received part of their training on courses which are of at least an equivalent level.

   The Member States shall ensure that institutions providing nursing training are responsible for the coordination of theoretical and clinical training throughout the entire study programme.

4. Theoretical education is that part of nurse training from which trainee nurses acquire the professional knowledge, skills and competences required under paragraphs 6 and 7. The training shall be given by teachers of nursing care and by other competent persons, at universities, higher education institutions of a level recognised as equivalent or at vocational schools or through vocational training programmes for nursing.

5. Clinical training is that part of nurse training in which trainee nurses learn, as part of a team and in direct contact with a healthy or sick individual and/or community, to organise, dispense and evaluate the required comprehensive nursing care, on the basis of the knowledge, skills and competences which they have acquired. The trainee nurse shall learn not only how to work in a team, but also how to lead a team and organise overall nursing care, including health education for individuals and small groups, within health institutes or in the community.

   This training shall take place in hospitals and other health institutions and in the community, under the responsibility of nursing teachers, in cooperation with and assisted by other qualified nurses. Other qualified personnel may also take part in the teaching process.

   Trainee nurses shall participate in the activities of the department in question insofar as those activities are appropriate to their training, enabling them to learn to assume the responsibilities involved in nursing care.

6. Training for nurses responsible for general care shall provide an assurance that the professional in question has acquired the following knowledge and skills:

   a comprehensive knowledge of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and the physical and social environment of the human being;

   b knowledge of the nature and ethics of the profession and of the general principles of health and nursing;

   c adequate clinical experience; such experience, which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patient;

   d the ability to participate in the practical training of health personnel and experience of working with such personnel;

   e experience of working together with members of other professions in the health sector.

7. Formal qualifications as a nurse responsible for general care shall provide evidence that the professional in question is able to apply at least the following competences regardless of whether the training took place at universities, higher education institutions of a level recognised as equivalent or at vocational schools or through vocational training programmes for nursing:

a competence to independently diagnose the nursing care required using current theoretical and clinical knowledge and to plan, organise and implement nursing care when treating patients on the basis of the knowledge and skills acquired in accordance with points (a), (b) and (c) of paragraph 6 in order to improve professional practice;

b competence to work together effectively with other actors in the health sector, including participation in the practical training of health personnel on the basis of the knowledge and skills acquired in accordance with points (d) and (e) of paragraph 6;

c competence to empower individuals, families and groups towards healthy lifestyles and self-care on the basis of the knowledge and skills acquired in accordance with points (a) and (b) of paragraph 6;

d competence to independently initiate life-preserving immediate measures and to carry out measures in crises and disaster situations;

e competence to independently give advice to, instruct and support persons needing care and their attachment figures;

f competence to independently assure the quality of, and to evaluate, nursing care;

g competence to comprehensively communicate professionally and to cooperate with members of other professions in the health sector;

h competence to analyse the care quality to improve their own professional practice as a nurse responsible for general care.

V.2. NURSE RESPONSIBLE FOR GENERAL CARE

5.2.1. Training programme for nurses responsible for general care

The training leading to the award of a formal qualification of nurses responsible for general care shall consist of the following two parts.

A. Theoretical instruction

a. Nursing:

- Nature and ethics of the profession
- General principles of health and nursing
- Nursing principles in relation to:
  - general and specialist medicine
  - general and specialist surgery
  - child care and paediatrics
  - maternity care
  - mental health and psychiatry
  - care of the old and geriatrics

b. Basic sciences:

- Anatomy and physiology
- Pathology
- Bacteriology, virology and parasitology
- Biophysics, biochemistry and radiology
- Dietetics
- Hygiene:
  - preventive medicine
  - health education
- Pharmacology

c. Social sciences:

- Sociology
- Psychology
- Principles of administration
- Principles of teaching
- Social and health legislation
- Legal aspects of nursing

B. Clinical instruction

- Nursing in relation to:
  - general and specialist medicine
  - general and specialist surgery
  - child care and paediatrics
  - maternity care
  - mental health and psychiatry
  - care of the old and geriatrics
  - home nursing

One or more of these subjects may be taught in the context of the other disciplines or in conjunction therewith.

The theoretical instruction must be weighted and coordinated with the clinical instruction in such a way that the knowledge and skills referred to in this Annex can be acquired in an adequate fashion.

Glossary

Reasonable adjustments: where a student requires reasonable adjustment related to a disability or adjustment relating to any protected characteristics as set out in the equalities and human rights legislation.

Approved education institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Educators: in the context of the NMC *Standards for education and training* educators are those who deliver, support, supervise and assess theory, practice and/or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections.

(Good) health and character requirements: as stipulated in NMC legislation (Articles 9(2)(b) and 5(2)(b) of the Nursing and Midwifery Order 2001) 'good health' means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability. Each applicant seeking admission to the register or to renew registration, whether or not they have been registered before, is required to declare any pending charges, convictions, police cautions and determinations made by other regulatory bodies.

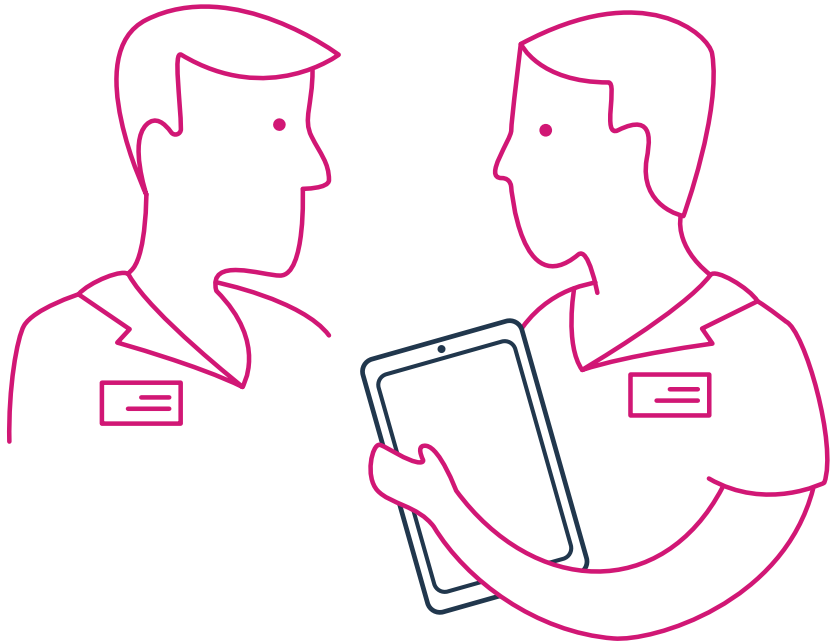
People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and others within and outside the learning environment.

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Recognition of prior learning (RPL): a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes, this means it includes both theory and practice achievement.

Simulation: an artificial representation of a real world practice scenario that supports student development through experiential learning with the opportunity for repetition, feedback, evaluation and reflection. Effective simulation facilitates safety by enhancing knowledge, behaviours and skills.



Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the NMC *Standards for education and training* this includes students, educators, partner organisations, service users, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC approved education programme whether full time or less than full time.

Supernumerary: students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role. Placements should enable students to learn to provide safe and effective care, not merely to observe; students can and should add real value to care. The contribution students make will increase over time as they gain proficiency and they will continue to benefit from ongoing guidance and feedback. Once a student has demonstrated that they are proficient, they should be able to fulfil tasks without direct oversight. The level of supervision a student needs is based on the professional judgement of their supervisors, taking into account any associated risks and the students' knowledge, proficiency and confidence.

The role of the Nursing and Midwifery Council

What we do

We regulate nurses, midwives and nursing associates in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses, midwives and nursing associates who fall short of our standards.

We maintain a register of nurses, midwives and nursing associates allowed to practise in the UK.

These standards were approved by Council at their meeting on 28 March 2018 and have been updated to include the regulation of pre-registration nursing associate programmes on 8 October 2018.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

NIPEC

Future Nurse Future Midwife Northern Ireland

Standards for Student Supervision and Assessment

A Guide for those Responsible for Student Supervision and Assessment in Practice

QUEEN'S UNIVERSITY BELFAST
The Open University
Ulster University
HSC Health and Social Care

Contents

1. Introduction

Northern Ireland has three Approved Education Institutions (AEIs), The Open University, Queen's University Belfast and Ulster University who deliver NMC approved programmes. Through partnership working the NI regional Model was developed to implement and deliver the NMC Education Standards (2018), which includes the Standards for Student Supervision and Assessment (SSSA).

The Nursing and Midwifery Council (NMC) Realising professionalism: Standards for education and training - Part 2: Standards for student supervision and assessment (2018) sets out the expectation for the learning, support and supervision of students in the practice learning environment (PLE).

This guide provides details on the various roles and how they work together to ensure practice supervision and assessment meets the NMC Education Standards (2018) for SSSA. It will outline the responsibilities, preparation and support for these roles.

It also includes details on the regional approach to the practice assessor database, the roles of the Practice Education Teams or equivalent, and link lecturer/practice tutors.

2. The Northern Ireland Regional Model - Standards for Student Supervision and Assessment

The process of supervising and assessing students is one of partnership between the AEIs and practice partners to ensure that safe and effective learning and assessment upholds public protection. It is a process, which fosters a positive learning relationship with the student and enhances their professional and personal development. Supervision and assessment helps empower the student in becoming a more resilient critical thinker and decision maker who can analyse, reflect on and improve their practice.

Students experiencing practice or work placed learning must be supported to learn without being counted as part of the staffing levels required for safe effective care in that setting. While students will maintain supernumerary status they should always be considered part of the team and integral to the workforce through their contribution in providing safe and effective care. Students should be observing and participating in practice and should add real value to care while evidencing their learning.

The agreed model for SSSA will reflect the new roles of the:

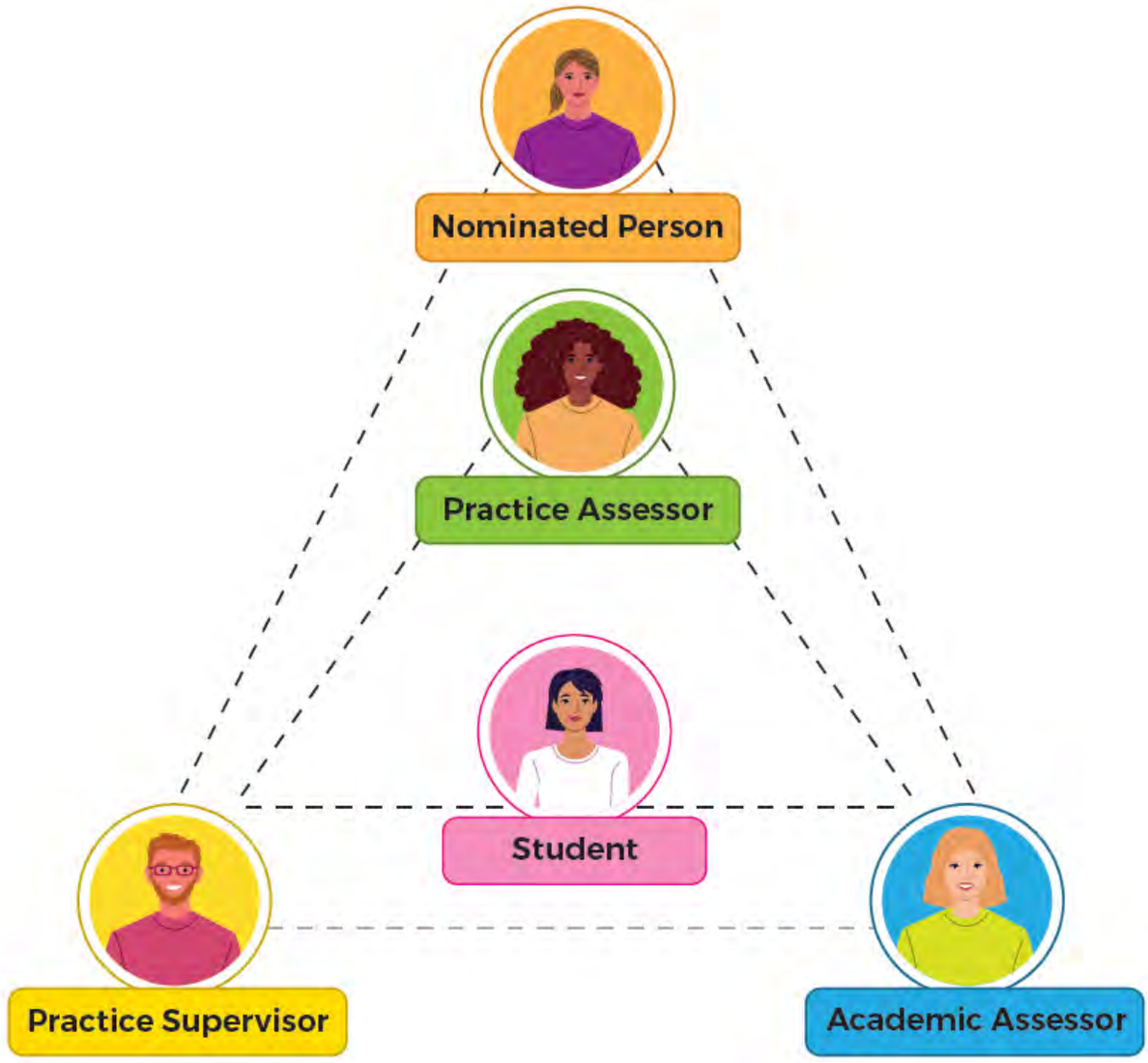
- nominated person (ward sister/charge nurse/team leader/manager)
- practice supervisor (all registered nurses/midwives & other healthcare professionals)
- practice assessor (registered nurse/midwife, designated medical prescribers)
- academic assessor (link lecturer/practice tutor).

Every student will be allocated:

- at least one practice supervisor for every practice learning experience
- a practice assessor for each practice learning experience or series of practice learning experiences
- an academic assessor for each part of the programme.

Separating out the supervision and assessment roles ensures greater consistency and objectivity in the assessment process. The academic assessor works in partnership with the practice assessor to evaluate and recommend the student for progression for each part of the programme informed by feedback sought and received from practice supervisor/s and practice assessors as illustrated in Diagram 1.

Diagram 1

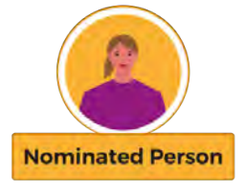


The shared responsibility of the practice assessor and the academic assessor ensures that robust, objective, fair and transparent assessments and shared decision-making will uphold public protection and ensure only those students who have met all the programme requirements and proficiencies and are clearly able to demonstrate the principles of The Code (2018) are entered onto the NMC professional register.

3. The Nominated Person

3.1. Who can be the Nominated Person?

The nominated person for each practice learning environment will normally be the ward sister/charge nurse/team leader/manager. The name of the nominated person will be detailed on the Practice Learning Environment Educational Audit (PLEEA).



3.2. What is the role of the Nominated Person?

The nominated person will:

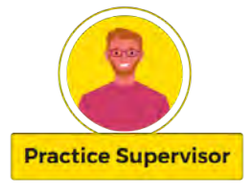
- ensure continuity of the practice learning experience for the student
- actively support student learning
- be responsible for assigning students to each practice supervisor and practice assessor
- consider the registrant's scope of practice when assigning practice supervisors and practice assessors
- support the practice supervisor/s and practice assessor/s to manage student underperformance or concerns in collaboration with the Practice Education Team (when appropriate), the link lecturer and academic assessor
- ensure the practice assessor/s and practice supervisor/s receive appropriate preparation and have ongoing access to support
- liaise with the Practice Education Team (when appropriate) or AEI
- co-ordinate and monitor quality assurance processes to support the PLE meet the NMC Education Standards (2018) i.e. student evaluation, educational audit, maintenance of the practice assessor database and continuing professional development requirements for the practice supervisor and practice assessor.

3.3. Who will support the Nominated Person?

The nominated person will be supported by the:

- line manager
- link lecturer/practice tutor
- academic assessor
- peers
- Practice Education Team or equivalent.

4. Supervision of Students



Practice supervision enables students to learn safely and achieve proficiency and autonomy in their professional role. Every student will be allocated at least one practice supervisor for each PLE however there could be multiple practice supervisors in the same PLE to support the student achieve a range of learning outcomes. When identifying the practice supervisor/s the registrant's scope of practice will be considered. There may be different models of supervision within the PLE such as 1:1 or Hub and Spoke [1].

It is anticipated that students will work with and learn from a range of people who may not be registered healthcare professionals but who can positively contribute to their learning; this practice learning experience will be coordinated by the practice supervisor/s.

4.1. Who can be the Practice Supervisor/s?

All NMC registered nurses and midwives are capable of supervising students and serving as role models for safe and effective practice. Students may also be supervised by other registered health and social care professionals. Each PLE will provide opportunities for the practice assessor to observe the student across a range of environments in order to inform decisions for assessment and progression.

To supervise a prescribing student the practice supervisor must:

- be a registered health care professional on a professional register with equivalent prescribing qualifications [notated on a professional register where relevant]
- be able to evidence active prescribing
- have completed a preparation programme to support them to undertake the role.

4.2. What is the role of the Practice Supervisor?

The practice supervisor will:

- have current knowledge and experience of the area in which they are providing support, supervision and feedback
- serve as role models for safe and effective practice in line with The Code (2018) and their professional duty of candour
- organise and co-ordinate student learning activities in practice, ensuring quality, safe and effective practice learning experiences that uphold public protection and the safety of people
- ensure the level of supervision provided to students reflects their learning needs and stage of learning
- support learning in line with their scope of practice to enable the student meet their

[1] Hub and Spoke is defined as a base practice learning environment/experience, (the hub) from which the students learning is complemented by additional activities in the spoke).

proficiencies and programme outcomes

- ensure requirement and rights around informed consent are implemented and that public protection is maintained
- use their professional judgment and local/national policy to determine where activities may be safely delegated to students and the level of supervision required
- be accountable for their decisions
- support and supervise students, providing feedback on their progress towards achievement of proficiencies and skills
- set and monitor realistic achievement of proficiencies through the development of evidence identified within the programme specific Northern Ireland Practice Assessment Document (NIPAD) for nursing or the Midwifery Ongoing record of Achievement (MORA).
- contribute to the student's ongoing record of achievement in the student's NIPAD/MORA by periodically recording relevant observations on the conduct, proficiency and achievement of the students they are supervising
- facilitate practice based independent learning as appropriate
- support learning in an inter-professional environment, selecting and supporting a range of learning opportunities for students with other professions
- encourage and coordinate students to work with and learn from a number of people who are not registered healthcare professionals but who can positively contribute to their learning
- contribute to student assessments to inform decisions for progression at summative assessment through reviewing evidence to ensure its authenticity, standard and completeness
- liaise with others (e.g. Practice Education Team, practice assessor, link lecturer/practice tutor, academic assessor, nominated person) to provide feedback and identify any concerns about the student's performance and agree action as appropriate
- identify when a student is underperforming, or where there are professional concerns. Take prompt action to notify the appropriate key persons and document the concerns/underperformance in the student's NIPAD/MORA -

    - for further information, refer to Escalating Concerns/Issues Regarding a Student in Practice Learning Environments (Appendix Two).
    - the student's practice assessor must also be notified.

The supervisory role that non-registered colleagues play in supervising students will be dependent on their skill, knowledge and experience. They will be prepared for this role (Appendix One) and receive ongoing support.

4.3. Who will support the Practice Supervisor?

The practice supervisor can access support from the:

- nominated person
- link lecturer for the student
- other practice supervisors
- practice assessor

- academic assessor
- Practice Education Team or equivalent
- Trust nurse prescribing lead[2]
- supervision and annual appraisal process
- reflective discussion during the revalidation process

4.4. Preparation for the Role of Practice Supervisor/s

There will be an opportunity for mentors, sign-off mentors and practice teachers to have recognition of prior learning and move directly to the new role of practice supervisor following completion of a practice supervisor practice assessor transitioning programme. Practice supervisors will have the knowledge and experience that meets the NMC Education Standards (2018) and have an understanding of the proficiencies and programme outcomes that they are supporting students to achieve.

- Preparation programmes will be available, delivered and supported by key personnel in both practice and education environments (Appendix One)
- Preparation programmes will be delivered via e-Learning and/or face-to-face
- The opportunities to prepare for the role will be flexible and designed to meet the needs of practice supervisors.

5. Assessment of Students

The student will have a practice assessor for each practice learning experience or series of practice learning experiences and an academic assessor for each part of the programme. The academic assessor will not simultaneously be the practice supervisor and practice assessor for the same student. Students will not be assigned the same academic assessor on concurrent parts of the programme. The practice assessor will not simultaneously be the practice supervisor and practice assessor for the same student except in exceptional circumstances[3].

5.1. Assessment Process

Practice assessors will conduct all assessments. During the final stage of each part of the programme or at agreed progression points depending on the programme, the practice assessor will work in partnership with the academic assessor to undertake student assessment. They will take into account feedback from practice supervisor/s and other practice assessors to evaluate and recommend the student for progression to the next part of the programme and ultimately onto the NMC professional register. Assessment and confirmation of proficiencies are based on an understanding of the student's achievement across theory and practice and is provisional until all practice hours are completed and there are no emerging professional/performance issues.

[2] Trust nurse prescribing lead Specific to NMP prescribing programmes
[3] In exceptional circumstances the same individual may fulfil the role of practice assessor and practice supervisor for NMP, SCPHN & SPQ

The joint assessment will be face to face; however, in exceptional circumstances, for example inclement weather or illness other communication media will be acceptable including Zoom, Face-time and Skype.

5.2. Assessor Database

HSC Trusts will maintain their own practice assessor database and AEIs will maintain a practice assessor database for the Independent Sector. A practice assessor database will record the following details: Name, NMC PIN, Part of NMC Register, Field of Practice and Date of Preparation for Role.

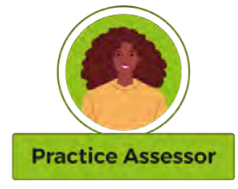
All existing mentors, sign off mentors and practice teachers will automatically transition onto a practice assessor database following suitable preparation. The current mentor register will also be maintained until all students are transitioned onto the NMC Education Standards (2018) programme/s.

The AEIs will maintain an academic assessor database.

5.3. Practice Assessor

5.3.1. Who can be the Practice Assessor?

There will be an opportunity for mentors, sign-off mentors and practice teachers to have recognition of prior learning and move directly into the new role of practice assessor following a preparation programme. It is expected that all practice supervisors will progress to take on the role of practice assessor.



All practice assessors will have completed the practice assessor preparation programme and evidenced that they meet the NMC Education Standards (2018) outcomes for the role. There are some specific programme requirements depending on the practice assessor's registration and the programme the student is studying:

- to assess a nursing student, you must be a registered nurse with appropriate equivalent experience for the student's field of practice.
- to assess a midwifery student you must be a registered midwife.
- to assess a specialist community public health nurse (SCPHN) student you must be a registered SCPHN with appropriate equivalent experience for the student's field of practice.
- to assess students studying for an NMC post–registration qualification, you will be assigned practice and academic assessors in accordance with the relevant programme standards. (see Appendix Three for additional practice assessors guidance for Specialist Practice Qualifications)
- to assess a prescribing student you must be:
    - a registered healthcare professional and an experienced and current prescriber with suitable equivalent qualifications for the programme the student is undertaking
    - able to evidence active prescribing for a minimum of three years (usually)
    - able to confirm that your scope of prescribing practice aligns to, or exceeds that of the prescribing student.

In exceptional circumstances, the same person may fulfil the role of the practice supervisor and practice assessor for Prescribing Programmes, Specialist Practice and SCPHN. In such

instances, the student, practice supervisor/practice assessor and the AEI representative will need to evidence why it is necessary for the practice supervisor and practice assessor role to be carried out by the same person.

5.3.2. What is the role of the Practice Assessor?

The practice assessor will:

- conduct all assessments and work in partnership with the academic assessor to evaluate and recommend the student for progression for each part of the programme in line with programme standards
- make and record objective, evidenced-based assessments on conduct, proficiency and achievement, drawing on student records, direct observations, student self-reflection, and other resources
- periodically observe the student across environments in order to inform decisions for assessment and progression in partnership with the academic assessor
- ensure that assessment decisions are informed by feedback sought and received from practice supervisor/s
- confirm that all the evidence required for the specific part of the programme has been provided by the student and authenticated by practice assessors and practice supervisor/s. This will include evidence of authenticity, standard of completeness and relevancy to the claimed proficiencies
- in exceptional circumstances, agree alternative arrangements with the academic assessor, link lecturer/practice tutor and student if all three parties cannot be present at the assessment
- maintain current knowledge and expertise relevant to the proficiencies and programme outcomes they are assessing
- provide assurances that they maintain their professional knowledge and skills and critically reflect on their role through a range of processes, which includes NMC revalidation, supervision and appraisals.

5.3.3. Who will support the Practice Assessor?

The practice assessor can access support from the:

- nominated person
- link lecturer/practice tutor for the practice area
- academic assessor for student/s
- relevant programme leader
- Practice Education Team or equivalent
- Trust nurse prescribing lead (if relevant)

The practice assessor can gain additional support during discussions at supervision, annual appraisals, revalidation- by the use of critical reflection on their role and with other practice assessors and academic assessors in sharing best practice and discussing assessment decisions (group supervision/learning sets).

To note: practice assessors new to the role may wish to shadow an experienced practice assessor, this should be discussed with the nominated person.

There will be an opportunity on an annual basis to participate in discussions and updates on the role of the practice assessor. This updating may be accessed in a variety of ways including discussions with one of the individuals listed above, drop in sessions, teaching/assessing events and online learning etc.

5.3.4. Preparation for the role of Practice Assessor

There will be an opportunity for current mentors, sign-off mentors and practice teachers to have recognition of prior learning and move directly into the new role of practice assessor. The opportunities to prepare for the role will be flexible and designed to meet the needs of the practice assessor depending on their previous experience and identified learning needs.

Preparation programmes can be accessed in two ways:

- The nominated person will recommend the practice supervisor for the role of practice assessor at supervision/appraisal.
- Self-nomination validated by the line manager.

Preparation programmes will be delivered and supported by key personnel in practice and education environments using a range of learning methods including face-to-face and an e-Learning package which can be accessed via the HSC Learning with additional resources available on the NIPEC website.

5.4. Academic Assessors

The programme lead for each NMC programme will allocate an appropriate academic assessor for each part of the student's programme. AEIs will identify the academic assessor for each part of the programme through their local clinical allocation system and the academic assessor will be advised of their student's practice assessor.

5.4.1. Who can be the Academic Assessor?

The academic assessor will:

- be an affiliated member of staff from the student's AEI
- be a registered nurse or midwife
- hold relevant qualifications as required by their AEI
- have completed an academic assessor preparation programme or equivalent.

To note: the academic assessor for prescribing programmes may be a registered healthcare professional with appropriate equivalent experience for the student's field of practice. Students will not be assigned the same academic assessor for concurrent parts of the programme. The academic assessor will not simultaneously be the practice supervisor and practice assessor for the same student.

5.4.2. What is the role of the Academic Assessor?

The academic assessor will:

- maintain current knowledge and expertise relevant to the proficiencies and programme outcomes they are assessing and confirming
- collate and confirm student achievement of proficiencies and programme outcomes in the academic environment for each part of the programme
- communicate and collaborate with the practice assessor at scheduled relevant points during the student's programme
- make and record objective, evidence-based decisions on conduct, proficiency and achievement, and make recommendations for progression drawing on student records and other resources
- have an understanding of the student's learning and achievement in practice including any concerns around underperformance
- liaise with the link lecturer concerning any student underperformance issues
- work in partnership with the practice assessor to evaluate and recommend the student for progression for each part of the programme in line with programme standards and for entry (or additional entry) to the NMC professional register.
- forward the outcome of summative assessments to the appropriate person in a timely manner and advise the appropriate AEI personnel of any issues concerning the student's progress.

5.4.3. Who will support the Academic Assessor?

The opportunities to prepare for the role will be flexible and designed to meet the needs of the academic assessor. Link lecturers/practice tutors will simultaneously undertake the role of academic assessor following completion of a preparation programme or equivalent (Appendix One).

5.4.4. Preparation for the role of Academic Assessor

In order to fulfil their role the academic assessor will receive on-going training and support from their AEI to develop their professional practice and knowledge.

6. Link Lecturer/Practice Tutor

The Schools of Nursing in each of Northern Ireland's three AEIs operate a link lecturer/practice tutor system with an identified member of staff allocated to each PLE. All current link lecturers/practice tutors will transition to the role of academic assessor following completion of the academic assessor preparation programme.

6.1. What is the role of the Link Lecturer/Practice Tutor?

The link lecturer/practice tutor will:

- undertake the role of academic assessor for allocated students
- support students and practice supervisors in clarifying the learning opportunities available to develop evidence for the NIPAD/MORA
- be available to support and advise students and practice supervisor/s in relation to challenges to student learning within the PLE
- ensure that necessary measures are taken to make effective use of the learning potential in PLEs

- maintain accurate and appropriate records as required
- assure quality practice learning environments through the PLEEA and monitor the quality of the learning experience in collaboration with practice partners
- ensure the relevant process is followed in the event of concerns/issues regarding a student (Appendix Two)
- collaborate with the appropriate AEI personnel, nominated person, practice supervisor and the Practice Education Team (where applicable) regarding issues which may impact on students' learning experiences or performance
- encourage students to complete evaluation questionnaires
- provide assurances that they maintain their professional knowledge and skills and critically reflect on their role through a range of processes which includes NMC revalidation, supervision and appraisals.

6.1.1. Independent Sector: Link Lecturer/Practice Tutor

Within the Independent Sector the link lecturer in addition to the above list is responsible for:

- providing professional support to the nominated person or equivalent, the practice supervisor, the practice assessor and students
- ensuring quality practice learning environments through the PLEEA
- monitoring the quality of the practice learning experience in collaboration with the AEIs and through student evaluation questionnaires.

7. Practice Education Teams

Practice Education Teams provide professional support, advice and guidance to the nominated person, practice supervisors and practice assessors. In partnership with AEIs, they will support students to ensure that the NMC Education Standards (2018) are met including the SSSA.

The Practice Education Team will:

- work in partnership with others to contribute to systems that monitor the effectiveness of learning and education activities within all NMC approved programmes
- collate and maintain the practice assessor database and facilitate a process to share required information with AEIs within GDPR regulations
- ensure the quality of the PLE through the completion and monitoring/updating of the PLEEA
- monitor the quality of the practice learning experience in collaboration with the AEIs and through student evaluations.

Where there are no Practice Education Teams, e.g. Independent Sector, the link lecturer/practice tutor will provide this support.

8. Raising Concerns Regarding Student Progress

In the event of student concerns, issues or underachievement there is an expectation that communication will take place via face to face in a timely manner. If the practice supervisor or practice assessor requires support to engage in a courageous conversation they should inform the nominated person and seek guidance from the Practice Education Team (or equivalent) and /or the academic assessor. For further details refer to Escalating Concerns/Issues Regarding a Student in Practice Learning Environments (Appendix Two).

9. Glossary of Terms

Academic assessor: A registrant who collates and confirms the student's achievement of proficiencies and programme outcomes in the academic environment for each part of the programme.

Approved Education Institutions (AEI) : The status awarded to an institution that works in partnership with practice learning providers in delivering NMC approved programmes.

Duty of candour: The professional duty of candour -"Every healthcare professional must be open and honest when things go wrong".
https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/

GDPR: General Data Protection Regulation.

Hub and Spoke: A base practice learning experience, the hub, from which the student's learning is complemented by additional activities, the spoke.

Mentor: A registrant who facilitates learning, supervises and assesses students in a practice setting.

NIPAD: Northern Ireland Practice Assessment Document – a tool to guide learning and a record of a student's learning and achievement in practice.

NMC Education Standards: The standards that are required to be met by all nursing and midwifery students on NMC approved programmes prior to entry to the register.

NMC Professional Register : Shows who can practise as a nurse or midwife in the UK.

NMP: Non–Medical Prescribing/Nursing and Midwifery Prescribing also referred to as Prescribing Programmes.
https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-prescribers/standards-of-proficiency-for-nurse-and-midwife-prescribers/

MORA: Midwifery On-going Record of Achievement- a tool to guide learning and a record of a student midwife's learning and achievement in practice.

Nominated person: Usually the ward sister/charge nurse/team leader/manager or an identified suitable person who will actively supports student learning.

Non-Registered Health Care Support Staff – (In the context of supporting students) Students will work with and learn from a range of people who may not be registered healthcare professionals but who can positively contribute to their learning; this learning experience will be coordinated by practice supervisor/s. The supervisory role that non-registered professionals play will be dependent on their skills, knowledge and experience.

Other Registered Health and Social Care Professionals: Health and social care professionals registered with a regulated health and social care body i.e GMC, HCPC, GPhC NISCC. In the context of the SSSA they will be suitably prepared to undertake the role of practice supervisor.

Parts of a programme: One part will usually constitute one year of a programme (parts 1-3) however; this will vary depending on what programme the student is studying and at which AEI. This detail will be included in the programme specific preparation.

Practice assessor: Registrants who assess and confirm the student's achievement of practice learning for a practice learning experience or a series of practice learning experiences**.**

Practice assessor/academic assessor database: The collection of information specially organised to store limited specific information relating to practice assessors/academic assessors.

Practice Education Team: Indirectly support students through providing direct support to staff involved in supervision and assessment in practice activities to develop quality practice learning experiences for students.

Practice Learning Environment (PLE): A setting/ward/unit (etc.) which has been audited by practice and AEI/s and approved for students to undertake a practice learning experience as part of their programme. Learning environment includes any physical location where learning takes place as well as the system of shared values, beliefs and behaviours.

Practice Learning Environment Educational Audit (PLEEA): The NMC requires that approved education institutions (AEIs), together with practice learning partners, regularly review all learning environments and provide assurance that they are safe and effective through proper oversight and effective governance processes, with clear lines of responsibility and accountability especially in responding to standards that are not met.

Practice Learning Experience: Students are supported to gain experiences and skills whilst in a practice learning environment. Multiple practice learning experiences could be acquired whilst the student works under different practice supervisors in one practice learning environment, for example, using a hub and spoke model.

Practice Partners: Organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Practice supervisor : Any registered health and social care professional working in a practice environment. They will have been prepared and supported to take up their role and have up-to-date knowledge and experience relevant to the student they are supervising.

Scope of Practice: Exercise professional judgement and be accountable for all work**.**

SCPHN: Specialist Community Public Health Nurse.

Sign-off mentor: Registrants who meet specified criteria in order to be able to sign-off a student's practice proficiency at the end of an NMC approved programme.

Supernumerary: Supported to learn without being counted as part of the staffing required for safe and effective care in that setting.

SPQ: Specialist Practice Qualification.

The Code (2018) – "Professional standards of practice and behaviour for nurses, midwives and nursing associates." can be accessed here: https://www.nmc.org.uk/standards/code/

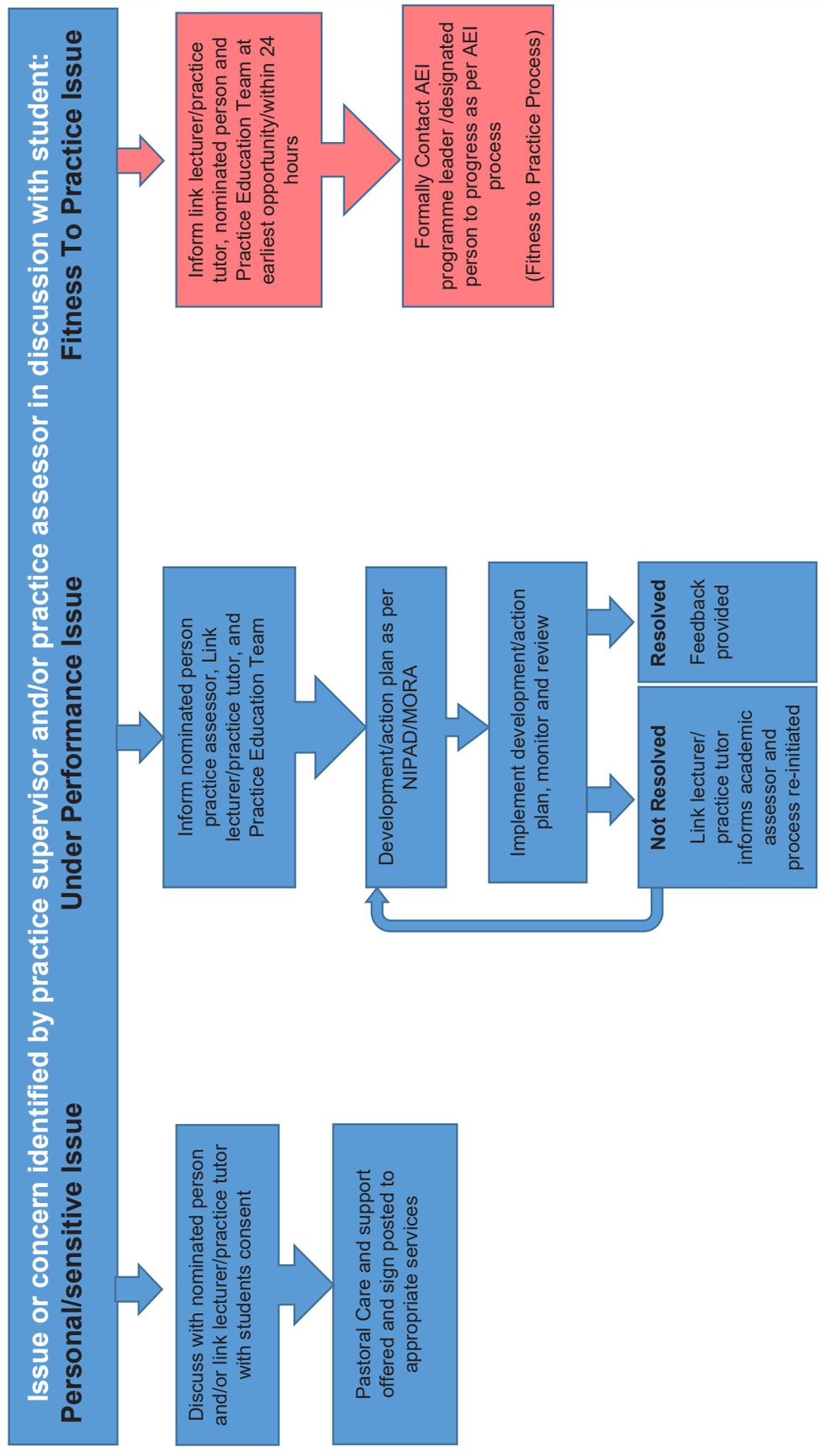
Appendix One – Training Requirements: Roles

	Roles			
Training Requirements	**Practice Supervisor** All NMC Registrants and/or other Registered Health and Social Care Professionals	**Practice Assessor** All NMC Registrants to include Current Mentors, Sign off Mentors, and Practice Teachers with appropriate equivalent experience for the student's field of practice Registered Health Care Professional with suitable equivalent qualifications for the programme that the student is undertaking	**Academic Assessor** Current Link Lecturers/Practice Tutors	**Non-Registered Health Care Support Staff**
• **SSSA Roles & Responsibilities**	✓	✓	✓	✓ NIPAD/ MORA Learning outcomes identified to specific area
• **Curriculum Update – aligned to standards of proficiency for NMC approved programme the student is undertaking (links below)**	✓	✓	✓	✓
• **Overview Northern Ireland Practice Assessment Document (NIPAD) aligned to programme nursing student is undertaking /** • **Midwifery On-Going Record of Achievement (MORA)**	✓	✓	✓	✓
• **Completion of self-declaration**	✓	✓	✓	**N/A**

2020 Curriculum - all NMC Approved Programmes Links to NMC proficiencies are available on the NMC website					
Future nurse: Standards of proficiency for registered nurses	Future Midwife: Standards of proficiency for midwives	Standards for Prescribing Programmes	Post Graduate Specialist Community Public Health Nurse (SCPHN)	Post Graduate Specialist Practice Qualification (SPQ)	Return to Practice Standards

Registrants new to SSSA roles must also undertake an ELearning FNFM Supervision and Assessment Fundamentals module only available at www.hsclearning.com. Anyone undertaking SSSA practice supervision and assessment must complete the relevant FNFM preparation programme. The above table is a broad overview of the preparation content, for specific details about supporting students and which preparation programme you should complete, please visit https://nipec.hscni.net/service/fnfm/ for more information.

Appendix Two - Escalating Concerns/Issues Regarding a Student in Practice Learning Environments



Appendix Three: Additional Guidance re Specialist Practice Qualification - Practice Assessors

All Practice Assessors involved in SPQ student support must attend/undertake an SPQ induction programme (which will include the programme specific curriculum and NIPAD update) provided by the AEI to ensure they have knowledge of the programme standards. When selecting an SPQ practice assessor, the practice assessor must be a registered nurse in the same field of practice[4] as the student. In addition to this, the following criteria should be applied in order of preference:

1. Has the same SPQ pathway as the student; if not achievable then
2. Has an SPQ (different to student's pathway); if not achievable then
3. Is a registered nurse (without an SPQ) and has extensive experience in the specialist area.

In exceptional circumstances, as set out in the FNFM NI Model for SSSA (2019) the same person may fulfil the role of the practice supervisor and practice assessor for the Specialist Practice and SCPHN students undergoing training in a practice learning environment. The rationale being that there may only be one individual in this practice learning environment who can fulfil both roles. In such instances, the student, practice supervisor/assessor and the AEI will need to evidence why it is necessary for the practice supervisor and assessor role to be carried out by the same person. This will be monitored through the educational audit in collaboration with practice and AEI.

To Note: Practice supervisors involved in SPQ student support should, where possible, attend/undertake an SPQ induction programme.

[4] The fields of practice are identified as: Adult nursing, Mental Health nursing, Children's nursing and Learning Disabilities nursing

NOTES

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E-mail: enquiries@nipec.hscni.net

This document can be downloaded from the NIPEC website
https://nipec.hscni.net/

February 2021
IBSN 978-1-903580-61-1

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

NIPEC

Northern Ireland Future Nurse Future Midwife (FNFM) - Key Facts

Introduction and Context

The Nursing and Midwifery Council (NMC) have published a series of standards and proficiencies for nursing and midwifery education which set out the skills and knowledge that the next generation of nurses and midwives will need to deliver safe and effective care. These standards take into account the changes in society and the health care reforms which have implications for registrants, employers, educators, students and all those who support students in practice. They aim to raise the ambition in terms of what is expected of a nurse and midwife and maximise the quality and safety of nursing and midwifery education and training.

Why Change?

- The health and care landscape is changing rapidly
- The care provided by integrated teams is increasing
- There is a growing focus on person-centred care closer to home
- Nurses and midwives are taking on additional responsibilities
- The use of technology in health care is increasing
- Nurses and midwives are working across a range of settings.

The standards of proficiencies for registered nurses (2018) are presented under seven platforms and two annexes:

1. Being an **accountable** professional
2. **Promoting health** and preventing ill health
3. **Assessing** needs and **planning care**
4. Providing and **evaluating care**
5. **Leading and managing** nursing care and working in teams
6. Improving **safety and quality** of care
7. **Coordinating** care

Annex A: Communication & Relationship Management Skills
Annex B: Nursing Procedures

The standards of proficiencies for midwives (2019) are presented under six domains:

1. Being an **accountable, autonomous, professional** midwife
2. Safe and effective midwifery care: promoting and providing **continuity of care and carer**
3. **Universal care** for all women and newborn infants
4. Additional **care for women and newborn infants with complications**
5. Promoting excellence: the midwife as **colleague, scholar and leader**
6. The midwife as **skilled practitioner**

Northern Ireland Practice Assessment Document/Midwifery Ongoing Record of Achievement

Students undertaking NMC approved programmes are required to evidence how they meet the proficiencies of the programme they are studying. Pre-and post-registration nursing students will record their evidence of practice learning in the Northern Ireland Practice Assessment Document (NIPAD). Midwifery students will evidence their practice learning in the Midwifery Ongoing Record of Achievement (MORA). The NIPAD/MORA provides:

- a framework for the support, supervision and assessment of students in practice
- a means of communication for those supporting students learning in practice
- evidence of learning in practice and an on-going record of the student's achievements
- a structure to support the management of students who are underperforming and require additional support.

Standards for Student Supervision and Assessment (SSSA)

The process of student supervision and assessment is one of partnership between Northern Ireland's three universities and their practice partners. This partnership helps ensure safe and effective student learning and assessment along with enhanced professional and personal development. Supervision and assessment will help uphold public protection, empower the student to be a more resilient critical thinker and decision maker who can analyse, reflect on and improve their practice. Separating out the roles of student supervision and assessment ensures greater consistency and objectivity in the assessment process. Practice assessors, practice supervisors and academic assessors must be suitably prepared for the role.

MAHI - STM - 102 - 5529
Standards for Student Supervision and Assessment (SSSA)

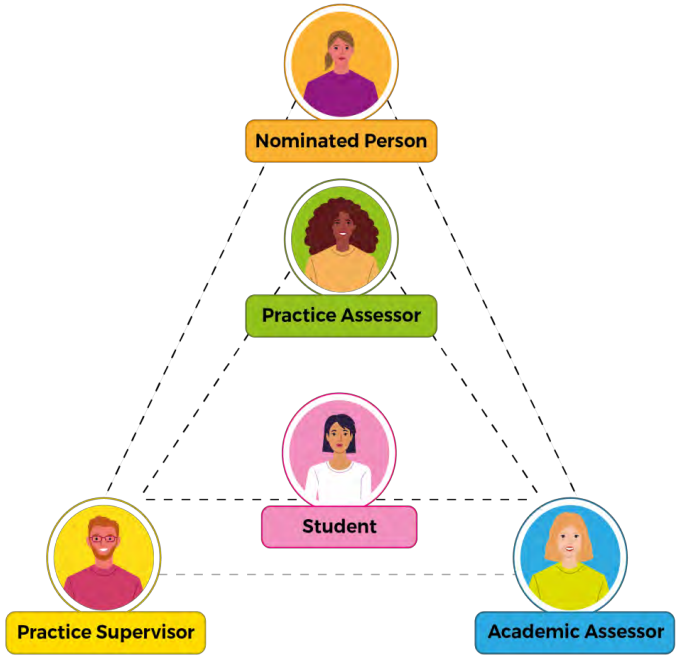
The nominated person is the ward sister/charge nurse, team leader or manager. T**he nominated person:**

- ✓ promotes a quality practice learning environment
- ✓ allocates the student a practice assessor and at least one practice supervisor, while considering the registrants' scope of practice
- ✓ ensures continuity of the student's practice learning experience
- ✓ actively supports student learning
- ✓ ensures supervisors & assessors have access to suitable role preparation
- ✓ supports the management of student underperformance, linking with the Practice Education Team and university staff (link lecturer/practice tutor) where relevant.

The practice supervisor/s - all registered nurses and midwives are capable of being a practice supervisor, along with other registered health and social care professionals. A student will be allocated at least one practice supervisor during their practice learning experience but may work alongside several supervisors.

Practice supervisor/s:

- ✓ serve as a role model
- ✓ support the student to safely achieve a range of proficiencies and skills
- ✓ ensure student learning opportunities are facilitated
- ✓ provide feedback to the student to support learning
- ✓ provide feedback to the practice assessor regarding the student's progress and performance
- ✓ contribute to the student's assessments to inform decisions for progression
- ✓ record relevant observations of progress in the student's Northern Ireland Practice Assessment Document (NIPAD) or Midwifery Ongoing Record of Achievement (MORA).
- ✓ identifies, escalates and supports the management of student underperformance issues.



Students undertaking a practice learning experience must be supported to learn without being counted as part of the staffing requirements. While students maintain supernumerary status, they should always be considered part of the team and integral to the workforce through their contribution in providing person centred, safe and effective care. The level of supervision can decrease with the student's increasing proficiency and confidence.

Students should be observing and participating in practice and add real value to care while they evidence their learning.

The practice assessor* is a registered nurse (with equivalent experience for the student's field of practice) for nursing students or a registered midwife for midwifery students. Each student will be allocated a practice assessor for each practice learning experience or series of practice learning experiences.

Practice assessors:

- ✓ set the learning objectives for the practice learning experience with the student at their initial meeting and undertake the progress and final review meetings
- ✓ periodically observes the student in practice
- ✓ receive feedback from practice supervisor/s on student performance
- ✓ work in partnership with academic assessors to evaluate and recommend the student for progression to each part of their programme, in line with the programme standards (formative and summative assessments)
- ✓ manage student underperformance issues and support students and practice supervisor/s throughout
- ✓ are not simultaneously the practice supervisor for the same student

** Can be another healthcare professional in certain circumstances e.g. Nursing and Midwifery Prescribing*

The shared responsibility of the practice assessor and the academic assessor ensures that only those students who meet all programme requirements and proficiencies, and who are clearly able to demonstrate the principles of The Code (2018) are entered onto the NMC professional register

The academic assessor* is a registered nurse (with equivalent experience for the student's field of practice) for nursing students or a registered midwife for midwifery students & has the relevant qualifications required by the university. The student will have an academic assessor for each part of their programme.

Academic assessors:

- ✓ collate and confirm student achievement of proficiencies and programme outcomes in the academic environment for each part of the programme
- ✓ work in partnership with the practice assessor in evaluating and recommending the student for progression to each part of their programme.

** Can be another healthcare professional in certain circumstances e.g. Nursing and Midwifery Prescribing*

Department of Health
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NIPEC

Future Nurse Future Midwife

Key Information for Registered Health and Social Care Professionals Supporting Nursing and Midwifery Students in Practice

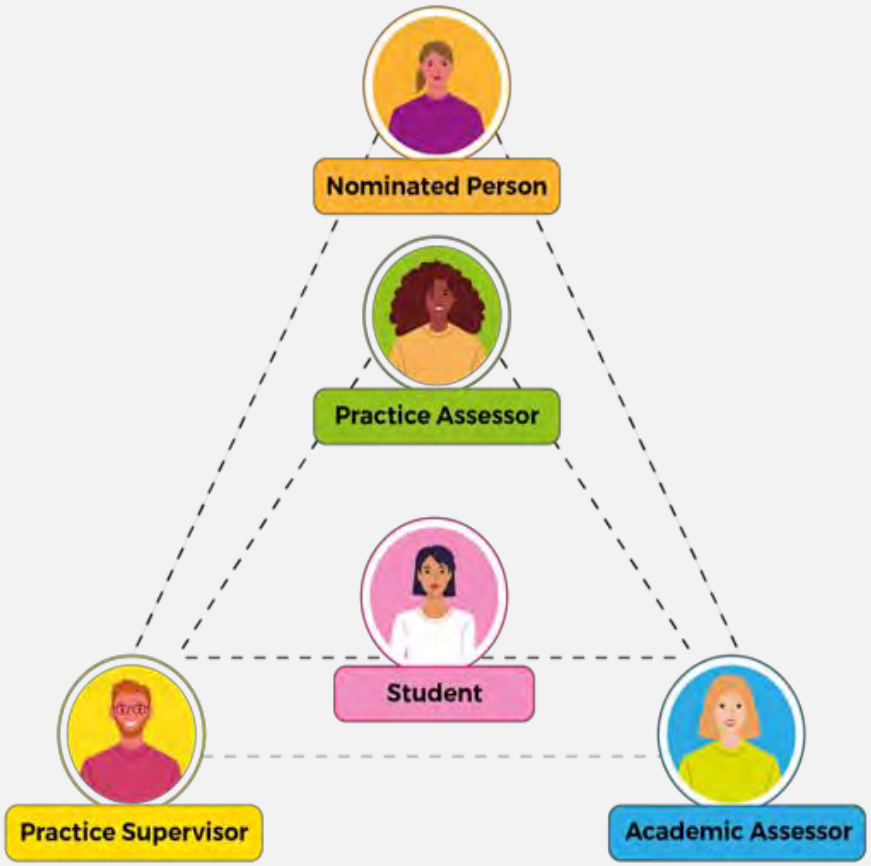
Introduction

Registered Health and Social Care Professionals (HCPs) have always supported students from all disciplines to learn and develop skills in practice. Practice learning experiences enable students to gain an insight and appreciation into the diverse roles of the inter-professional team in delivering safe and effective care.

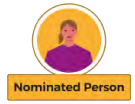
The Nursing and Midwifery Council (NMC) Education Standards (2018) recognised that students work with and learn from a range of people who may not be registered nurses or midwives but who positively contribute to their learning experience.

The NMC Standards for Student Supervision and Assessment (SSSA) (2018) acknowledge the contribution of HCPs in nursing and midwifery education and outlines the roles of all health and social care professionals involved in supporting and supervising nursing and midwifery students in practice. The SSSA were published on May 2018 and will come into effect in NI from September 2020 for Nursing Students and September 2021 for Midwifery students. The diagram overleaf details the roles aligned to the SSSA.

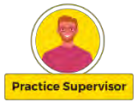
Diagram 1: Roles in Student Supervision and Assessment



All of the above individuals will work together to ensure safe and effective practice learning experiences for the student which upholds public protection and safety.



The nominated person for each practice learning environment will normally be the ward sister/charge nurse/team leader/ manager.



All NMC registered nurses and midwives are capable of supervising students and serving as role models for safe and effective practice. **Health Care Professionals** who receive appropriate preparation may also fulfil this role.

All NMC registered nurses and midwives are capable of being a practice assessor and will have been completed the preparation programme and evidenced that they meet the NMC Education Standards (2018) outcomes for the role.
** In exceptional circumstances, non-nursing registrants may fulfil the role of the practice supervisor and practice assessor for example prescribing programmes as the practice assessor must be a registered health care professional and an experienced and current prescriber with suitable qualifications for the programme.*

Link lecturer /practice tutor

Northern Ireland's three universities operate a link lecturer/ practice tutor system with an identified member of staff allocated to each practice learning environment who is the regular point of contact for the student.

The academic assessor will be an affiliated member of staff from the student's university and a registered nurse or midwife.
** Can be another healthcare professional in certain circumstances e.g. Nursing and Midwifery Prescribing*

Practice Education Team

Each HSC Trust has a Practice Education Team to provide professional support, advice and guidance to the nominated person, practice supervisors and practice assessors within the HSCTs. The universities will provide support to independent and voluntary sector.

How You Might Facilitate Student Learning

Students will record all practice learning experiences in an electronic or printed version of the Northern Ireland Practice Assessment Document (NIPAD) or the Midwifery On going Record of Achievement (MORA) which are tools to guide nursing and midwifery learning and achievement in practice. Supporting information on the NIPAD/MORA can be found in the students Handbook.

Prior to working with a practice supervisor the student will have identified and noted the learning objectives, skills and proficiencies which they need to obtain during their practice placement.

Examples may include:

- a **dietician** may engage the student in educating a person on the importance of adhering to a specific diet to maintain normal blood sugars
- a **doctor** may supervise a student undertaking the non-medical prescribing programme to achieve a range of competencies and proficiencies
- an **obstetric physiotherapist** may teach the midwifery student about pelvic girdle pain and the management of incontinence following child birth
- an **occupational therapist** may role model and carry out an Activities of Daily Living (ADL) assessment and discuss how this assessment informs care delivery
- a **pharmacist** may teach a student about medicine management and medicines optimisation for individual patients
- a **physiotherapist** may teach a student about a specific respiratory condition and demonstrate how to undertake chest auscultation
- a **radiographer** may teach a student about ultrasound scans in pregnancy
- a **speech and language therapist** may teach a student about communication skills and how best to support a person with communication difficulties

Following each learning experience, the HCP can provide the student with constructive feedback on their achievement, proficiency and/ or overall conduct and note the learning achieved in their NIPAD/MORA; feedback may also be given to the student's nominated person, practice assessor, link lecturer/practice tutor e.g. if professional concerns are raised. This will be documented within the NIPAD/MORA and will also require direct communication with the students Practice Assessor.

Resources available which may support you for the Role:

There are a wide range of resources available online via the NIPEC FNFM website on the NIPEC FNFM Resource page and the Health and Social Care Learning Centre including:

1. A Guide for those Responsible for Student Supervision and Assessment in Practice is available on NIPEC FNFM Resource page and is in draft until all NMC programmes have been approved

2. Raising and escalating concerns flowchart (contained within the above document) can be viewed in Appendix One.

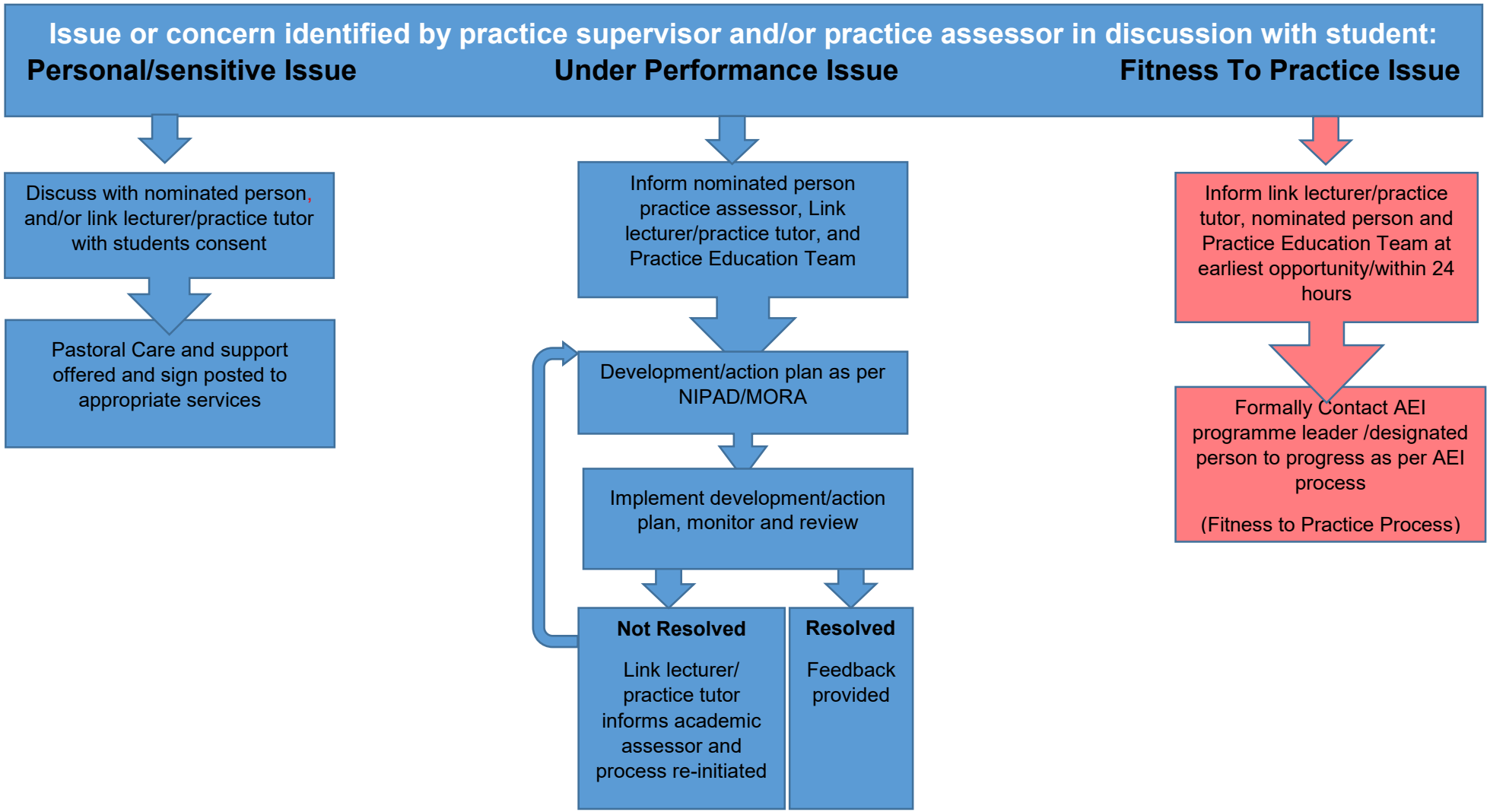
3. Health and Social Care Learning Centre Programmes: *(log in to your HSC Learning Centre account to view)*
    a. The Fundamentals of Supervision and Assessment Programme
    b. FNFM Practice Supervisor Practice Assessor Transitioning Programme
    c. FNFM Practice Supervisor Practice Assessor New to Role Programme

4. Standards Student Supervision and Assessment (SSSA) Frequently asked questions trifold leaflet available on NIPEC FNFM Resource page: a fact sheet with frequently asked questions and answers to support staff as they take on the new role

5. Practice Supervisor Practice Assessor Fact Sheet available on NIPEC FNFM Resource page: a fact sheet with key information to support staff as they take on the new roles.

6. Practice Education Teams within each HSC Trust and the Link Lecture are available to provide support, advice and guidance to the nominated person, practice supervisors and practice assessors and will support students to ensure that the NMC Education Standards (2018) are met including the SSSA.

Appendix One: Escalating Concerns/Issues regarding a Student in Practice Learning Environments



Student's name:	
Student ID	
Intake Year	
University	

NORTHERN IRELAND PRACTICE ASSESSMENT DOCUMENT PRE-REGISTRATION NURSING

LEARNING DISABILITIES NURSING - PART 1

Students, supervisors and assessors, please note the NMC requirement R1.3:

Please ensure people have the opportunity to give and if required withdraw, their informed consent to students being involved in their care.

Please keep your Practice Assessment Document (PAD) with you at all times in practice in order to review your progress with your practice supervisor/s, practice assessor and/or academic assessor.

Contents

Acknowledgements

The Northern Ireland Practice Assessment Document (NIPAD) has been developed in collaboration with:

- Department of Health (Northern Ireland)
- Northern Ireland Practice Education Council (NIPEC)
- Queen's University Belfast
- Open University
- Ulster University
- Health and Social Care Trusts
- Representatives from the Independent and Voluntary Sector in Northern Ireland
- Service Users
- Students
- Registered healthcare professionals in practice
- Patient Client Council
- Public Health Agency

We would like to acknowledge the help, support and direction from the regional PAD groups in England, Scotland and Wales who helpfully shared their work with us, enabling us to align with their approach as much as possible. Some elements of this NIPAD are adapted from their work.

WELCOME TO THE NORTHERN IRELAND PRACTICE ASSESSMENT DOCUMENT (NIPAD)

This NIPAD is designed to support and guide you towards successfully achieving the criteria set out in the *Future nurse: Standards of proficiency for registered nurses* and *Standards for education* (NMC 2018). It is therefore a tool to support learning and assessment in practice and provides a record of your achievements through the evidence that you develop in practice.

You will work and learn alongside many professionals in practice and you will be supervised and assessed continuously by practice supervisors, practice assessors, and academic assessors. This form of continuous assessment is an integral aspect of your learning and development as you progress to achieve the knowledge, skills and attributes of a registered professional nurse or midwife. It is therefore important that you are able to show and document evidence of your progressive achievement in this NIPAD. You should engage positively in all learning opportunities and take responsibility for your own learning; ask for direction and guidance and know how to access support when, and as, you need it. Do not be afraid to ask for help or support, this is an important attribute of being a professional.

You will work with, and receive written feedback from, a range of people including service users (people in your care, including their families and carers), practice supervisors, practice assessors, academic assessors and other health care professionals. It is essential that you reflect on this feedback and your wider learning objectives and positively engage in reflective dialogue with those who are supervising and assessing you in practice.

It is important you read the Practice Learning Handbook (the Handbook) before starting to complete this NIPAD. This handbook is an essential resource, which outlines how this NIPAD works. In the Handbook you will find policies and procedures related to learning in practice, as well as definitions of your role as a pre-registration nursing or midwifery student. You will also find the roles of those supporting you in practice i.e. practice supervisors, practice assessors and academic assessors in the Handbook. You should also have the Handbook with you to make available to those staff supporting you in practice should they require it.

Please keep your NIPAD with you at all times to show it to practice supervisor/s, practice assessors and/or academic assessor. This must be provided to your practice assessor at the beginning of every practice learning experience (within two days) and be at hand for review of your progress, including documenting your development and learning needs.

GUIDANCE FOR USING THE NIPAD TO FACILITATE LEARNING AND ASSESSMENT IN PRACTICE

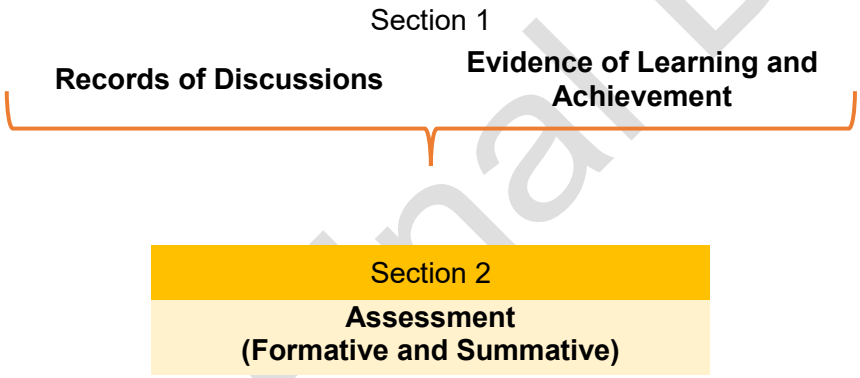
Assessment criteria in the NIPAD are based on the NMC *Future nurse: Standards of proficiency for registered nurses* and *Standards for education and training* (NMC 2018). The proficiencies have been designed by the NMC to apply across all four fields of nursing practice and all care settings (NMC 2018). *Students must be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen fields of nursing practice (NMC, 2018, p6).*

The NIPAD, often referred to as your portfolio, is structured in two main sections:

1. The Ongoing Achievement Record which is composed of two sub parts
    a. Records of Discussions
    b. Evidence of Learning and Achievement
2. Assessment Documents for formative and summative assessment.

Section 1 provides the evidence of your learning journey and how you have met the standards of proficiency; this achievement is ratified in section 2 at time of assessment.

Figure 1 – Structure of the NIPAD



Components of Assessment and Feedback

The NMC standards of proficiency are set out under 7 Platforms and two annexes (Annex A: Communication and relationship management skills and Annex B: Nursing Procedures) (NMC 2018). These are mapped against the evidence that you must develop in order to demonstrate that you have achieved these proficiencies and related skills. This mapping is set out at the back of this NIPAD. These can be assessed in a range of practice learning experiences but must be achieved to the required standard *by the end of each part of the programme (e.g. end of each year).* These are the forms of evidence you will be demonstrating achievement in and are detailed in the Handbook:

- **Professional Values in Practice**
- **Communication and Relationship Management Skills**
- **Promoting Health and Preventing Ill Health**
- **Leading and Coordinating Care**
- **Reflections**
- **Care Documentation**
- **Health Numeracy & Calculation of Medicines**
- **Quality Improvement in Practice**
- **Service User/Carer Feedback**
- **Child-Centred Care Worksheet**

Other Documents

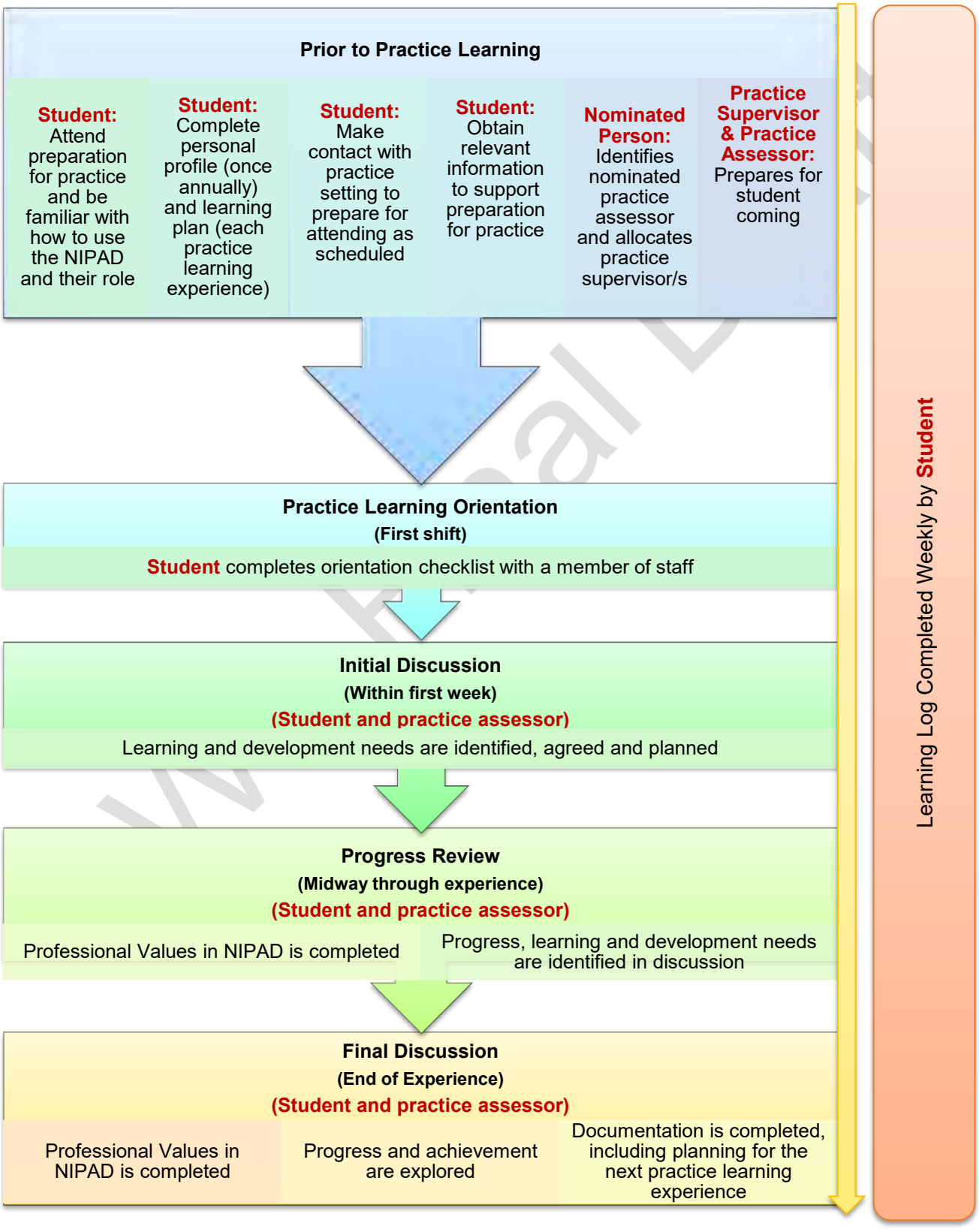
Other documents that you will need to complete in your NIPAD are:

- **Signature Log:** This should be completed by anyone who makes an entry into your NIPAD
- **Record of Underperformance:** This should be completed if your practice supervisor/s and nominated practice assessor have concerns about your performance, outside of set review times (Initial Discussion, Progress Review and Final Discussion)
- **Record of Attendance:** This should be completed daily and authenticated weekly by your practice supervisor/s
- **Practice Supervisor Notes**: These are completed by your practice supervisor/s as they feel necessary
- **Practice Assessor Notes:** These are completed by the practice assessor at each your initial, mid and final review
- **Academic Assessor Notes:** These are completed by the academic assessor at each visit to you in practice
- **Record of Learning with Other Health Care Professionals:** At times, you will have learning opportunities with other health care professionals (e.g. physiotherapist, social worker). This record is where you identify what you have learned and this is authenticated by that professional.

THE ONGOING RECORD OF ACHIEVEMENT

The NMC require students to have an Ongoing Record of Achievement (ORA) that documents their learning achievements and developmental needs. It also helps to capture development of the evidence. Your ORA is made up of the NIPADs for Parts 1 to 3 of your programme and must always be presented together. Students and those supporting them should follow the process below for completing this element of the NIPAD:

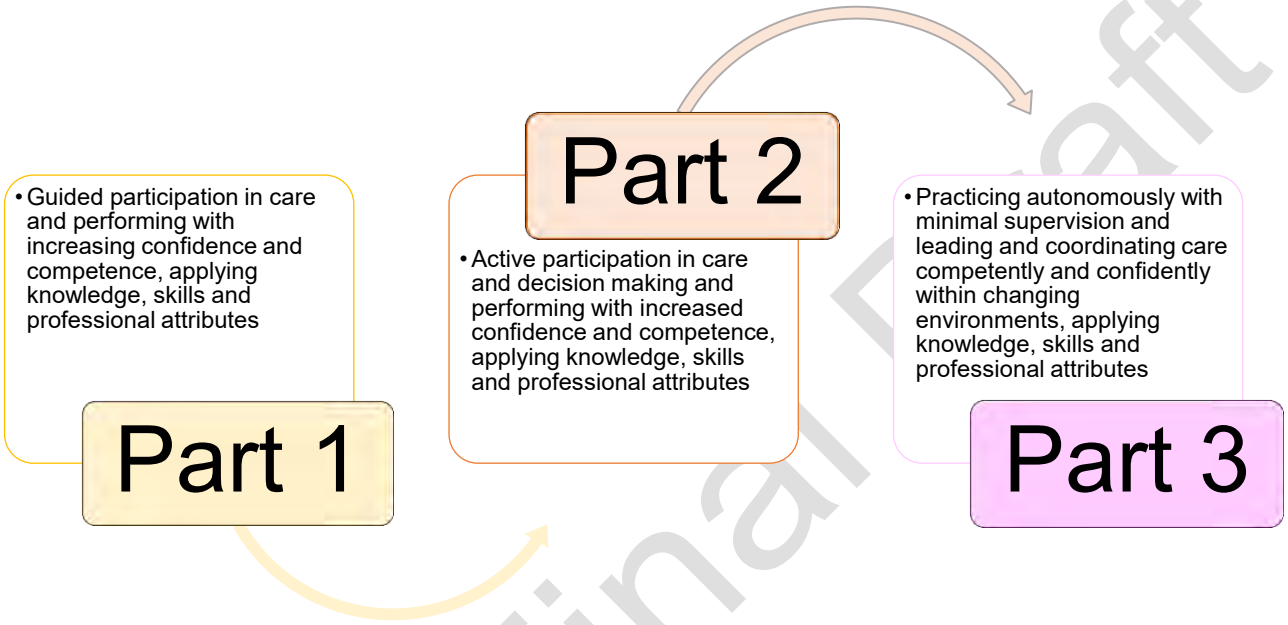
Figure 2: The Ongoing Record of Achievement



ASSESSMENT IN PRACTICE

Each part of the programme addresses a number of the NMC 2018 Standards of Proficiencies. The evidence that students develop in each part is developmental and incremental in that in the subsequent part, students increase the level they are practicing with a view to them meeting the required standards in the final Part of the programme. This is broadly described in Figure 3. An overview of the programme structure is provided in Figure 4, illustrating where practice learning occurs.

Figure 3 – Incremental Skills Development Over Each Part of the Programme



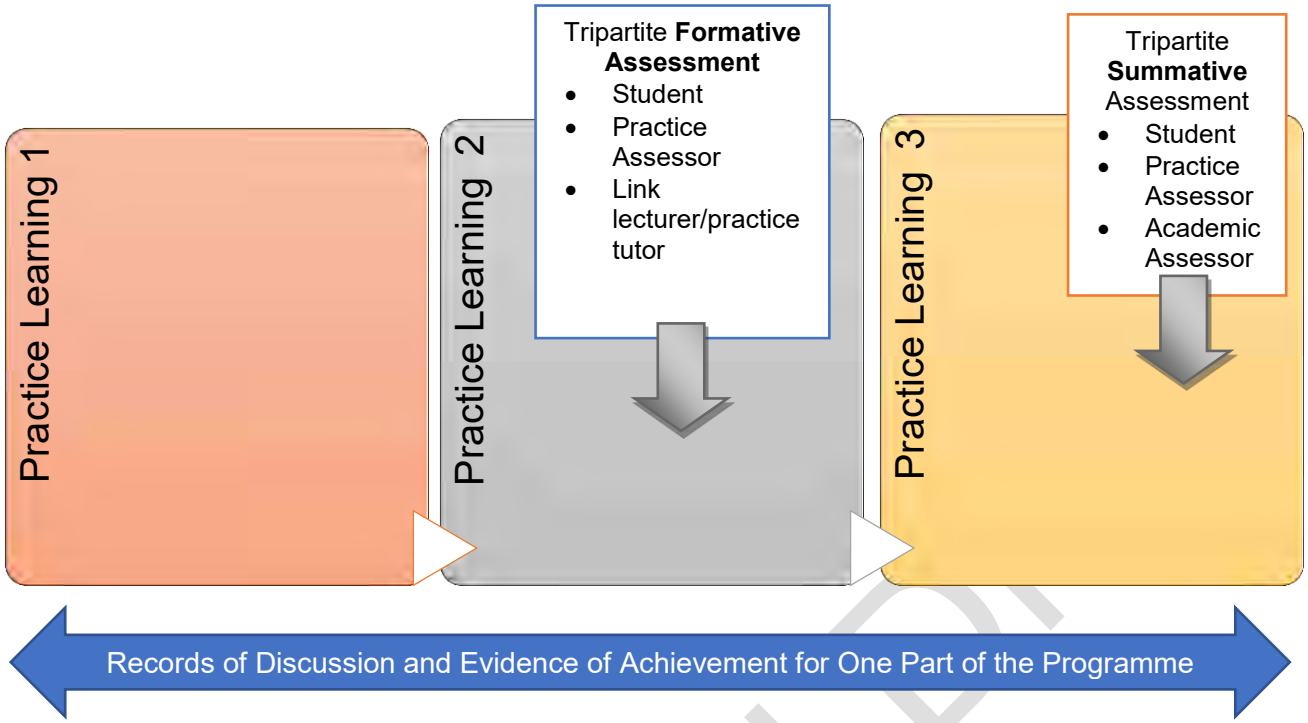
Students will develop their evidence across the whole part of the programme, at the end of which they will have a summative assessment. This is figuratively illustrated in Figure 4 (please note the number of practice learning experiences will vary). However, the learning journey has a variety of formative processes to support them in developing evidence for that summative assessment:

- The Records of Discussions for each practice learning experience provide formative feedback on the student's achievements and areas for development. These form a central component of the summative assessment as they are a form of communication between the practice supervisor/s and the practice and academic assessors.

- Tripartite formative assessment halfway through the total weeks of practice learning for that Part. The purpose of this tripartite formative assessment is to identify progress to date and to focus on the student's future learning and development of evidence that needs to occur before the summative assessment takes place. Additionally, evidence within the NIPAD to date is reviewed to ensure it is of sufficient standard to support the achievement of the identified proficiencies.

The first attempt at the tripartite summative assessment is undertaken towards the end of the final practice learning experience of that part of the course. Students must be afforded a period of two further weeks in which they can address any deficits in evidence for that Part of the programme. The final two weeks is the period of time for the student to address any aspects of their learning and development that prevented them from passing the first attempt at summative assessment. They will then have a second and final attempt at summative assessment at the end of those final two weeks..

Figure 4: Assessment Strategy Across Each Part of the Programme in Practice



Guidance on Formative assessment and Summative Assessment processes are located in the Handbook and should be followed.

PERSONAL PROFILE

Please complete this personal profile prior to commencing your first week of practice learning for the part of the course (year).

Your Details	
Student's name	
University ID	
Field	
Home Town (Optional)	

WHO I AM
Please provide an overview of yourself (e.g. what is important to me, what are my values and beliefs). The information you chose to share will give those supporting you in practice a sense of who you are and what you aspire to be as a professional nurse

WHERE I HAVE COME FROM
Please provide an overview of your educational and work experiences to date (e.g. your experience with working with people, in healthcare settings, courses you have completed).

MY DESTINATION
Please provide an overview of your aspirations for the future.

Student's signature::……. Date:……

PROFESSIONAL ASSESSMENT DOCUMENT SIGNATURE LOG – PART 1

In order that all records in your NIPAD can be traced, please ensure that any individual who makes a record in/adds a signature to your NIPAD also adds their signature to this log along with the other details indicated.

Initials	Signature	Print Full Name	Designation	Place of Work	Date

Initials	Signature	Print Full Name	Designation	Place of Work	Date

SECTION 1

RECORD OF DISCUSSIONS AND FEEDBACK

INITIAL DISCUSSION

PRACTICE LEARNING ENVIRONMENT:

Practice Learning Plan

Learning plan to be completed by the student prior to commencement of practice learning experience in order to identify learning and development plans for the experience.

Learning Opportunities

Initial Discussion

Student and practice assessor to discuss and agree learning opportunities related to this practice learning experience within the first week.

Record of Practice Learning Plan Discussion	
Practice assessor please tick (✓) as appropriate:	
I verify that the student has the Handbook available and we will use it when necessary.	Yes ☐ No ☐
I verify that I have seen and reviewed the student's NIPAD, including any development/action plans, in the first two days of this practice learning experience.	Yes ☐ No ☐
The student and I have reviewed and agreed the learning plan for this experience.	Yes ☐ No ☐
From these reviews, the student and I have identified and prioritised learning needs.	Yes ☐ No ☐
The student and I have reviewed progress in developing evidence for this part of the programme and identified priorities for this experience. Omit from first experience of the programme	Yes ☐ No ☐

Practice assessor's signature…….. *Date* ……

Student's signature ……... *Student ID:*…… *Date* ……

ORIENTATION

(Complete on First Shift)

Name of Practice learning environment:	
Name of Staff Member:	
This should be undertaken by an appropriate member of staff (identified by the nominated person) in the practice learning environment	
The following criteria need to be met on commencement of practice learning	
Introduction to staff including identification of practice supervisor(s) and practice assessors	Yes ☐ No ☐
A general orientation to the health and social care practice learning environment has been undertaken	Yes ☐ No ☐
The local fire procedures have been explained Tel……	Yes ☐ No ☐
The student has been shown the: • fire alarms • fire exits • fire extinguishers	Yes ☐ No ☐
Resuscitation policy and procedures have been explained. Tel……..	Yes ☐ No ☐
Resuscitation and first aid equipment has been shown and explained	Yes ☐ No ☐
The student knows how to summon help in the event of an emergency	Yes ☐ No ☐
The student is aware of where to find local policies/ways of working • Health and safety • Incident reporting procedures • Infection control (Including PPE) • Handling of messages and enquiries • Handling complaints • Other policies	Yes ☐ No ☐
The student has been made aware of information governance requirements (e.g. GDPR, data protection, confidentiality)	Yes ☐ No ☐
The shift times, meal times and reporting sick policies have been explained	Yes ☐ No ☐
The student is aware of their professional role in practice in line with NMC	Yes ☐ No ☐
Policy regarding safeguarding has been explained	Yes ☐ No ☐
The student is aware of the policy and process of raising and escalating concerns	Yes ☐ No ☐
Lone working policy has been explained	Yes ☐ No ☐ N/A ☐
Risk assessments/reasonable adjustments relating to disability/learning/pregnancy/breastfeeding needs have been discussed (where disclosed)	Yes ☐ No ☐ N/A ☐
The following criteria need to be met prior to use of equipment:	
The student has been shown and given a demonstration of the equipment used in the practice learning environment, including moving and handling	Yes ☐ No ☐
The student has been shown and given a demonstration of the medical devices used in the placement area	Yes ☐ No ☐

Student's signature…….. *Date* ……

Staff member's signature …….. *Date* ……

PROGRESS REVIEW

Professional Values in Practice (Part 1) – To be completed by practice assessor

Students are required to demonstrate high standards of professional conduct at all times during their practice learning experiences. Students should work within ethical and legal frameworks and be able to articulate the underpinning values of The Code (NMC, 2018). The practice assessor has responsibility for assessing Professional Values at the Progress Review and Final Discussion for each practice learning experience.

Criteria		Progress Review Achieving?	Final Discussion Achieving?
Prioritise People	1. The student maintains confidentiality in accordance with the NMC code.	Yes ☐ No ☐	Yes ☐ No ☐
	2. The student is non-judgemental, respectful and courteous at all times when interacting with all people	Yes ☐ No ☐	Yes ☐ No ☐
	3. The student maintains the person's privacy and dignity, seeks informed consent prior to care and advocates on their behalf.	Yes ☐ No ☐	Yes ☐ No ☐
	4. The student is caring, compassionate and sensitive to the needs of others.	Yes ☐ No ☐	Yes ☐ No ☐
	5. The student understands the professional responsibility to adopt a healthy lifestyle, to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care.	Yes ☐ No ☐	Yes ☐ No ☐
Practise Effectively	6. The student maintains consistent, safe and person-centred practice.	Yes ☐ No ☐	Yes ☐ No ☐
	7. The student is able to work effectively within the inter-disciplinary team with the intent of building professional relationships.	Yes ☐ No ☐	Yes ☐ No ☐
	8. The student makes a consistent effort to engage in active learning, as evident through their attitude, motivation and enthusiasm	Yes ☐ No ☐	Yes ☐ No ☐
Preserve safety	9. The student demonstrates openness (candour), trustworthiness and integrity.	Yes ☐ No ☐	Yes ☐ No ☐
	10. The student reports any concerns to the appropriate professional member of staff when appropriate e.g. safeguarding.	Yes ☐ No ☐	Yes ☐ No ☐
	11. The student demonstrates the ability to listen, seek clarification and carry out instructions safely.	Yes ☐ No ☐	Yes ☐ No ☐
	12. The student is able to recognise and work within the limitations of own knowledge, skills and professional boundaries and understand that they are responsible for their own actions.	Yes ☐ No ☐	Yes ☐ No ☐
Promote Professionalism and Trust	13. The student's personal presentation and dress code is in accordance with the local and University policy.	Yes ☐ No ☐	Yes ☐ No ☐
	14. The student maintains an appropriate professional attitude regarding punctuality in accordance with the local and University policy.	Yes ☐ No ☐	Yes ☐ No ☐
	15. The student demonstrates that they are self-aware and can recognise their own emotions and those of others in different situations.	Yes ☐ No ☐	Yes ☐ No ☐
	16. The student acts as a role model of professional behaviour for fellow students and nursing associates to aspire to	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐

Progress Review	If "No" to any of the above, please provide specific detail:		
	Practice assessor name:		Date:
	Practice assessor signature:		

If there are any "no" responses, then this must trigger a development plan (below). This must involve the practice assessor and the nominated person (as appropriate) in liaison with the link lecturer/practice tutor.

Future Developmental Plan – Professional Values	
Goal	**Plan**

Practice assessor's signature……. *Date* ……

Student's signature …….. ……. *Student ID:*…… *Date* ……

Progress Review Continued…
Student and practice assessor please tick (✓) as appropriate:

We verify that we have reviewed progress in achieving the learning plan as agreed in the initial discussion.	Yes ☐ No ☐
From this review, we have identified developmental goals for the remainder of this experience.	Yes ☐ No ☐ N/A ☐

Future Developmental Plan (General)	
Goal	**Plan**

Practice assessor, please acknowledge below the student's achievement and progress to date.

Practice assessor*, please tick (✓) and comment as appropriate:*

Have you completed a Professional Values Assessment	Yes ☐ No ☐
Have you identified any areas of concern?	Yes ☐ No ☐
Have concerns been escalated to the nominated person and the link lecturer/practice tutor?	Yes ☐ No ☐ N/A ☐ Date (if applicable):_____
Please give specific details regarding any concerns:	

Practice assessor*'s signature*…….. *Date* ……

Progress Review Continued…

Student's self-assessment/reflection on progress
Reflect on your overall progression referring to your personal learning needs, professional values and proficiencies. Identify your strengths and document areas for development.

Knowledge:
Skills:
Attitudes and values:

Student's signature: …….. Student ID:…….. Date……

FINAL DISCUSSION
To be completed by the practice assessor

Please acknowledge below the student's achievement and progress to date:

Professional Values in Practice

If "No" to any of the statements in the Professional Values in Practice Template, please provide specific detail:		
Practice assessor name:		Date:
Practice assessor signature:		

Please tick (✓) and comment as appropriate:

Have you completed a Professional Values Assessment	Yes ☐ No ☐
Have you identified any areas of concern?	Yes ☐ No ☐
Have concerns been escalated to the nominated person and the link lecturer/practice tutor?	Yes ☐ No ☐ N/A ☐ Date (if applicable):_____

Please give specific details regarding any concerns:

Please identify specific areas to take forward to the next practice learning experience. Every student must have a learning and development plan.

Learning and Development Needs	How Will These be Achieved?

Practice assessor, please complete this checklist:

Checklist for Assessed Documents	
The professional value statements have been signed at both Progress Review and Final Discussion.	Yes ☐ No ☐
The relevant proficiencies/nursing procedures that the student has achieved in this area (where applicable) have been signed.	Yes ☐ No ☐
The practice learning hours have been checked and signed.	Yes ☐ No ☐
All records of discussion and developmental plans have been completed and signed as appropriate.	Yes ☐ No ☐
Those who have made entries in this NIPAD have completed the signature log.	Yes ☐ No ☐
The student has completed their weekly learning log.	Yes ☐ No ☐
I have communicated any ongoing learning and development/action plan or concerns to the practice assessor in the next practice learning experience	Yes ☐ No ☐ N/A ☐ Date (if applicable):_____

Practice assessor's signature…….. *Date* ……

Student's self-assessment/reflection on progress
Reflect on your overall progression referring to your personal learning needs, professional values and proficiencies. Identify your strengths and document areas for development.

Knowledge:
Skills:
Attitudes and values:

Student's signature: …….. Student ID:…….. Date……

MAHI - STM - 102 - 5558

RECORD OF ATTENDANCE

Name of Student :……. Student ID No: ……. Practice assessor: …….

Location of Experience: ……. Dates of Experience: ……. No. of Weeks: …….

Key: **A** = Attended as Scheduled **S** – Sickness/Absence **T** = Time Made Up for Sickness/Absence

	Week No.: 1 Dates:		**Week No.: 2 Dates:**		**Week No.: 3 Dates:**		**Week No.: 4 Dates:**		**Week No.: 5 Dates:**		**Week No.: 6 Dates:**		
Monday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	
Tuesday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	
Wednesday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	
Thursday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	
Friday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	
Saturday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	
Sunday	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	No. of Hrs: …….	☐ **A** ☐ **S** ☐ **T**	**Totals (Completed at the end of experience)**
Hours Worked													
Hours Sick/Absent													
Hours Made-Up													
Hours Worked on Night Duty													
Practice assessor/supervisor signature													
Date													

WEEKLY LEARNING LOG

Practice learning environment		**Week**		**Date Commencing**	
What did I learn this week?					
What did I find a challenge?					
What is my focus for next week?					
Practice supervisor/s comments:					

Student's signature …….. *Date* ……

Practice supervisor's signature …….. *Date* ……

Practice learning environment		**Week**		**Date Commencing**	
What did I learn this week?					
What did I find a challenge?					
What is my focus for next week?					
Practice supervisor/s Comments:					

Student's signature: …….. *Date* ……

Practice supervisor's signature: …….. *Date* ……

ADDITIONAL RECORDS

PRACTICE SUPERVISOR/S' NOTES

To be completed by practice supervisor/s as considered necessary.

Practice supervisor's name: (print):		Practice supervisor's signature:	
Date of record		Practice learning environment	
Practice supervisor's name: (print):		Practice supervisor's signature:	
Date of record		Practice learning environment	
Practice supervisor's name: (print):		Practice supervisor's signature:	
Date of record		Practice learning environment	

PRACTICE ASSESSOR'S NOTES

To be completed **if necessary** by the Practice assessor

Practice assessor's name (Print)		Practice assessor's signature	
Date of Record		Practice learning environment	
Practice assessor's name (Print)		Practice assessor's signature	
Date of Record		Practice learning environment	
Practice assessor's name (Print)		Practice assessor's signature	
Date of Record		Practice learning environment	

ACADEMIC NOTES
(LINK LECTURER/PRACTICE TUTOR/ACADEMIC ASSESSOR)

To be completed on every visit by link lecturer/practice tutor/academic assessor

Academic's name (Print)		Academic's signature	
Date of record		Practice learning environment	
Academic's name (Print)		Academic's signature	
Date of record		Practice learning environment	
Academic's name (Print)		Academic's signature	
Date of record		Practice learning environment	

DEVELOPMENT PLAN

This development plan template can be used for any process whereby a development plan is identified as necessary (e.g. after service user/carer feedback).

Learning and Development Needs	How Will This be Achieved?

We agree the above points and plan of action

Practice assessor's signature …… *Date* ……..

Student's signature …… *Date* ……

Date for review ……..

Review Following the Development Plan

Has the development plan been achieved?	Yes ☐ No ☐

If no, please develop a new development plan or record of underperformance

Practice assessor's signature …… *Date* ……..

Student's signature …… *Date* ……

RECORD OF UNDERPERFORMANCE

Please complete if you have concerns about a student underperforming outside of set review times (Initial, Progress and Final).

The Link lecturer/practice tutor/academic assessor should record their notes in the Link lecturer/practice tutor/academic assessor notes section. Practice assessor, please also cross-refer to this record in the Record of Discussions. This record is only to be used if required (duplicate as necessary). Underperformance is when a student is performing below the level expected for their stage of their education. This can be in relation to their knowledge, skills, attitudes or values.

Concerns Identified *Please link to NMC Proficiencies (located at back of NIPAD) and provide specific detail*		
Knowledge:		
Skills:		
Attitudes and values:		
Has this been escalated to the nominated person in practice?	Yes ☐ No ☐	
	Name:	
	Date:	
Has this been escalated to the Link Lecturer/Practice Tutor?	Yes ☐ No ☐	
	Name:	
	Date:	

Agreed Action Plan	Date	
Learning and Development Needs	**How Will This be Achieved?**	

We agree the above points and plan of action

Practice assessor's signature …… *Date ……..*

Student's signature: …… *Date ……*

Date for Review:	

Review Following the Action Plan	Date:	
Have the learning and development needs been achieved?	Yes ☐ No ☐	

If no, please provide detail on a new Record of Underperformance and ensure the practice assessor in the next practice learning experience has been informed of ongoing challenges

Practice assessor's signature …… *Date ……..*

Student's signature …… *Date ……*

SUPPORTING EVIDENCE

SERVICE USER/CARER FEEDBACK

Students must obtain feedback from three service user/carers for each part of the programme; these must have no areas of concern. This feedback is a required element for summative assessment. This feedback is important in providing the student, and those assessing and supervising them, with valuable insight into the personal experience of care. It is important that such feedback is authentic and safeguards the person providing feedback, who may feel vulnerable. The following process must be followed to obtain this feedback:

1. Feedback should be sought from service users and carers/families by the practice supervisor(s)/assessor. It should not be sought by the student directly as the process should be anonymous.

2. Practice supervisor(s)/assessor should seek the consent of service users and carers/families who are involved in providing feedback. Service users and carers/families should be informed that:

    a. Completion of feedback by service user is voluntary and will not impact on the care they receive.
    b. If the service user consents, their identity will remain confidential. The practice supervisor(s)/assessor will provide a copy of the documentation and invite the service users/carers to complete this. They may provide assistance if required/requested. Practice supervisor(s)/assessor should confirm that what they have recorded accurately represents the views of the service users and carers/families.
    c. No identifying details will be recorded on the documentation.
    d. Feedback received will help to inform the student's development across their programme.
    e. The student will not fail the practice learning component of their programme based on their feedback, but these are an essential component of the overall summative assessment process.

3. The practice supervisor(s)/assessor should sign and date the documentation.

4. The practice supervisor(s)/practice assessor should discuss the feedback with the student and record this within the NIPAD.

5. Should the feedback highlight any areas of concern, a learning plan must be developed by the student and practice assessor to address these. This must include obtaining an additional set of feedback from service users and carers/families to monitor development.

Service users' and carers'/families' feedback should be stored safely within the NIPAD and must be available for the summative assessment in order to confirm achievement of the linked practice learning outcomes.

INFORMATION FOR SERVICE USER/CARER/ FAMILY

We would like to give you the opportunity to provide feedback about your experience with the student nurse whose name is on the next page.

There are some important things for us to highlight before you decide if you wish to take part:

- Feedback received will help to inform the student's learning
- Your comments will help the nursing student to think about themselves and how they provide care. You can withdraw your feedback at any time.
- Your name/details will not be recorded on this form. This means that the student and other staff will not know that it is you who provided the feedback.
- You may choose not to fill in the form and that is okay.
- If you do not want to take part your care will not be affected.
- Should you require any help in completing the form then please ask a member of your family, carer/ friend or the person who gave you the form (this person is called the practice supervisor or practice assessor).

If you would like to take part then all that you need to do is fill out the form provided to you by the nurse. This involves some tick box questions and a space for comments.

Feedback about Student Nurse: _____

1. Did the student nurse tell you their name?	Yes ☐ No ☐ Not sure ☐
2. Did the student nurse ask could they participate in your care?	Yes ☐ No ☐ Not sure ☐
3. Was the student nurse kind and caring to you?	Yes ☐ No ☐ Not sure ☐
4. Did the student take into account your feelings/choices in all aspects of your care?	Yes ☐ No ☐ Not sure ☐
5. Did the student nurse listen to you?	Yes ☐ No ☐ Not sure ☐
6. Did the student take account of how you were feeling?	Yes ☐ No ☐ Not sure ☐
7. Did the student nurse check that you understood what was happening?	Yes ☐ No ☐ Not sure ☐
8. Did the student nurse talk with your family/carer (where appropriate)?	Yes ☐ No ☐ Not sure ☐

Please comment on what the student nurse did well

Please comment on what could the student nurse do differently

Thank you for taking the time to provide this feedback. You may withdraw this at any time if you wish. Please return it to the person who provided you with this form.

Practice supervisor/assessor, please confirm:

Feedback has come from a service user/carer	Yes ☐ No ☐	**Feedback has been discussed with the student**	Yes ☐ No ☐
Practice supervisor/assessor name		**Signature**	
Date			

Record of Service User/Carer Feedback

First Set of Feedback

Date obtained		**Any Issues Identified?**	Yes ☐ No ☐
Practice supervisor/ assessor Name		**If any issues, has there been a development plan devised?**	Yes ☐ No ☐ N/A ☐
Signature		**Date**	
Student Reflection on Service User/Carer Feedback			
Student's name:		**Student's signature:**	
Student ID		**Date**	

Second Set of Feedback

Date obtained		**Any Issues Identified?**	Yes ☐ No ☐
Practice supervisor/ assessor Name		**If any issues, has there been a development plan devised?**	Yes ☐ No ☐ N/A ☐
Signature		**Date**	
Student Reflection on Service User/Carer Feedback			
Student's name:		**Student's signature:**	
Student ID		**Date**	

Third Set of Feedback

Date obtained		**Any Issues Identified?**	Yes ☐ No ☐
Practice supervisor/ assessor Name		**If any issues, has there been a development plan devised?**	Yes ☐ No ☐ N/A ☐
Signature		**Date**	
Student Reflection on Service User/Carer Feedback			
Student's name:		**Student's signature:**	
Student ID		**Date**	

AUTHENTICATED REFLECTIVE ACCOUNTS – PART 1

In completing this evidence, please cross check with the Nursing Procedures and Communication and Relationships Skills records as aspects of the proficiencies therein may also have been achieved at the same time and can therefore be documented as achieved

What is expected?

In order to develop your skills as a reflective practitioner and also to evidence achievement of particular practice outcomes, you will be required to provide reflections that address the identified proficiencies below. Please note that you can address several of these in one reflection, as long as the reflective account addresses the proficiency sufficiently and the account is authentic. There is no set number of reflections but all proficiencies must be addressed by reflections by the end of this part of your course.

How do I develop this evidence?

Review the proficiencies listed and be aware of needing to reflect on these in practice. You can use situations you have observed or been part of in practice. In the situation where no opportunity to reflect on a specific proficiency has naturally occurred, you can have a focused discussion with a registrant about that proficiency and then reflect on that focused discussion.
This is not an academic piece of work and so does not require references. It is more important to have meaningful reflection. However, if you feel it is necessary to include some references, you can do so.

What template do I use?

There are many valid models of reflection that you can use. It is important you chose a model that works for you. Reflection is an essential element of professional practice and this can be seen in the revalidation process that the NMC have for registrants to meet the requirements to remain on the register. Using the NMC model may help you to be ready to use this process on registering as a nurse. Other models may appeal more to you. The choice is yours. The following are models that are recommended:

- NMC[1] revalidation model
- Rolfe[2] et al. (2001)
- Gibbs[3] (1988)
- Johns[4] (2009)

What things do I need to consider?

You must not use any identifying details in any reflections (e.g. names, practice learning environments, etc). You must protect the identity of people and remain professional, but honest, in your reflections.

Each reflection must be authenticated by a practice supervisor/s. Please give them adequate time to read your reflection so that they can provide verification and feedback.

Your reflection must not simply be a story. It must be critical and analytical and must lead to some future action.

Use the reflection Completion Summary Record to track your progress in completing these (next page)
NMC PROFICIENCIES TO BE ADDRESSED – PART 1

[1] Template for reflection available here: http://revalidation.nmc.org.uk/download-resources/forms-and-templates.html
[2] Rolfe, G., Freshwater, D. and Jasper, M. (2001) *Critical reflection in nursing and the helping professions: a user's guide*. Basingstoke: Palgrave Macmillan.
[3] Gibbs, G. (1988) *Learning by Doing*: *A guide to teaching and learning methods*. Oxford: Further Education Unit. Oxford Polytechnic.
[4] Johns, C. (2009) *Becoming a Reflective Practitioner* (3rd Edition). Oxford: Blackwell

1.3 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes

1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health

1.6 understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care

1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions

1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgements and decisions in routine, complex and challenging situations

1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural

6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken

6.11 acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others

Completion Summary Record

Proficiency	Date of Reflection	Practice supervisor's name:	Practice supervisor's signature:	Student's signature:
1.3				
1.5				
1.6				
1.9				
1.10				
1.14				
6.3				
6.11				

REFLECTION TEMPLATE

(Students must use a recognised reflective model)

Proficiencies being addressed (by number)	

Practice Supervisor, please verify that this reflection addresses the specified proficiencies indicated at the beginning of this template, and that the reflection is authentic to the student's experience					
Practice supervisor's name:		Practice supervisor's signature:		Date	
Student's name:		Student's signature:		Date	

PROMOTING HEALTH AND PREVENTING ILL HEALTH – PART 1

In completing this evidence, please cross check with the Nursing Procedures and Communication and Relationships Skills records as aspects of the proficiencies therein may also have been achieved at the same time and can therefore be documented as achieved.

Health education is an important aspect of the role of the professional nurse. Its goal is to support people to be as independent as possible in taking control of factors that can positively influence their health. In developing this form of evidence, you will address the following NMC proficiencies:

2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people

2.6 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing

2.7 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes

2.9 use appropriate communication skills and strength-based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability

2.10 provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care

In consultation with a registrant, identify a person in your care and undertake a health education episode to meet an identified need. You will need to use the teaching plan template on the next page to plan this session first. Following this, address the following and record your responses on the template provided:

1. Provide a brief overview of how your health education activity was planned, implemented and evaluated.
2. What factors did you consider in advance of the episode?
3. Reflecting on your experience, provide a brief critical analysis of the effectiveness of the episode.
4. What knowledge and skills did you use?
5. Reflecting on your development in undertaking your health education episode, evaluate how this will contribute to your future professional practice.

<u>Your teaching plan and activity sheet must be authenticated by a practice supervisor/s .</u>

TEACHING PLAN TEMPLATE

Topic	**Date**:
Person:	**Special Considerations:**
Location/arrangements:	
Resources needed:	**Person's existing knowledge:**
Aim:	
Person's learning outcomes:	

Time	Activity/Sequence	Notes
Evaluation of Teaching		
Summary/Recommendations		

Please note: the spaces for responses are not indicative of the volume of content necessary. You must write sufficiently to evidence achievement of the NMC proficiencies.

1. Provide a brief overview of how your health education episode was planned, implemented and evaluated.
2. Reflecting on your experience, provide a brief critical analysis of the effectiveness of the activity.
3. What knowledge and skills did you use?
4. Reflecting on your development in undertaking your health education episode, evaluate how this will contribute to your future professional practice.

Practice Supervisor, please sign below to verify the authenticity of this worksheet					
Student's name:		Student's signature:		Date	
Practice supervisor's name:		Practice supervisor's signature:		Date	

CARE DOCUMENTATION – PART 1

In completing this evidence, please cross check with the Nursing Procedures and Communication and Relationships Skills records as aspects of the proficiencies therein may also have been achieved at the same time and can therefore be documented as achieved.

To evidence that you have met the NMC proficiencies related to documenting care within a safe, person centred, evidence-based nursing context, you are required to engage in care documentation activities that will develop your application of knowledge and skills to this component of professional practice. This evidence must address the identified NMC proficiencies below and be completed by using the Learning Achievement Record. You should undertake this development with guided observation, participation in care and performing with increasing confidence and competence across Part 1 of your programme.

The types of care documentation may include, but is not limited to:

- Person-Centred Nursing Assessment
- Comprehensive Risk Assessment tools
- Evidence based plans of care, treatment, support or maintenance plans
- Referrals
- Evaluations/progress notes
- Discharge plans
- Transfer documentation

In developing this form of evidence, you will address the following NMC proficiencies:

1.9 Understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions

1.14 Provide and promote non-discriminatory, person centred and sensitive care at all times, reflecting on people's values, beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments

3.1 Demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.2 Demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology and social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans.

3.3 Demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person-centred care plans

3.4 Understand and apply a person-centred approach to nursing care demonstrating shared assessment, planning, decision-making and goal setting when working with people, their families, communities and people of all ages

3.5 Demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person centred evidence-based plans for nursing interventions with agreed goals

3.15 Demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made.

4.8 Demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain

6.3 Comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken

6.5 Demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools.
7.11 Demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed.

It is essential that students do not submit any actual documentation from practice to ensure that confidentiality of the people involved is maintained. You also must not use any identifying details in any evaluation/reflections to remain compliant with GDPR requirements.

The following care documentation must be completed, addressing the identified NMC proficiencies:

Care Documentation	Proficiencies to be Addressed	Guidance
Person-centred Nursing assessment	1.9, 1.14	1. Carry out an observation of a non-complex person-centred nursing assessment 2. Using guided participation, complete one non-complex person-centred nursing assessment 3. Complete a Learning Achievement Record
Plan of Care	3.1, 3.2, 3.3, 3.4, 3.5, 4.8	1. Based on your completion of a nursing assessment, select **two care needs** – one of which must be from the list below, and using guided participation, complete an evidence-based plan of care for each of these care needs. 2. Complete a Learning Achievement Record **List of Foci** Anxiety Confusion Pain and discomfort Change in behaviour(s)
Care Evaluation	3.15	1. With guided participation, complete a written evaluation of nursing care provided for one person in your care over a minimum period of one shift 2. Complete a Learning Achievement Record
Risk Assessment	6.3, 6.5. 7.11	There are a number of different risk assessment tools used in different care settings. Here are some suggested tools that you may wish to consider (this list is not exhaustive): • MUST • Moving and Handling • Pressure Sore Risk (e.g. Braden Scale) • Falls risk • NEWS2 • Alcohol intake risk assessment 1. With guided participation, for **one** identified risk arising from your participation in a nursing assessment, complete a risk assessment using a recognised risk assessment tool. 2. Complete a Learning Achievement Record

You will have four Learning Achievement Records for Part 1 to capture your learning and development for the above. Record below your progress for quick reference.

Summary Record of Care Documentation Completed – Part 1

Care Documentation	Date Completed	Practice supervisor's name:	Practice supervisor's signature:	Student's signature:
Assessment				
Plan of Care				
Evaluation of Care				
Risk Assessment Tool				

CARE DOCUMENTATION - LEARNING ACHIEVEMENT RECORD – PART 1

Please use this template to record the achievement of proficiencies addressed through completion of care documentation (e.g. care plans, observation sheets, assessment tools). For example, if you complete a care plan that addresses four proficiencies, identify these, summarise your learning from undertaking this activity and ask a practice supervisor/s to check the documentation, verify it meets the standard required and sign this record. **Do not attach any actual (original or copies) care documentation.** Please duplicate as required.

Students should use the following guiding questions to help complete this record:

- Identify ways in which your ideas, thinking, knowledge, understanding and practice have been challenged and/or changed
- Explain how you overcame any difficulties experienced and what you learned about yourself in the process
- Identify key factors that have enabled you to grow in confidence and competence when delivering person-centred care
- Describe what was learned from/through this learning experience
- Explain what you might do differently if completing this/similar learning experience/ task again

Care Documentation	☐ Assessment ☐ Evaluation of Care	☐ Plan of Care ☐ Risk Assessment Tool

Please summarise your learning and development in completing this care documentation, making explicit reference to the proficiency(ies) being addressed.

Practice Supervisor, please tick (✓) as appropriate below and then sign below:
I have reviewed the identified evidence and confirm:

1. It is person-centred — Yes ☐ No ☐
2. It meets the identified proficiency(ies) — Yes ☐ No ☐
3. That this record is authentic. — Yes ☐ No ☐

Practice supervisor's name:		**Practice supervisor's signature:**		**Date**	
Student's name:		**Student's signature:**		**Date**	

QUALITY IMPROVEMENT IN PRACTICE – PART 1

In completing this evidence, please cross check with the Nursing Procedures and Communication and Relationships Skills records as aspects of the proficiencies therein may also have been achieved at the same time and can therefore be documented as achieved.

Registered nurses make a key contribution to the continuous monitoring and quality improvement of care and treatment in order to enhance health outcomes and people's experience of nursing and related care. They assess risks to safety or experience and take appropriate action to manage those, putting the best interests, needs and preferences of people first. It is therefore essential that they develop the skills for quality improvement within their pre-registration education.

In the first part of your programme, you need to develop insight and understanding into how data is captured that informs quality improvement processes through analysis and sharing. In this open, collaborative approach, a team response can be made to address issues and enhance care. In developing your evidence for quality improvement in practice, you will be meeting the following NMC proficiencies:

5.11 effectively and responsibly use a range of digital technologies to access, input, and share, and apply information and data within teams and between agencies

6.9 work with people, their families, carers and colleagues to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences

This log should not be the means to raise and escalate a concern. You must follow the procedures for this as outlined in the Handbook in line with your responsibilities as a student. You must also not breach confidentiality in the log; do not use identifying details of the practice area/setting or people involved.

In consultation with your practice supervisor/s, you are required to:

1. Observe an audit activity (e.g. hand washing audit) and determine how the information is recorded, accessed by others and shared with the wider team

Describe the audit activity that you observed.
How does this audit contribute to the quality improvement agenda?
How are the results of the audit recorded and accessed by others?

2. Determine the processes within the organisation for quality improvement

What mechanisms are in place within the organisation to undertake quality improvement?

3. Understand the complaints process and how complaints are used to respond to concerns and improve practice

Outline the complaints process of the organisation
How are complaints monitored and analysed?
What actions occur from complaints that influence the quality of care?

If a person approaches you wanting to make a complaint, what is the organisations policy on how you should respond?

4. Identify at least two risk assessment strategies that occur within a practice learning environment that are in place to monitor quality.

Risk Assessment 1

Please provide a brief description of the risk assessment strategy
Why was this strategy put in place and how does it contribute to improving the quality of care?
Reflect on the strategy. Does it create an effective culture for quality improvement?

Risk Assessment 2

Please provide a brief description of the risk assessment strategy
Why was this strategy put in place and how does it contribute to improving the quality of care?
Reflect on the strategy. Does it create an effective culture for quality improvement?

Authentication

I have read the responses to questions one to four and confirm that they are authentic and accurate				Yes ☐ No ☐
Practice supervisor's name:		Practice supervisor's signature:		**Date:**
Student's name:		Student's signature:		**Date:**

LEADING AND COORDINATING CARE – PART 1

In completing this evidence, please cross check with the Nursing Procedures and Communication and Relationships Skills records as aspects of the proficiencies therein may also have been achieved at the same time and can therefore be documented as achieved.

Registered nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. They are responsible for managing nursing care and are accountable for the appropriate delegation and supervision of care provided by others in the team including lay carers. They play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues. Additionally, nurses play a leadership role in coordinating and managing the complex nursing and integrated care needs of people. This includes people at any stage of their lives, across a range of organisations and settings.

In completing this set of evidence, you will demonstrate that you have developed the skills to lead and coordinate care on an incremental basis across all parts of your course. This begins with understanding how care is integrated across professional roles and settings. In developing your evidence for leading and coordinating care, you will be meeting the following NMC proficiencies:

5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make use of the contributions of others involved in providing care

5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance

In consultation with a practice supervisor/s, identify a person whose care you have been involved in whilst in practice. Explain the role of each member of the multidisciplinary team and how they contributed to the care of this person. Complete the log below:

Provide a brief overview of person in your care that you have chosen to focus on. Remember not to provide any names or details that would enable them or the practice area to be identified.
Identify the members of the multidisciplinary team involved in this person's care and explain their role and responsibilities. Do not provide a broad definition of their roles but instead apply your response to the specific needs of the person in your care.
Discuss how they contributed to the care of the person and how they worked together effectively

What factors contribute to them working effectively together and factors were inhibitors

Enablers	Inhibitors

Summarise the approaches you used to work in partnership with the person and carer in reaching shared decision about future care.
Reflect on the effectiveness by which you communicated with the individual and team.
Request constructive feedback from your supervisor about how you performed within the team caring for a person. Reflect/discuss how receiving constructive feedback can help you to provide safe and

compassionate care.

Registrant's Authentication

I have read this log and confirm that it is authentic and accurate				Yes ☐ No ☐
Practice supervisor's name:		Practice supervisor's signature:		**Date:**
Student's name:		Student's signature:		**Date:**

CHILD-CENTRED CARE WORKSHEET

During your programme you will have the opportunity to interact and/or care for children who require input from health care professionals to either prevent or manage health care needs. The proficiencies required to care for children and their families is an integral part of your professional practice and learning to care for people across the lifespan. This worksheet will assist you to meet the following proficiencies:

1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom.

1.11 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges

1.12 demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable

1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments.

2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances.

2.5 promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes.

2.11 promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity, and

2.12 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.

3.1 demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages

3.16 demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.

4.2 work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate

4.5 demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs

5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care

6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken.

7.1 understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors

7.2 understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom

7.10 understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services

This activities in the worksheet can be completed at any point across the three parts of your programme, depending upon the practice learning environments where you will care for children. It is important for your professional development that you begin completion of the worksheet when you first encounter children during practice learning. A text that may be helpful in focusing on child-centred care is:

Carter, B., Bray, L., Dickinson, A., Edwards, M., Ford, K., (2014) *Child centred Nursing – Promoting critical thinking.* Sage: London

1. With reference to 'Parental Responsibility' as defined in 'The Children (Northern Ireland) Order 1995, identify who has parental responsibility for a child. Write a brief account of how health professionals confirm who has parental responsibility for a child under 16 years, prior to interventions
2. Read the regional consent form and pay particular attention to consent for those under 16 years. Reflect on what you have read and record your understanding of the concept of consent for under 16 years. Discuss with you practice supervisor if needed.
3. Access The Safeguarding Board for Northern Ireland (SBNI) website and briefly explain why this board was established https://www.safeguardingni.org/
4. Discuss with your practice supervisor how the 'Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment framework supports professionals in meeting the needs of children and their families. https://www.safeguardingni.org/
5. List and briefly describe the categories of child abuse as outlined in Co-operating to Safeguard Children and Young People in Northern Ireland (2017) section 2.6. https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland
6. Read section 3.2.2 Co-operating to Safeguard Children (2017) and Young People in Northern Ireland (2017) and in discussion with your practice supervisor identify the Paediatrician and named nurse who have responsibility to ensure that safeguarding procedures are implemented throughout the Health and Social Care Trust (HSCT)
7. Observe a health professional adding an entry to the Personal Child Health Record (PCHR). Explain how this contributes to professionals working in partnership with families to monitor a child's health and development. Discuss health screening that has been documented in the PCHR, with your

practice supervisor.
8. Consult the current Northern Ireland immunisation schedule for children https://www.nidirect.gov.uk/articles/childhood-immunisation-programme Identify one of the communicable disease and check the most up to date statistic https://www.publichealth.hscni.net/directorate-public-health/health-protection/vaccination-coverage and note if herd immunity threshold has been achieved in the HSCT where you are currently in practice learning
9. Reflect on and document a brief account of a situation where you provided, current health promoting, advice to a parent and or child.
10. Identify one child/teenager who has been admitted to a healthcare setting or is being cared for in the community as a result of illness or injury. Write a brief discussion about how the assessment process was altered to take account of the child's developmental stage.
11. Provide a critical discussion on the importance of taking a child or family centred approach when caring for a child or young adult within any health and social care setting. You may use examples from practice to inform your discussion.
12. Reflect on and document a brief account of a situation where you communicated with the child and family in a way that demonstrates respect for culture diversity and individual needs, and the extent to which care provided was family or child centred.
13. Identify one child/teenager who has been admitted into a healthcare setting or is being cared for in the community as a result of illness or injury. Write a reflection on how the principles of child or family centred care were applied to the nursing care of this child and discuss this with your practice supervisor.

14. Young people may transition from child to adult health services for a range of reasons. Outline some difficulties that this transition might present for a child and their family and discuss how the nurse can facilitate a smooth transition.

Practice supervisor, please sign below to verify the authenticity of this worksheet					
Student Name		Student Signature		Date	
Practice Supervisor Name		Practice Supervisor Signature		Date	

MAHI - STM - 102 - 5595

RECORD OF LEARNING WITH OTHER HEALTH CARE PROFESSIONALS

Students may use this record sheet to record learning activities that have occurred with other healthcare professionals

Date of Activity	Location of Activity	Attendance Times	No. of Hours	Verifier's Name	Verifier's Signature	Designation
		From: To:				
Briefly describe the experience and your learning						
	Student's signature:			Date		
Health care professional comments						
Date of Activity	**Location of Activity**	**Attendance Times**	**No. of Hours**	**Verifier's Name**	**Verifier's Signature**	**Designation**
		From: To:				
Briefly describe the experience and your learning						
	Student's signature:			Date		
Health care professional comments						

Name of Student: …… **Student ID:** ……

MAHI - STM - 102 - 5596

COMMUNICATION AND RELATIONSHIP MANAGEMENT SKILLS – ACROSS ALL PARTS

THIS COMMUNICATION AND RELATIONSHIP MANAGEMENT LOG MUST BE CARRIED FORWARD IN YOUR NIPAD FOR EACH OF THE THREE PARTS OF YOUR PROGRAMME AND MUST BE ACHIEVED IN PRACTICE LEARNING PRIOR TO ENTRY TO THE NMC REGISTER. THEY SHOULD BE ACHIEVED AT THE LEVEL COMMENSURATE TO THE STUDENT'S STAGE OF THE PROGRAMME.

STUDENTS SHOULD ACTIVELY SEEK THE OPPORTUNITY TO PRACTICE AND DEVELOP THESE SKILLS THROUGHOUT ALL PRACTICE LEARNING EXPERIENCES.

1. **Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care**							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
1.1	Actively listens, recognises and responds to verbal and non-verbal cues • Demonstrates respect for all individuals, particularly those who may require additional support and protection across the life span		Yes ☐ No ☐			Yes ☐ No ☐	
1.2	Uses prompts and positive verbal and non-verbal reinforcement		Yes ☐ No ☐			Yes ☐ No ☐	
1.3	Uses appropriate non-verbal communication including touch, eye contact and personal space		Yes ☐ No ☐			Yes ☐ No ☐	
1.4	Makes appropriate use of open and closed questioning		Yes ☐ No ☐			Yes ☐ No ☐	

1. **Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care**							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
1.5	Uses caring conversation techniques: • introduces self during interactions with individuals, families, carers and colleagues • connects emotionally, shows compassion and empathy • develops effective therapeutic relationships • is curious • listens attentively and is non-judgemental • is collaborative • celebrates achievements • demonstrates a willingness to learn about and understand each person's unique situation		Yes ☐ No ☐			Yes ☐ No ☐	
1.6	Checks understanding and use clarification techniques (e.g. paraphrasing, summarising and reflecting) • Avoids use of professional jargon when interacting with individual, families or carers		Yes ☐ No ☐			Yes ☐ No ☐	
1.7	Is aware of own unconscious bias in communication encounters (e.g. equality and diversity)		Yes ☐ No ☐			Yes ☐ No ☐	
1.8	Writes accurate, clear, legible and factual records and documentation		Yes ☐ No ☐			Yes ☐ No ☐	
1.9	Confidently and clearly presents and shares appropriately verbal and written reports with individuals and groups		Yes ☐ No ☐			Yes ☐ No ☐	

1. **Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care**							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
1.10	Analyses and clearly records and shares digital information and data in line with General Data Protection Regulation (GDPR)		Yes ☐ No ☐			Yes ☐ No ☐	
1.11	Provides clear verbal, digital or written information and instructions when delegating or handing over responsibility for care		Yes ☐ No ☐			Yes ☐ No ☐	
1.12	Recognises the need for, and facilitates access to translator services and material, e.g. provides information in alternative languages		Yes ☐ No ☐			Yes ☐ No ☐	

2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
2.1	Shares information and check understanding about the causes, implications and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis	Achieved within Promoting Health and Preventing Ill Health activities					
2.2	Uses clear language and appropriate written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment		Yes ☐ No ☐			Yes ☐ No ☐	
2.3	Recognises and accommodates intellectual, physical and sensory impairments during all communications		Yes ☐ No ☐			Yes ☐ No ☐	
2.4	Supports and manage the use of personal communication aids (e.g. PECS, Makaton, etc.)		Yes ☐ No ☐			Yes ☐ No ☐	
2.5	Identifies the need for and manages a range of augmentative and alternative communication techniques e.g. signing, gesture, symbols or computers		Yes ☐ No ☐			Yes ☐ No ☐	

2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
2.6	Uses repetition and positive reinforcement strategies • Is aware of the need for task analysis and behaviour support to assist in the development of adaptive living skills • Assists individuals to attend to activities of living to maintain their physical and mental health		Yes ☐ No ☐			Yes ☐ No ☐	
2.7	Assesses motivation and capacity for behaviour change and clearly explains cause and effect relationships related to common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use		Yes ☐ No ☐			Yes ☐ No ☐	
2.8	Provides information and explanation to people, families and carers and responds to questions about their assessment, diagnosis, management, treatment and care plans		Yes ☐ No ☐			Yes ☐ No ☐	
2.9	Engages in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity		Yes ☐ No ☐			Yes ☐ No ☐	

3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
3.1	Uses motivational interviewing techniques effectively and appropriately (see the Handbook for exemplar actions in this technique/intervention)		Yes ☐ No ☐			Yes ☐ No ☐	
3.2	Uses solution focused therapy techniques effectively and appropriately (see the Handbook for exemplar actions in this technique/intervention		Yes ☐ No ☐			Yes ☐ No ☐	
3.3	Uses reminiscence therapy techniques effectively and appropriately (see the Handbook for exemplar actions in this technique/intervention)		Yes ☐ No ☐			Yes ☐ No ☐	
3.4	Talking therapies	Addressed at 3.1, 3.2, 3.3, 3.6, 3.7 and 3.9)					
3.5	Uses de-escalation strategies and techniques effectively and appropriately (see the Handbook for exemplar actions in this technique/intervention)		Yes ☐ No ☐			Yes ☐ No ☐	
3.6	Uses cognitive behavioural therapy techniques effectively and appropriately (see the Handbook for exemplar actions in this technique/intervention)		Yes ☐ No ☐			Yes ☐ No ☐	
3.7	Uses play therapy effectively and appropriately (see the Handbook for exemplar actions in this technique/intervention)		Yes ☐ No ☐			Yes ☐ No ☐	
3.8	Uses distraction and diversion strategies effectively and appropriately including (e.g. talking, exercise, art, music, deep breathing/mindfulness, relaxation)		Yes ☐ No ☐			Yes ☐ No ☐	

3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
3.9	**Uses positive behaviour support approaches effectively and appropriately, including:** • Develops person-centred care plans which focus on improving quality of life • Identifying strategies to help person stay happy and calm • Recognising early warning signs of behaviour that is challenging and identifying strategies to manage same • Identifying the reason behind behaviour • Reinforcing positive behaviours • Facilitating the development of skills in self-management		Yes ☐ No ☐			Yes ☐ No ☐	

4. Evidence-based, best practice communication skills and approaches for working with people in professional teams							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
4.1	**Demonstrates effective supervision, teaching and performance appraisal through the use of:** clear instructions and explanations when supervising, teaching or appraising others		Yes ☐ No ☐			Yes ☐ No ☐	
	• clear instructions and check understanding when delegating care responsibilities to others		Yes ☐ No ☐			Yes ☐ No ☐	
	• unambiguous, constructive feedback about strengths and weaknesses and potential for improvement		Yes ☐ No ☐			Yes ☐ No ☐	
	• encouragement to colleagues that helps them to reflect on their practice		Yes ☐ No ☐			Yes ☐ No ☐	
	• unambiguous records of performance		Yes ☐ No ☐			Yes ☐ No ☐	
4.2	**Demonstrate effective person and team management through the use of:** strengths-based approaches to developing teams and managing change		Yes ☐ No ☐			Yes ☐ No ☐	
	• active listening when dealing with team members' concerns and anxieties		Yes ☐ No ☐			Yes ☐ No ☐	
	• a calm presence when dealing with conflict		Yes ☐ No ☐			Yes ☐ No ☐	

4. Evidence-based, best practice communication skills and approaches for working with people in professional teams							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
	• appropriate and effective confrontation strategies including: ○ listening attentively ○ exploring the root cause of the confrontation ○ depersonalising the situation ○ staying calm and in control of emotions ○ trying to see the other person's perspective ○ recognition of own role ○ gives the other person options ○ being open to compromise		Yes ☐ No ☐			Yes ☐ No ☐	
	• de-escalation strategies and techniques when dealing with conflict including: ○ use of neutral non confrontation body language ○ speaking in a calm voice ○ being respectful – direct but courteous ○ hearing the person out ○ recognising role and limitations ○ setting goals (for example SMART) ○ remains professional - disengage if required		Yes ☐ No ☐			Yes ☐ No ☐	

4. Evidence-based, best practice communication skills and approaches for working with people in professional teams							
Proficiency		**Practice learning environment**	**Achieved?**	**Practice supervisor initials**	**Practice learning environment**	**Achieved?**	**Practice supervisor initials**
	• effective co-ordination and navigation skills through: ○ appropriate negotiation strategies (e.g. listening, rapport building and problem solving, being assertive and be willing to compromise)		Yes ☐ No ☐			Yes ☐ No ☐	
	○ appropriate escalation procedures		Yes ☐ No ☐			Yes ☐ No ☐	
	○ appropriate approaches to advocacy		Yes ☐ No ☐			Yes ☐ No ☐	

HEALTH NUMERACY & CALCULATION OF MEDICINES – PART 1

Introduction

As a nurse you will need to be competent in basic and more complex numeracy skills and drug administration. This learning log is designed to give you some focus and guidance of skills that will be required during practice placements. Primarily, by completing this learning log you will address a variety of NMC proficiencies (NMC, 2018).

Is competent in basic proficiencies relating to Providing and Evaluating Care (*):	
4.5	Demonstrate the knowledge and skills required to support people with commonly encountered mental and physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs
4.14	Understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines
4.15	Demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage
4.16	Demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing
4.17	Apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration, and
Is competent to perform NMC Standards for Registered Nurse Annex B: Nursing Procedures	
11.2	recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them
11.4	undertake accurate drug calculations for a range of medications
11.6	exercise professional accountability in ensuring the safe administration of medicines to those receiving care
11.7	administer injections using intramuscular, subcutaneous and intradermal routes and manage injection equipment
11.8	administer medications using a variety of routes
11.11	undertake safe storage, transportation and disposal of medicinal products

Using Numbers in Everyday Nursing Practice

Early Warning Scores

You will be using numbers every day in practice from observing and recording temperature, blood pressure, heart rate, respiration rate to calculating body mass index and balancing a person's fluid intake and output. The following activities will help improve your knowledge on the significance of accurate recording and the importance of record keeping and reporting.

In your practice learning environment, complete the NEWS2 chart for two people in your care, completing each case study below.

Case Study One

1. Complete the following:

Vital Sign	Measurement	Item Score for NEWS2
Respiration Rate		
Oxygen Saturations		
Air or Oxygen		
Blood Pressure		
Heart Rate		
Consciousness/New Confusion		
Temperature		
Total NEWS2 Score		

2. Discuss the relevance of these scores, the clinical risk and necessary response.

Practice supervisor, please verify that:					
The student has undertaken this work independently				Yes ☐ No ☐	
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Case Study Two

1. Complete the following:

Vital Sign	Measurement	Item Score for NEWS2
Respiration Rate		
Oxygen Saturations		
Air or Oxygen		
Blood Pressure		
Heart Rate		
Consciousness/New Confusion		
Temperature		
Total NEWS2 Score		

2. Discuss the relevance of these scores, the clinical risk and the necessary response.

Practice Supervisor, please verify that					
The student has undertaken this work independently				Yes ☐ No ☐	
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Fluid Intake and Output Balance

Fluid intake and output charts are an assessment tool to identify and monitor a person's fluid input and output. Such records and calculations need to be completed and calculated accurately.

ACTIVITY FOUR

To demonstrate your ability in clinical practice you must complete a fluid intake and output chart for two people in your care. You will need to confirm the amount in ml used to record as a cup, or glass etc. within your practice learning environment (the sizes of cups and glasses can vary in volume from setting to setting). Check this with your practice supervisor/s.

Case Study One

1. Complete the fluid intake and output chart based on the person's input and output.
2. Add up the total input and output and calculate the difference between the input and output. Remember to take into consideration insensible losses.

Total Intake	Total Output	Any Factors You Considered in Relation to Insensible Losses

3. Analyse the difference between the intake and output and describe the actions you would take. Provide a rationale for each action.

Provide your analysis below	
Action(s) You Would Take	**Rationale**

Practice supervisor, please verify that					
The student has undertaken this work independently				Yes ☐ No ☐	
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Case Study Two

1. Complete the fluid intake and output chart based on person's input and output.

2. Add up the total input and output and calculate the difference between the input and output. Remember to take into consideration insensible losses.

Total Intake	Total Output	Any Factors You Considered in Relation to Insensible Losses

3. Analyse the difference between the intake and output and describe the actions you would take. Provide a rationale for each action.

Provide your analysis below	
Action(s) You Would Take	**Rationale**

Practice supervisor, please verify that					
The student has undertaken these calculations independently				Yes ☐ No ☐	
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Body Mass Index (BMI)

BMI is one of the assessment tools to assist in assessing if your patient is over or underweight.

ACTIVITY FIVE

In your practice placement choose three people in your care and calculate their BMI and place them in the appropriate nutritional status category.

Please note you will need to **convert the units of measurement** into the correct form first:

Case Study One

Weight	Height	BMI	Category	Date Completed

Case Study Two

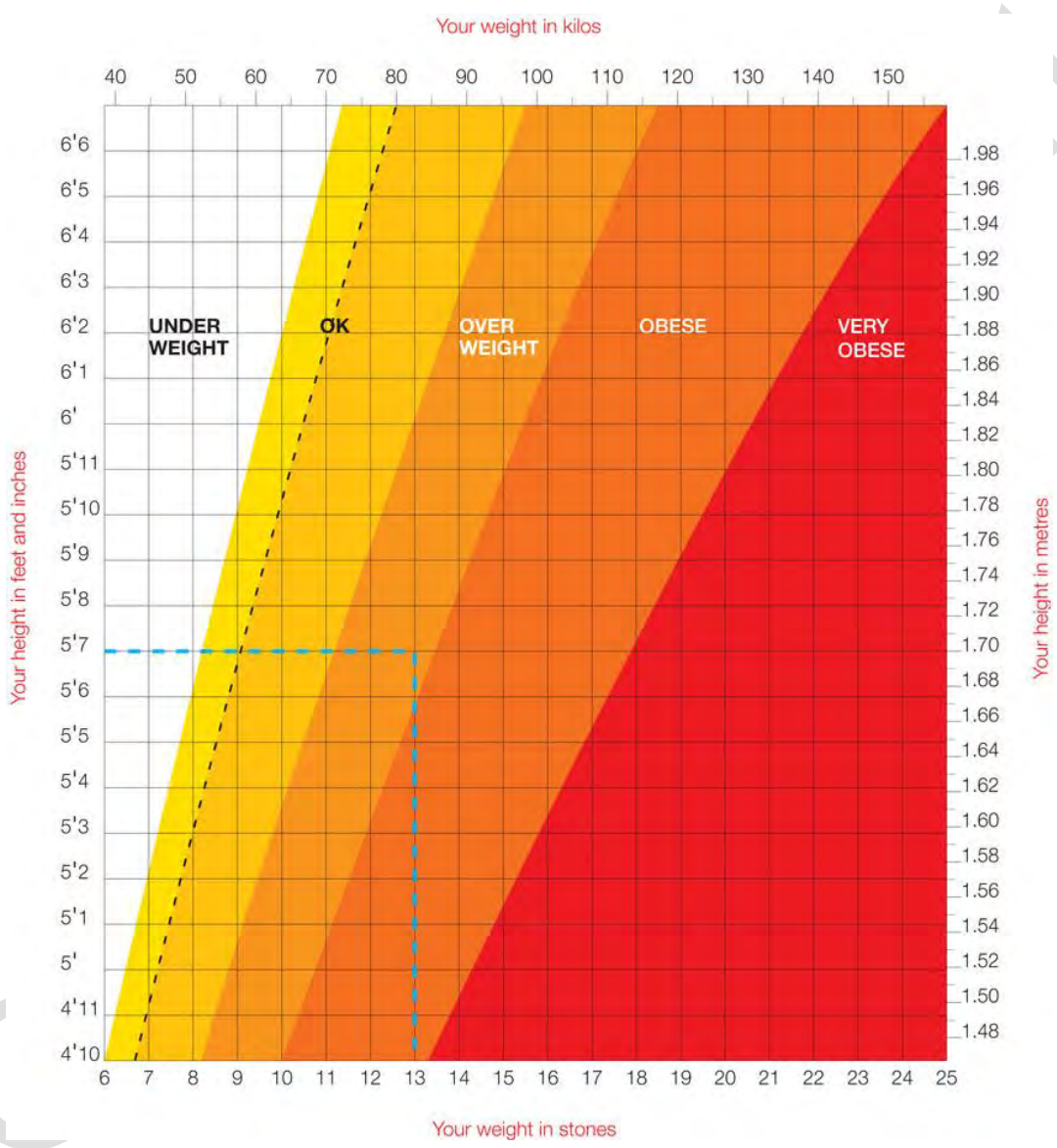
Weight	Height	BMI	Category	Date Completed

Case Study Three

Weight	Height	BMI	Category	Date Completed

Practice supervisor, please verify that					
The student has undertaken these calculations independently				Yes ☐	No ☐
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐	No ☐
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Figure 5 – Body Mass Index Chart

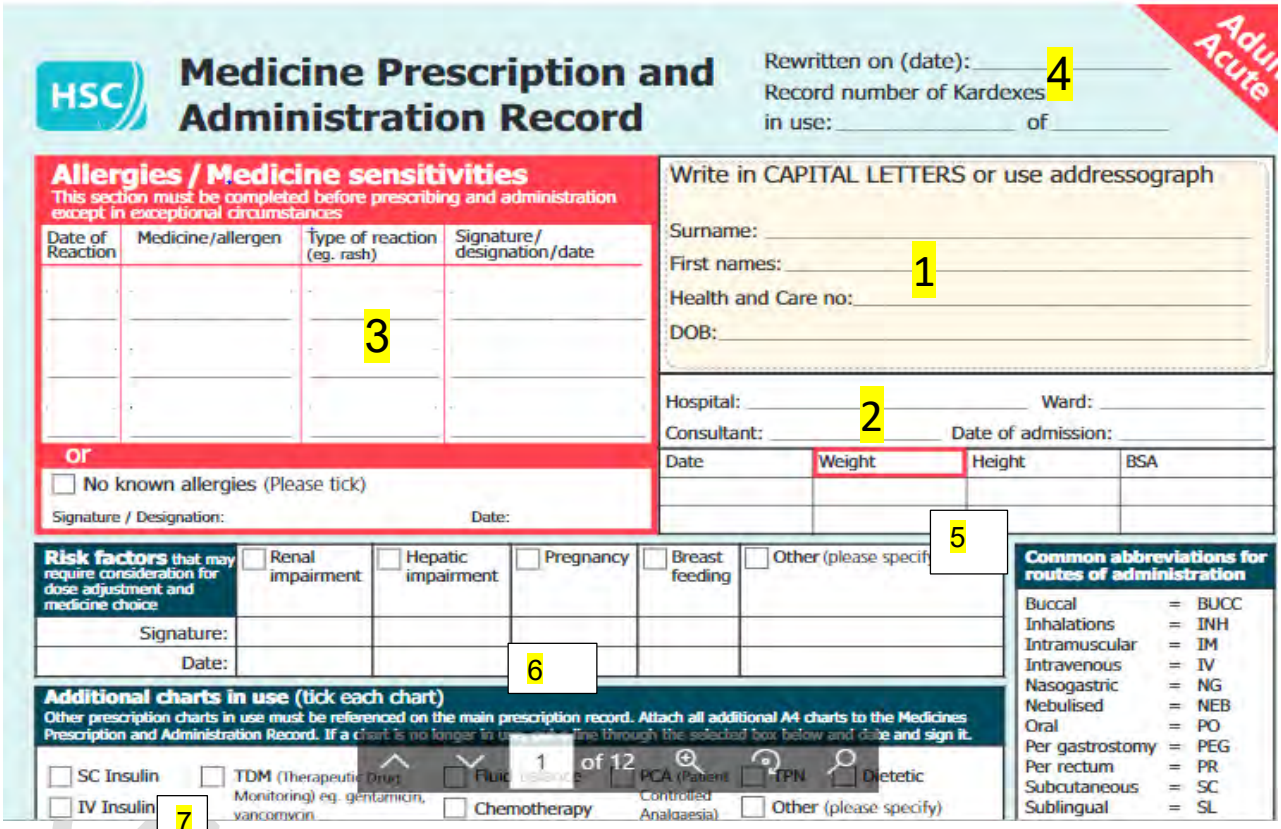


Prescription Validity

Explain the relevance of the seven identified areas on the medicine prescription and administration record below and indicate why you would check these before commencing administration of medication

1.	
2.	
3.	
4.	
5.	
6.	
7.	

Figure 6 – Medicine Prescription and Administration Record



Practice supervisor, please verify that					
The student has undertaken this validity check independently				Yes ☐ No ☐	
I (practice supervisor) have discussed and checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Figure 7 – Non-Medical Prescriber Prescription

List the four patient details which should be completed on the prescription:
1.
2.
3.
4.

List the five legal requirements a prescriber must ensure is completed on a prescription:

1.
2.
3.
4
5.

Are electronic signatures acceptable on a community prescription?

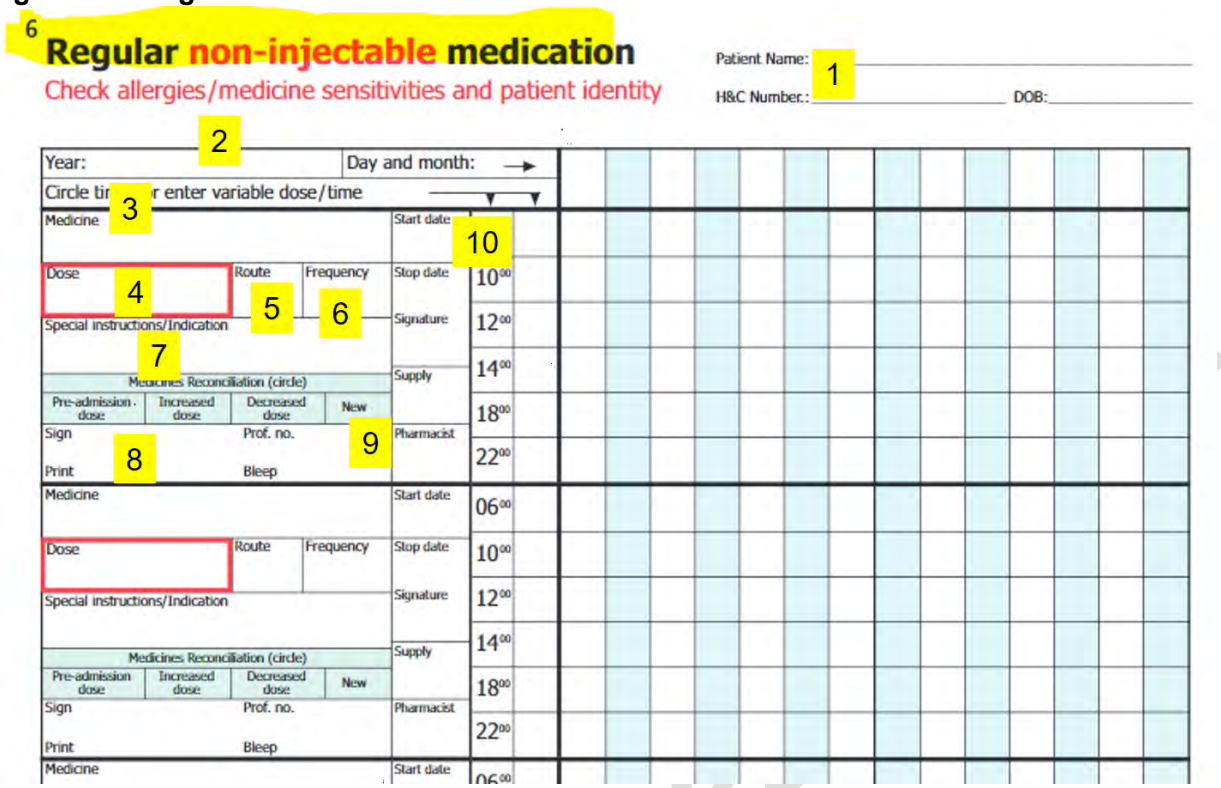
List the five medication details which should be completed on the prescription:
1.
2.
3.
4.
5

What should be written on the script to indicate no further items?

Practice supervisor, please verify that					
The student has undertaken this validity check independently				Yes ☐ No ☐	
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Medicine and Administration Record

Figure 8 – Drug Kardex



List the *10* components of a valid prescription and explain their relevance

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Practice supervisor, please verify that					
The student has undertaken this validity check independently				Yes ☐ No ☐	
I (practice supervisor) have checked the answers and confirm they are correct				Yes ☐ No ☐	
Practice supervisor's name (print)		Practice supervisor's signature		Date	

Safe Administration of Medicines - Administration Procedure

Complete an observed medication administration with your practice supervisor where you undertake the administration and demonstrate your proficiency against the criteria in the template below. Afterwards, complete the template with your practice supervisor to record your achievement. You must do this on two occasions in part 1.

Assessment 1	Achieved/Not Achieved
Checked for: • Person's details completed • Allergies or previous drug reactions • Drug name • Start date/finish date • Route of administration • Dose (strength if applicable) • Frequency • Time for administration • If already given or omitted • If any contraindications • Potential interactions • Any storage directions	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Verbalises action of medication, including checking (e.g. BNF) if necessary	Yes ☐ No ☐
Considers matters around consent and ethical administration	Yes ☐ No ☐
Correctly identifies medication to be given	Yes ☐ No ☐
Checks • Drug name against prescription • Dose against prescription • Expiry date	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Calculates dose	Yes ☐ No ☐
Under the direct supervision of a RN Prepares for administration, including any required checks with additional staff	Yes ☐ No ☐
Checks person's identity against: • Wrist band • Verbally • Prescription chart	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Checks allergies with person	Yes ☐ No ☐
Under the direct supervision of a RN administers medication to person	Yes ☐ No ☐
Observes the person taking the medication	Yes ☐ No ☐
Documents administration correctly	Yes ☐ No ☐
Confirms how adverse reactions are notified	Yes ☐ No ☐
Practice supervisor, please verify that	
The student has undertaken this medication administration under your supervision	Yes ☐ No ☐
I (practice supervisor) confirm the accuracy of the assessment record completed	Yes ☐ No ☐

Practice supervisor's name (Print)		Practice supervisor's signature		Date	

Assessment 2	Achieved/Not Achieved
Checked for: • Person's details completed • Allergies or previous drug reactions • Drug name • Start date/Finish date • Route of administration • Dose (strength if applicable) • Frequency • Time for administration • If already given or omitted • If any contraindications • Potential interactions • Any storage directions	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Verbalises action of medication, including checking (e.g. BNF) if necessary	Yes ☐ No ☐
Considers matters around consent and ethical administration	Yes ☐ No ☐
Correctly identifies medication to be given	Yes ☐ No ☐
Checks • Drug name against prescription • Dose against prescription • Expiry date	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Calculates dose	Yes ☐ No ☐
Under the direct supervision of a RN prepares for administration, including any required checks with additional staff	Yes ☐ No ☐
Checks person's identity against: • Wrist band • Verbally • Prescription chart	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Checks allergies with person	Yes ☐ No ☐
Under the direct supervision of a RN administers medication to person	Yes ☐ No ☐
Observes the person taking the medication	Yes ☐ No ☐
Documents administration correctly	Yes ☐ No ☐
Confirms how adverse reactions are notified	Yes ☐ No ☐
Practice Supervisor, please verify that	
The student has undertaken this medication administration under your supervision	Yes ☐ No ☐
I (practice supervisor) confirm the accuracy of the assessment record completed	Yes ☐ No ☐

Practice supervisor's name (Print)		Practice supervisor's signature		Date	

Calculations in Nursing

One of the most important ways in which you will have to use your calculation skills in your practice is when you are preparing and administering medicines for different routes of administration. While you have been introduced to the basic theory behind drug calculations in Part 1 of your programme, it is important that you are competent in calculating the correct volumes and dosages in practice.

The important information that you need for getting to grips with dose calculations are:

- The type of formulations containing the drug – e.g. tablets, capsules or suspensions (volumes of fluid)
- The amount of the drug contained in each tablet, capsule or volume of fluid etc.
- The prescribed dose required to be given at each administration

Based on medications prescribed for people in your care, complete the tables below. Do not use the same drug twice and all entries must be completed. An example is provided for each section.

Enteral Drug (Tablet/Capsule)		Dose Prescribed	Dose each unit is supplied in	Number needed for prescribed dose	Show Calculation	Practice Supervisor Initials	Date
e.g.	Paracetamol	1g	500mg	2 tablets	500mg x 2 = 1g		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Enteral Drug (Liquid/Suspension)		Dose Prescribed	Dose each unit is supplied in	Amount needed for prescribed dose	Show Calculation	Practice Supervisor Initials	Date
e.g.	Amoxicillin	500mg	250mg in 5 ml	10ml	250mg x 2 = 500mg 250mg in 5ml, 5ml x 2 = 10ml		
1.							
2.							
3.							
4.							
5.							

Parenteral Drugs (Injections)		Dose Prescribed	Dose each unit is supplied in	Amount needed for prescribed dose	Show Calculation	Practice Supervisor Initials	Date
e.g.	Haloperidol	2 mg	5 mg in 1 ml	0.4 ml	If 5mg in 1ml, 1mg in 0.2ml. 2mg = 0.2ml x 2 = 0.4ml		
1.							
2.							
3.							

NURSING PROCEDURES – LEARNING DISABILITIES NURSING - PART 1

STUDENTS SHOULD ACTIVELY SEEK THE OPPORTUNITY TO PRACTICE AND DEVELOP THESE SKILLS THROUGHOUT ALL PRACTICE LEARNING EXPERIENCES

In this part of the programme, students should be practicing at the following level:
Guided participation in care and performing with increasing confidence and competence, applying knowledge, skills and professional attributes

Key: Yes: *Student demonstrates achievement to the expected standard*
No: *Student does not yet demonstrate achievement to the expected standard*
NOA: *No opportunity available*

Please see the Handbook for further detail on these Keys.

Practice Learning 1 Location	
Practice Learning 2 Location	
Practice Learning 3 Location	

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
1.1	**Assesses mental health and wellbeing status using appropriate tools/framework(s)** • (e.g. PASSAD, Depression Scales, Folstein Mini-Mental State Examination, Recovery and Wellness tools.	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
1.11	Identifies and responds appropriately to signs of mental and emotional stress or vulnerability (e.g. sensory impairment, dementia, autistic spectrum disorder, distress, delirium, behaviours that challenge) • Contributes to a culture of mental health recovery and wellness that fosters self-determination and resilience • Acts as an advocate for the person, their family or their carers • Engages actively with individuals, families and carers to enable their full involvement in the care/treatment process, on the basis of informed choice	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1 Assessment	1 Registrant's Initials	1 Date	2 Assessment	2 Registrant's Initials	2 Date	3 Assessment	3 Registrant's Initials	3 Date
1.2.2	**Identifies and responds appropriately to signs and symptoms of physical distress (e.g. pain, thirst, hunger, nausea, constipation)** • Demonstrates application of the nursing process • Demonstrates an ability to see the person as the expert in his or her experience • Demonstrates an ability to see the person and not just his or her symptoms • Demonstrates respect for the contribution of families, friends and carers • Recognises when additional actions are needed to address additional care needs	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
2.1 +2.10	**Accurately takes, records and interprets:** • Temperature	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Radial Pulse (manual)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Brachial Pulse (manual)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	• Carotid Pulse (manual)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Respirations	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Oxygen Saturations (SaO_2)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Capillary Refill/Perfusion (Central and Peripheral)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• National Early Warning Score	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Blood Pressure (sphygmomanometer)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Blood Pressure (electronic)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Recognises changes in Level of Consciousness (AVPU)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
2.6 + 5.2	**Accurately measures/calculates and records** • Weight	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Height	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Length	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Body Mass Index (BMI), including correctly categorising result	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Nutritional Status using contemporary assessment tool(s) (e.g. MUST)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
2.11	Can identify/recognises signs of all forms of abuse	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Responds to signs of all forms of abuse, documenting and reporting same and making appropriate onwards referrals • Is aware of the referral process to other professions and statutory or voluntary agencies	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
2.14	Administers basic mental health first aid (e.g. non-judgmental listening, providing reassurance, providing support/referral information)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
2.15	Administers basic physical first aid	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
2.16	Recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support: • Protects person from injury	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Manages a person safely while in a seizure	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Can demonstrate knowledge of emergency medication	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Can place person in recovery position (at appropriate time)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Management of mild airway obstruction	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Management of severe airway obstruction	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	• Opening, clearing and maintaining airway	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Check for breathing and pulse simultaneously	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Correctly identifies how to gain expert help in cardiac arrest	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Performs CPR correctly – Adult ○ Compressions (hand position, rate, depth, recoil)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Ventilations (chest rises and falls, correct use of bag-valve-mask)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Performs CPR correctly – Infant and Child ○ Compressions (hand position, rate, depth, recoil)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Ventilations (chest rises and falls, correct use of bag-valve-mask)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
3.1 + 3.5	Reviews behavioural intervention/s and documents decisions of care	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	Recognises own position in supporting people presenting with behaviours that challenge	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Can identify and plan for sleep and rest needs, articulating optimal hours for sleep	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
3.3	Uses correct moving and handling techniques	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Correctly identifies necessary pressure relieving aids/appliances based on assessment	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
3.4	Takes appropriate action (including advocacy) to ensure privacy and dignity at all times	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
3.5	Can recognise fatigue and tiredness and articulate the difference between them	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Can articulate, plan and promote the need for activity in fatigue	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Can articulate and educate people on sleep hygiene measures	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1			Practice Learning Experience No. 2			Practice Learning Experience No. 3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	Can articulate and educate people on energy management related to their health status	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
4.3	Assesses needs for, and provides appropriate assistance with, washing, bathing, shaving and dressing	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
4.4	Identifies and manages skin irritations, rashes and pressure areas	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
4.5	Undertakes oral assessment (using recognised tool when appropriate) and determines appropriate plan for oral hygiene	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Can correctly undertake oral hygiene	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Assesses need for eye care and ear care, setting out plan when appropriate	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Can correctly undertake eye care and ear care to minimise infection and optimise status	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Assesses need for nail care and articulates associated risks (e.g. diabetes, peripheral vascular disease)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1			Practice Learning Experience No. 2			Practice Learning Experience No. 3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	Identifies correctly when referral for chiropody/podiatry is required, completing same	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
4.8	Assesses, responds to and effectively manages pyrexia and hypothermia.	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
5.1 + 5.3 + 5.4 + 5.5	Uses negotiating and other skills to encourage people who might be reluctant to drink to take adequate fluids	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Supports people who need to adhere to specific diet and fluid regimens and educates them of the reason	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Identifies people who are unable to or have difficulty in eating or drinking and effectively assists them using appropriate feeding and drinking aids and appliances where necessary	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Ensures that time is given at mealtimes to promote a sociable and pleasant experience for the person which includes choice	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Ensures correct positioning of the person and self during mealtimes (e.g. person and student are comfortably seated at eye level)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	Assesses the risk associated with eating and drinking and correctly identifies when referral to other professionals is appropriate (e.g. dietician, speech and language therapist)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Follows food hygiene procedures	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
7.1	Assesses abilities and needs in relation to mobility using appropriate tool/framework	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Uses a validated risk tool to identifying and categorise risk of falls	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Works with interdisciplinary team to identify correct aids/appliances and support needs to maximise safe movement/mobilisation	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
7.2 + 7.3	Engages with and advocates safe moving and handling equipment and techniques	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
7.4 + 9.7	Uses appropriate safety techniques and devices. • Ensures equipment is safe to use prior to its use	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1 Assessment	1 Registrant's Initials	1 Date	2 Assessment	2 Registrant's Initials	2 Date	3 Assessment	3 Registrant's Initials	3 Date
	• Checks equipment has been serviced as required, documenting same	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Identifies when equipment is faulty or in need of service, responding appropriately to maximise safety	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Safe use and disposal of medical devices (COSHH regulations)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
8.1	Observes, assesses the need for intervention and appropriately responds to: • Restlessness	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Agitation	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Breathlessness	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
9.1 - 9.8	**Follows local and national guidelines and adheres to standard infection prevention & control precautions**	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Demonstrates effective hand-washing technique (seven stages)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	Demonstrates appropriate use of personal protective equipment	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Disposes of waste and sharps appropriately	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Uses aseptic non-touch technique (ANTT) and aseptic technique appropriately	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Recognises potential signs of infection and records and reports to appropriate senior members of staff	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Identifies when people require to be nursed in isolation or in protective isolation settings	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Prepares and decontaminates nursing equipment appropriately	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
11.2 + 11.6	Under the direct supervision of an RN and before administering any prescribed drug, reviews the person's prescription chart and checks the following: • Correct: o Person	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No.								
		1			2			3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	○ Drug	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Dose	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Date and time of administration	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Route and method of administration	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Diluent (as appropriate)	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Ensures: ○ Validity of prescription	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ Prescription is legible	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	○ No allergies/sensitivities to prescribed medication	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NMC Annex B Ref	Nursing Procedure	Practice Learning Experience No. 1			Practice Learning Experience No. 2			Practice Learning Experience No. 3		
		Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date	Assessment	Registrant's Initials	Date
	If any omissions, lack of clarity or illegibility of prescription exists, the student under the direct supervision of an RN does not proceed with administration and should consult the prescriber	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Accurately records administration of medication	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Observes for effect of medication, responding and recording as appropriate	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	Identifies, records and communicates known allergies and/or sensitivities	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
11.11	Demonstrates ability to safely store medicines as per regional/local policy.	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
11.7 + 11.8	Is competent in medicines calculations and administration relating to: • Tablets and capsules	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
	• Enteral liquid medicines	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		
11.10	Recognises and response promptly to side effects and adverse reactions of medication	☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA			☐ Yes ☐ No ☐ NOA		

NURSING PROCEDURES – ACROSS PARTS 1, 2 AND 3 – LEARNING DISABILITIES NURSING

THIS NURSING PROCEDURES RECORD MUST BE CARRIED FORWARD IN YOUR NIPAD FOR EACH OF THE THREE PARTS OF YOUR PROGRAMME. THEY SHOULD BE ACHIEVED AT THE LEVEL COMMENSURATE TO THE STUDENT'S STAGE OF THE PROGRAMME.

THESE NURSING PROCEDURES MUST BE ACHIEVED IN PRACTICE LEARNING PRIOR TO ENTRY TO THE NMC REGISTER

STUDENTS SHOULD ACTIVELY SEEK THE OPPORTUNITY TO PRACTICE AND DEVELOP THESE NURSING PROCEDURES THROUGHOUT ALL PRACTICE LEARNING EXPERIENCES

Key: Yes: *Student demonstrates achievement to the expected standard*
No: *Student does not yet demonstrate achievement to the expected standard*

Please see the Handbook for further detail on these Keys.

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
1.12	Undertakes cognitive screening assessment using a recognised tool (e.g. MOCA), classifying score correctly	☐ Yes ☐ No				☐ Yes ☐ No			
1.13	Can identify presenting factors of cognitive distress and impairment and respond appropriately	☐ Yes ☐ No				☐ Yes ☐ No			
1.2.1	Can identify symptoms and signs of physical ill health	☐ Yes ☐ No				☐ Yes ☐ No			
2.5	Can undertake blood glucose monitoring correctly following regional/local policy: Correctly calibrate device	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	Correctly interpret and record blood glucose result, responding appropriately	☐ Yes ☐ No				☐ Yes ☐ No			
2.2 + 2.9	Undertake venous cannulation safely	☐ Yes ☐ No				☐ Yes ☐ No			
	Correctly obtain specimens for analysis: • Sputum	☐ Yes ☐ No				☐ Yes ☐ No			
	• Faeces	☐ Yes ☐ No				☐ Yes ☐ No			
	• MSSU	☐ Yes ☐ No				☐ Yes ☐ No			
	• Catheter specimen of urine	☐ Yes ☐ No				☐ Yes ☐ No			
	• Specimen Swab (e.g. screening, wounds)	☐ Yes ☐ No				☐ Yes ☐ No			
	• Venous blood	☐ Yes ☐ No				☐ Yes ☐ No			
	• Vomit	☐ Yes ☐ No				☐ Yes ☐ No			
	Accurately interpret and explain blood results based on recognised parameters: • Serum biochemistry (urea and electrolytes, liver function, thyroid function, CRP and nutritional markers)	☐ Yes ☐ No				☐ Yes ☐ No			
	• Full blood count/picture	☐ Yes ☐ No				☐ Yes ☐ No			
	• Coagulation screen	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	• Venous blood gases	☐ Yes ☐ No				☐ Yes ☐ No			
	Accurately interprets arterial blood gases and identifies respiratory/metabolic status	☐ Yes ☐ No				☐ Yes ☐ No			
2.16	Recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support: • Is aware of the person's epilepsy management plan during a seizure	☐ Yes ☐ No				☐ Yes ☐ No			
	• Can demonstrate knowledge of emergency medication	☐ Yes ☐ No				☐ Yes ☐ No			
	• Under direct supervision of a RN, can safely administer emergency antiepileptic medication (AED) (e.g. buccal/ intravenously/ rectal)	☐ Yes ☐ No				☐ Yes ☐ No			
	• Correctly identifies treatment of anaphylaxis o Drug(s) used o Drug dosage o Route of administration o When to administer o When to repeat	☐ Yes ☐ No				☐ Yes ☐ No			
2.17	Recognises and responds to behaviours which challenge, providing appropriate, least restrictive option and/or safe holding	☐ Yes ☐ No				☐ Yes ☐ No			
	Can articulate the legal and ethical application of restraint practices (chemical mechanical & physical)	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	Identifies the need for debriefing for service user and staff following an incident of physical or chemical restrictive intervention	☐ Yes ☐ No				☐ Yes ☐ No			
	Completes post-incident documentation after an incident of physical intervention	☐ Yes ☐ No				☐ Yes ☐ No			
	Demonstrates direct methods of observation Including 1:1 observation	☐ Yes ☐ No				☐ Yes ☐ No			
	Identifies antecedents and/or consequences of behaviour	☐ Yes ☐ No				☐ Yes ☐ No			
	Demonstrates awareness of Differential Reinforcements (e.g. DRO, DRI, DRA, DRL)	☐ Yes ☐ No				☐ Yes ☐ No			
	Demonstrates awareness of de-escalation techniques	☐ Yes ☐ No				☐ Yes ☐ No			
	Demonstrates awareness of risk assessment processes such as Promoting Quality Care (PQC)	☐ Yes ☐ No				☐ Yes ☐ No			
3.1	Uses recognised pain tool to assess person's experience of pain	☐ Yes ☐ No				☐ Yes ☐ No			
	Can correctly categorise pain type (e.g. visceral, neuropathic)	☐ Yes ☐ No				☐ Yes ☐ No			
	Correctly identifies necessary type of analgesia for type of pain experience	☐ Yes ☐ No				☐ Yes ☐ No			
	Correctly identifies appropriate timings for administration of analgesia	☐ Yes ☐ No				☐ Yes ☐ No			
3.2 + 9.8	Demonstrates ability to use appropriate bed making techniques, including ability to change bed sheets with a person confined to bed	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	Minimises potential for spread of infection through appropriate disposal of laundry	☐ Yes ☐ No				☐ Yes ☐ No			
4.1 + 4.2 + 4.6 + 9.3	Demonstrates the ability to assess skin, including: • Grading of pressure damage using an appropriate tool	☐ Yes ☐ No				☐ Yes ☐ No			
	• Condition of skin (e.g. hydration, hygiene, signs of malnutrition)	☐ Yes ☐ No				☐ Yes ☐ No			
	Can articulate necessary nutrition and hydration for optimal skin condition	☐ Yes ☐ No				☐ Yes ☐ No			
	Uses aseptic techniques when applying: • Vacuum closures	☐ Yes ☐ No				☐ Yes ☐ No			
	• Suture and clip removal and safe disposal	☐ Yes ☐ No				☐ Yes ☐ No			
	• Pressure bandaging (no compression)	☐ Yes ☐ No				☐ Yes ☐ No			
	Can assess a wound, including: • Use of correct wound assessment tool	☐ Yes ☐ No				☐ Yes ☐ No			
	• Staging of wound	☐ Yes ☐ No				☐ Yes ☐ No			
	• Identify appropriate dressing/intervention for wound type	☐ Yes ☐ No				☐ Yes ☐ No			
	• articulate and set out appropriate plan of care	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
4.7	Uses aseptic techniques when managing wound and drainage processes.	☐ Yes ☐ No				☐ Yes ☐ No			
5.1 + 5.3 - 5.5 + 5.7	Identifies, responds to and manages nausea and vomiting	☐ Yes ☐ No				☐ Yes ☐ No			
	Identifies people who are unable to or have difficulty in eating or drinking and effectively assists them using appropriate feeding and drinking aids and appliances where necessary	☐ Yes ☐ No				☐ Yes ☐ No			
	Administers enteral feeds safely and maintains equipment in accordance with local policy	☐ Yes ☐ No				☐ Yes ☐ No			
	Safely, maintains and uses nasogastric, PEG and other feeding devices	☐ Yes ☐ No				☐ Yes ☐ No			
	Monitors and assesses people receiving intravenous fluids	☐ Yes ☐ No				☐ Yes ☐ No			
	Assess infusion sites and manage complications appropriately	☐ Yes ☐ No				☐ Yes ☐ No			
	Accurately measures and records fluid and nutritional intake, identifying and responding appropriately to dehydration and fluid overload	☐ Yes ☐ No				☐ Yes ☐ No			
2.3 + 2.5	Applies ECG electrodes in correct anatomical position and acquires a clear: 3 lead ECG tracing	☐ Yes ☐ No				☐ Yes ☐ No			
	• 12 lead	☐ Yes ☐ No				☐ Yes ☐ No			
	Interprets ECG tracing correctly using PQRST system	☐ Yes ☐ No				☐ Yes ☐ No			
2.4	Can analyse person's blood group/rhesus factor and compatibility with donor blood products	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	Correctly sets up transfusion as per local/regional policy	☐ Yes ☐ No				☐ Yes ☐ No			
	Can articulate rationale for observations and describe features of haemolytic reaction	☐ Yes ☐ No				☐ Yes ☐ No			
	Can articulate how to respond to haemolytic reaction	☐ Yes ☐ No				☐ Yes ☐ No			
2.8	Undertake chest auscultation and: • Identifies optimal patient position and correct anatomical location for auscultation	☐ Yes ☐ No				☐ Yes ☐ No			
	• Identifies clear/healthy sounds	☐ Yes ☐ No				☐ Yes ☐ No			
	• Identifies when air entry is absent or has additional sounds present	☐ Yes ☐ No				☐ Yes ☐ No			
2.12 + 2.7	Can assess neurological status using the Glasgow coma scale: • Scoring the three components of the scale correctly	☐ Yes ☐ No				☐ Yes ☐ No			
	• Can demonstrate how to document assessment as a graph	☐ Yes ☐ No				☐ Yes ☐ No			
	• Can record findings using cumulative and breakdown score (e.g. 15/15, E4 V5 M6)	☐ Yes ☐ No				☐ Yes ☐ No			
	Can assess pupillary response: • Equality	☐ Yes ☐ No				☐ Yes ☐ No			
	• Speed of reaction	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	• Expectation on exposure to light (constriction then dilation), including consensual response	☐ Yes ☐ No				☐ Yes ☐ No			
	Can assess limb strength using muscle strength grading system (0-5 scale)	☐ Yes ☐ No				☐ Yes ☐ No			
	Can undertake sensory assessment using dermatomes chart	☐ Yes ☐ No				☐ Yes ☐ No			
5.6	Can safely insert, manage and remove oral/nasal/gastric tubes	☐ Yes ☐ No				☐ Yes ☐ No			
5.7 + 5.8 + 5.9	Can safely set up enteral/parenteral feeding system	☐ Yes ☐ No				☐ Yes ☐ No			
	Can assess administration site and determine its suitability for use	☐ Yes ☐ No				☐ Yes ☐ No			
	Can interpret an intravenous fluid prescription correctly and set-up infusion accordingly including type of fluid for infusion and correct rate	☐ Yes ☐ No				☐ Yes ☐ No			
	Demonstrates ability to manage intravenous infusion device	☐ Yes ☐ No				☐ Yes ☐ No			
	Safely determines appropriateness of intravenous infusion solution taking into consideration person's biochemical and hydration status.	☐ Yes ☐ No				☐ Yes ☐ No			
6.1 + 6.2	Correctly identifies appropriate aids and appliances necessary to maximise independence, dignity, privacy and respect in managing continence	☐ Yes ☐ No				☐ Yes ☐ No			
	Supports the person to maintain current levels of toileting skills	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	Assesses and identifies the presence of and categorises correctly urinary incontinence	☐ Yes ☐ No				☐ Yes ☐ No			
	Identifies the presence of and categorises correctly bowel/faecal incontinence	☐ Yes ☐ No				☐ Yes ☐ No			
	Assesses and identifies the presence of urinary and/or faecal urgency	☐ Yes ☐ No				☐ Yes ☐ No			
	Assesses and identifies the presence of and contributing factors to constipation and how to correct address them	☐ Yes ☐ No				☐ Yes ☐ No			
6.2	Can correctly and safely insert urinary catheter for all genders	☐ Yes ☐ No				☐ Yes ☐ No			
	Can correctly manage urinary catheter including: Undertaking safer catheter care	☐ Yes ☐ No				☐ Yes ☐ No			
	• Identifying when catheter should be changed	☐ Yes ☐ No				☐ Yes ☐ No			
	• Correctly choses and positions bladder drainage devices to minimise risk of infection	☐ Yes ☐ No				☐ Yes ☐ No			
	• Assists with self-catheterisation when required	☐ Yes ☐ No				☐ Yes ☐ No			
	• Can correctly remove urinary catheter	☐ Yes ☐ No				☐ Yes ☐ No			
6.3	Observes urinary output and identifies any concerns: • Low/high output	☐ Yes ☐ No				☐ Yes ☐ No			
	• Urinalysis results outside of homeostatic parameters	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
6.4	Articulates the correct frequency to assess bowel and bladder patterns	☐ Yes ☐ No				☐ Yes ☐ No			
	Accurately assesses bowel and bladder patterns, recording correctly and clearly	☐ Yes ☐ No				☐ Yes ☐ No			
	Correctly identifies and categories any altered bowel/bladder pattern (e.g. retention, constipation, frequency)	☐ Yes ☐ No				☐ Yes ☐ No			
6.5	Can undertake rectal examination and manual evacuation when appropriate	☐ Yes ☐ No				☐ Yes ☐ No			
	Under the direct supervision of an RN safely administers enemas	☐ Yes ☐ No				☐ Yes ☐ No			
	Under the direct supervision of an RN safely administers suppositories	☐ Yes ☐ No				☐ Yes ☐ No			
6.6	Can identify stoma care sites and use correct care products specific to needs of the person, providing rationale	☐ Yes ☐ No				☐ Yes ☐ No			
	Can articulate potential complications associated with stomas and stoma care products	☐ Yes ☐ No				☐ Yes ☐ No			
	Can provide education for self-management of stoma products and facilitates increasing independence in same	☐ Yes ☐ No				☐ Yes ☐ No			
8.2 + 2.7 + 8.5	Can manage the administration of oxygen using a range of routes and best practice approaches, including: • Articulating need for oxygen prescription	☐ Yes ☐ No				☐ Yes ☐ No			
	• Articulating understanding of flow rate and percentage for safe administration	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	• Setting up oxygen administration circuits: ○ Unhumidified circuits (face mask, nasal cannula)	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Humidified circuits	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Nebulisation circuit	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Non-invasive ventilation	☐ Yes ☐ No				☐ Yes ☐ No			
	• Educating people in correct use of inhaler (inhaler technique), including spacer devices	☐ Yes ☐ No				☐ Yes ☐ No			
8.3 + 2.7	Correctly take and interpret peak flow and oximetry measurements	☐ Yes ☐ No				☐ Yes ☐ No			
8.4	Under the direct supervision of an RN uses appropriate nasal and oral suctioning techniques	☐ Yes ☐ No				☐ Yes ☐ No			
9.9	Safely assesses and manages invasive medical devices and lines including: ○ Monitoring site for signs of inflammation/infection	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Care of the site including cleansing and dressing	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Correct labelling (where appropriate) and recording of related care	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Referring appropriately and timely for line replacement	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
10 + 2.7 + 5.9	Observes, and assesses the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including: ○ Pain	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Nausea	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Thirst	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Constipation	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Restlessness	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Agitation	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Anxiety	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Depression	☐ Yes ☐ No				☐ Yes ☐ No			
	Manages and monitors effectiveness of: • Symptom relief medication	☐ Yes ☐ No				☐ Yes ☐ No			
	• Infusion pumps and other devices	☐ Yes ☐ No				☐ Yes ☐ No			
	Assesses and reviews preferences and care priorities of the dying person and their family and carers	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	Understands and applies organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health	☐ Yes ☐ No				☐ Yes ☐ No			
	Understands and applies: • DNACPR (do not attempt cardiopulmonary resuscitation) decisions	☐ Yes ☐ No				☐ Yes ☐ No			
	• Verification of expected death	☐ Yes ☐ No				☐ Yes ☐ No			
	Provides care for the deceased person and the bereaved respecting cultural requirements and protocols.	☐ Yes ☐ No				☐ Yes ☐ No			
11.1	Assesses the person's ability to safely self-administer their own medicines	☐ Yes ☐ No				☐ Yes ☐ No			
11.7 + 11.8	Is competent in medicines calculations and administration relating to • Intraocular medicines	☐ Yes ☐ No				☐ Yes ☐ No			
	• Intraaural medicines	☐ Yes ☐ No				☐ Yes ☐ No			
	• Transdermal/Topical medicines	☐ Yes ☐ No				☐ Yes ☐ No			
	• Injections including: ○ SI unit conversion (e.g. insulin, syringe driver)	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Intramuscular injections	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Subcutaneous injections	☐ Yes ☐ No				☐ Yes ☐ No			

NMC Annex B Ref	Nursing Procedure	Assessment	Registrant's Initials	Date	Practice learning environment	Assessment	Practice Supervisor's Initials	Date	Practice learning environment
	○ Intradermal injections	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Intravenous injections (bolus)	☐ Yes ☐ No				☐ Yes ☐ No			
	○ Intravenous injections (infusion)	☐ Yes ☐ No				☐ Yes ☐ No			
11.9	Under the direct supervision of an RN administers and monitors medications using enteral equipment	☐ Yes ☐ No				☐ Yes ☐ No			
	Observes medical license in preparing medications for enteral administration	☐ Yes ☐ No				☐ Yes ☐ No			
	Can articulate potential complications with enteral administration of medications and how to respond (e.g. tube occlusion, impact on enteral feeding regimens)	☐ Yes ☐ No				☐ Yes ☐ No			

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ADDITIONAL NURSING PROCEDURES ACHIEVED ACROSS PARTS 1, 2 AND 3

THIS NURSING PROCEDURES RECORD MUST BE CARRIED FORWARD IN YOUR NIPAD FOR EACH OF THE THREE PARTS OF YOUR PROGRAMME.

THESE NURSING PROCEDURES ARE NOT MANDATORY TO BE ACHIEVED. THIS IS AN ADDITIONAL RECORD OF ACHIEVEMENT AND ADDITIONAL SKILLS ADDED. THEY MUST BE TAUGHT IN FULL, INCLUDING THE THEORY, BY THE REGISTRANT. SEE THE HANDBOOK FOR FURTHER DETAILS.

Key: Yes: *Student demonstrates achievement to the expected standard*
No: *Student does not yet demonstrate achievement to the expected standard*

Please see the Handbook for further detail on these Keys.

Nursing Procedure (Please write in additional procedures as/if required in the space provided)	**Assessment**	**Registrant's Initials**	**Date**	**Practice learning environment**
Can safely and appropriately undertake defibrillation of cardiac arrest rhythms using the Automated External Defibrillation (AED) mode	☐ Yes ☐ No			
Can undertake safe tracheostomy stoma site care (including change of tapes/securement devices and wound care)	☐ Yes ☐ No			
Safely and appropriately uses endotracheal suction	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Nursing Procedure (Please write in additional procedures as/if required in the space provided)	Assessment	Registrant's Initials	Date	Practice learning environment
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

SECTION 2

ASSESSMENT
(FORMATIVE AND SUMMATIVE)

FORMATIVE ASSESSMENT (TRIPARTITE) – PART 1

This process is completed by the practice assessor, link lecturer/practice tutor and student at defined stages within the part of the programme – approximately halfway through practice learning for this part of the programme. Please refer to the Handbook for further guidance. The purpose of this assessment is to provide formative feedback and direction for the summative assessment.

Practice assessor, please tick (✓) accordingly:

Are there any concerns highlighted in the NIPAD to date?	Yes ☐ No ☐
If yes, is there a sufficient development or action plan in place?	Yes ☐ No ☐ N/A ☐
Are all Records of Discussions complete and authenticated to date?	Yes ☐ No ☐
Is evidence to date authenticated?	Yes ☐ No ☐
Is there sufficient progress for this stage of this part of the course?	Yes ☐ No ☐

Practice assessor, link lecturer/practice tutor and student, following this formative assessment, please provide a summary of progress to date and outline key areas for development in the remaining weeks of practice learning prior to the summative assessment for this part of the course. This should include reference to any issues identified above.

Summary of Progress and Key Areas for Development
Practice assessor comments: *I, the practice assessor, am an NMC registrant, with appropriate equivalent experience for the student's field of practice)* ☐ *Practice assessor's signature:* …… *Date* ……
Link lecturer/practice tutor comments: *I, the link lecturer/practice tutor, am an NMC registrant, with appropriate equivalent experience for the student's field of practice)* ☐ *Link Lecturer/practice tutor's signature:* …… ……. *Date* ……
Student comments: *Student's signature:* …….. ……. *Student ID:*…… *Date* ……

SUMMATIVE ASSESSMENT (TRIPARTITE) – FIRST ATTEMPT – PART 1

This assessment is provisional until all practice hours are completed. It may be reviewed should an issue (professional or otherwise) arise in the time between the assessment and all hours being completed.

This assessment (both attempts) is undertaken by the practice assessor, academic assessor and student towards the end of the final practice learning experience of Part 1, permitting a minimum period of two weeks for a second attempt. Please refer to the Handbook for further guidance. The purpose of this assessment is to determine whether the requirements for progression to Part 2 of the programme have been achieved with sufficient supporting evidence provided.

Student details

Student's name:		Student ID	
Practice learning environment		Date	

Practice assessor, please complete:

Professional Values in Practice Have all Professional Values and Attributes assessments been achieved to date?	Achieved ☐ Not yet achieved ☐
If not yet achieved, please outline the details of any specific concerns below. If achieved, please tick the not applicable box here and put a line across the space below to prevent an entry. N/A ☐	

In considering the types of evidence below, for the related proficiencies to be achieved, all elements of that evidence set must be completed in full and authenticated. If this is the case, please tick ***Achieved*** to indicate that the proficiencies related to that evidence set are achieved. If incomplete or not authenticated, please tick ***Not yet achieved***.

Professional Values in Practice	Achieved ☐	Not yet achieved ☐
Service User/Carer Feedback (3)	Achieved ☐	Not yet achieved ☐
Authenticated Reflections	Achieved ☐	Not yet achieved ☐
Promoting Health and Preventing Ill Health	Achieved ☐	Not yet achieved ☐
Care Documentation	Achieved ☐	Not yet achieved ☐
Quality Improvement in Practice	Achieved ☐	Not yet achieved ☐
Leading and Coordinating Care Episode	Achieved ☐	Not yet achieved ☐
Nursing Procedures (Part 1)	Achieved ☐	Not yet achieved ☐
Health Numeracy & Calculation of Medicines	Achieved ☐	Not yet achieved ☐

Are all Records of Discussions to date complete and authenticated?	Yes ☐	No ☐
Has the student completed their practice learning evaluation?	Yes ☐	No ☐

If any of the above are not achieved or are incomplete, please complete **Action Plan to Achieve Proficiencies Not Yet Achieved**.
If all are achieved, please tick the not applicable box here. N/A ☐.

I **recommend** that the above-named student progresses to Part 2 of the programme	Yes ☐	No ☐
I **do not recommend** that the above named student progresses to Part 2 of the programme at this assessment point.	Yes ☐	N/A ☐

I, the practice assessor, am an NMC registrant, with appropriate equivalent experience for the student's field of practice) ☐

Practice assessor's Signature…… *Date* ……

Student Details

Student's name:		Student ID	
Practice learning environment		Date	

Academic assessor, please tick as appropriate:

At the time of this assessment, the above-named student **may progress** to the next part of the programme, subject to ratification at the Board of Examiners and in line with the course regulations	Yes ☐ No ☐
I, the academic assessor, am an NMC registrant, with appropriate equivalent experience for the student's field of practice) ☐ *Academic assessor's Signature……* *Date ……*	

Practice Assessor Comments (please do not leave blank)

Practice assessor's Signature…… *Date ……*

Academic assessor's comments (please do not leave blank)

Academic Assessor's Signature…….. *Date ……*

Student comments (please do not leave blank)

Student's signature: ……..Student ID:…… *Date ……*

SUMMATIVE ASSESSMENT (TRIPARTITE) – FIRST ATTEMPT – PART 1

Action Plan to Achieve Proficiencies Not Yet Achieved
(Please leave blank if student has achieved as required on the first attempt)

Agreed Action Plan	**Date**	
Learning and Development Needs	**How Will This be Achieved?**	
Date for Review:		

We agree the above points and plan of action

Practice assessor's signature …… *Date* ……..

Academic assessor's signature … …… *Date* ……..

Student's signature: …… *Date* ……

SUMMATIVE ASSESSMENT (TRIPARTITE) – FINAL ATTEMPT – PART 1

Student Details

Student's name:		Student ID	
Practice learning environment		Date	

In which evidence type was there a deficit of evidence to support achievement of proficiencies?

Professional Values in Practice	☐
Service User/Carer Feedback	☐
Authenticated Reflections	☐
Promoting Health and Preventing Ill Health	☐
Care Documentation	☐
Quality Improvement in Practice	☐
Leading and Coordinating Care Episode	☐
Nursing Procedures (Part 1)	☐
Health Numeracy & Calculation of Medicines	☐

Are all Records of Discussions to date complete and authenticated?	Yes ☐	No ☐
Has the student completed their practice learning evaluation?	Yes ☐	No ☐

Is the required evidence now present, authenticated and to standard	Yes ☐	No ☐
I **recommend** that the above-named student progresses to Part 2 of the programme	Yes ☐	No ☐
I **do not recommend** that the above-named student progresses to Part 2 of the programme	Yes ☐	N/A ☐

If ***No***, please provide details:

I, the practice assessor, am an NMC registrant, with appropriate equivalent experience for the student's field of practice) ☐

Practice assessor's signature…….. *Date* ……

Academic assessor, please tick as appropriate:

At the time of this assessment, the above-named student **may progress** to the next part of the programme, subject to ratification at the Board of Examiner's and in line with the course regulations	Yes ☐	No ☐
At the time of this assessment, the above-named student **may not progress** to the next part of the programme, subject to ratification at the Board of Examiner's and in line with the course regulations	Yes ☐	N/A ☐

I, the academic assessor, am an NMC registrant, with appropriate equivalent experience for the student's field of practice) ☐

Academic assessor's signature……. *Date* ……

SUMMATIVE ASSESSMENT (TRIPARTITE) – FINAL ATTEMPT – PART 1

Practice assessor comments (please do not leave blank)

Practice assessor's signature…….. *Date* ……

Academic assessor's comments (please do not leave blank)

Academic assessor's signature…….. *Date* ……

Student comments (please do not leave blank)

Student's signature: ……..*Student ID:*…… *Date* ……

Ulster University

School of Nursing

Specialist Nursing

Practice Learning Handbook

Revised 7 December 2019

Revised September 2016

ULSTER UNIVERSITY
FACULTY OF LIFE AND HEALTH SCIENCES
SCHOOL OF NURSING

SPECIALIST NURSING

PRACTICE LEARNING HANDBOOK

To be used in conjunction with the PRACTICE ASSESSMENT DOCUMENT

Course Director:

[redacted]

CONTENTS

MAHI - STM - 102 - 5662
IMPORTANT CONTACT DETAILS

Practice Learning Office

Rm MG230A
Magee campus

Monday-Thursday:	8.45am to 5.00pm
Friday:	8.45am to 4.00pm
Open for Students*:	**9.00am - 5.00pm (Mon – Fri)**

Sarah Nash
Executive Assistant (Practice Learning)
Email: nursingplacements@ulster.ac.uk
Tel No: [redacted]

School Office

Rm 12J07
Jordanstown campus

Monday - Thursday:	8.45am to 5.00pm
Friday:	8.45am to 4.00pm
Open for Students*:	**9.00am - 5.00pm (Mon – Fri)**
Open on Submission Days:	**9.00am – 4pm**

Lorraine Brownlie School Secretary **Email:** [redacted]

Gaynor McKinley Clerical Assistant **Email:** [redacted]

***These are the times students can attend in person.**
A telephone answering service and email contact are available 24 hours daily, seven days weekly for contact outside of these hours.

TRUST PRACTICE EDUCATION TEAMS FOR SPECIALIST NURSING PROGRAMMES

Trust	Contact
Belfast	**Carol Chambers** Practice Education Co-Ordinator [redacted]
Northern	**Claire Crowe** Practice Education Co Ordinator [redacted]
Southern	**Gail Doak** Practice Education Co Ordinator [redacted]
South Eastern	**Sonya McVeigh** Practice Education Co Ordinator [redacted]
Western	**Carol McGinn** Practice Education Co Ordinator [redacted]

SECTION 1: WELCOME AND BACKGROUND INFORMATION

Welcome and introduction

On behalf of the School of Nursing at Ulster University, we would like to welcome you to the practice component of your specialist nursing programme. We hope that you enjoy this element of your programme and find it both interesting and challenging.

There are two important booklets that guide this practice element of your programme:

- *The Practice Learning Handbook*
- *The Practice Assessment Document*

These two booklets should be read in conjunction with each other.

The Practice Learning Handbook

This Practice Learning Handbook provides you, your practice supervisor(s), practice assessor, and academic assessor with the core information relating to the practice learning component of the programme. In addition, it focuses on setting the context of practice learning and it gives guidance on how the Practice Assessment Document should be used to facilitate learning and development.

The Practice Assessment Document

The Practice Assessment Document is a separate pathway-specific document which is central to your development. It provides the documentation you need to complete during practice learning experiences to demonstrate that you have achieved competency as a specialist nurse. You should use the Practice Assessment Document as the basis for your interaction with your practice supervisor(s) and practice assessor. As you progress through the practice element of this programme, your Practice Assessment Document develops into a collection of evidence that demonstrates how you have applied theoretical knowledge and skills gained in class to your practice learning. It enables your practice supervisor(s), practice assessor, and academic assessor to undertake assessments to verify that evidence of learning exists and that this evidence is consistent with the competencies required for Specialist Practice as set out by the Nursing and Midwifery Council (NMC 2001). The individual components of the Practice Assessment Document will be discussed in more detail in Section 4. You should keep your Practice Assessment Document in a safe place and remember to adhere to guidelines for confidentiality in relation to any evidence you include within it. Your practice supervisor(s) and practice assessor will review your Practice Assessment Document during their meetings with you and at other times as necessary. Your pathway leader will fulfil the role of academic assessor. The academic assessor will work closely with your practice assessor, and appraise both your academic progress and practice development. At the end of your programme you will submit your Practice Assessment Document to Ulster University for moderation and for review by the External Examiner.

The primary responsibility for your learning during this programme is yours. You should use a wide range of resources available to help you. Your practice supervisor will be able to support you to avail of learning opportunities and experiences. It is important to ensure that you gain clinical learning experience regularly throughout the programme so that you develop and consolidate your knowledge and skills and your application of these within the context of specialist nursing practice. Therefore, it is important that you complete your Practice Assessment Document alongside your university based activities, reading and self-directed study.

What is Specialist Nursing?

Specialist nurses require sophisticated analytical ability when a high quality of service is expected. Specialist nursing has been defined by the NMC (2001, p4) and Department of Health (2018) as the exercising of higher levels of judgement, discretion and decision-making in clinical care.

The major focus in your specialist nursing programme is on development of knowledge and skills for the enhanced role of the specialist nurse which is beyond that of an experienced, highly competent nurse within the specialism. This includes activities such as role modelling exemplary practice, occupying a key role within the inter-professional team, practice development, education, service evaluation, research, providing leadership within the specialism, liaising with external agencies, and contributing to policy development within your specialism. This is in addition to being able to plan, provide and supervise high quality patient care. Preparation for this role must meet the Standards for Specialist Education and Practice set by the Nursing and Midwifery Council (NMC 2001), and Career Framework for Specialist Nursing (NIPEC, 2018).

Fostering a Person Centred Culture

The idea of a person-centred culture has been an established focus of the Strategy for Nursing, Midwifery and Health Visiting in Northern Ireland (NIPEC, 2012). As part of this course, you will be expected to demonstrate that you embrace a person-centred culture within all aspects of your work.

Programme structure

You may undertake your specialist nursing programme at BSc (Hons) and Post Graduate Diploma levels. The programme will normally last one year for full time students and two years for part time students. The Specialist Practice Qualification (SPQ) component of 75 days runs alongside this theoretical component. The overall structure of the programme is shown in Figure 1.

References

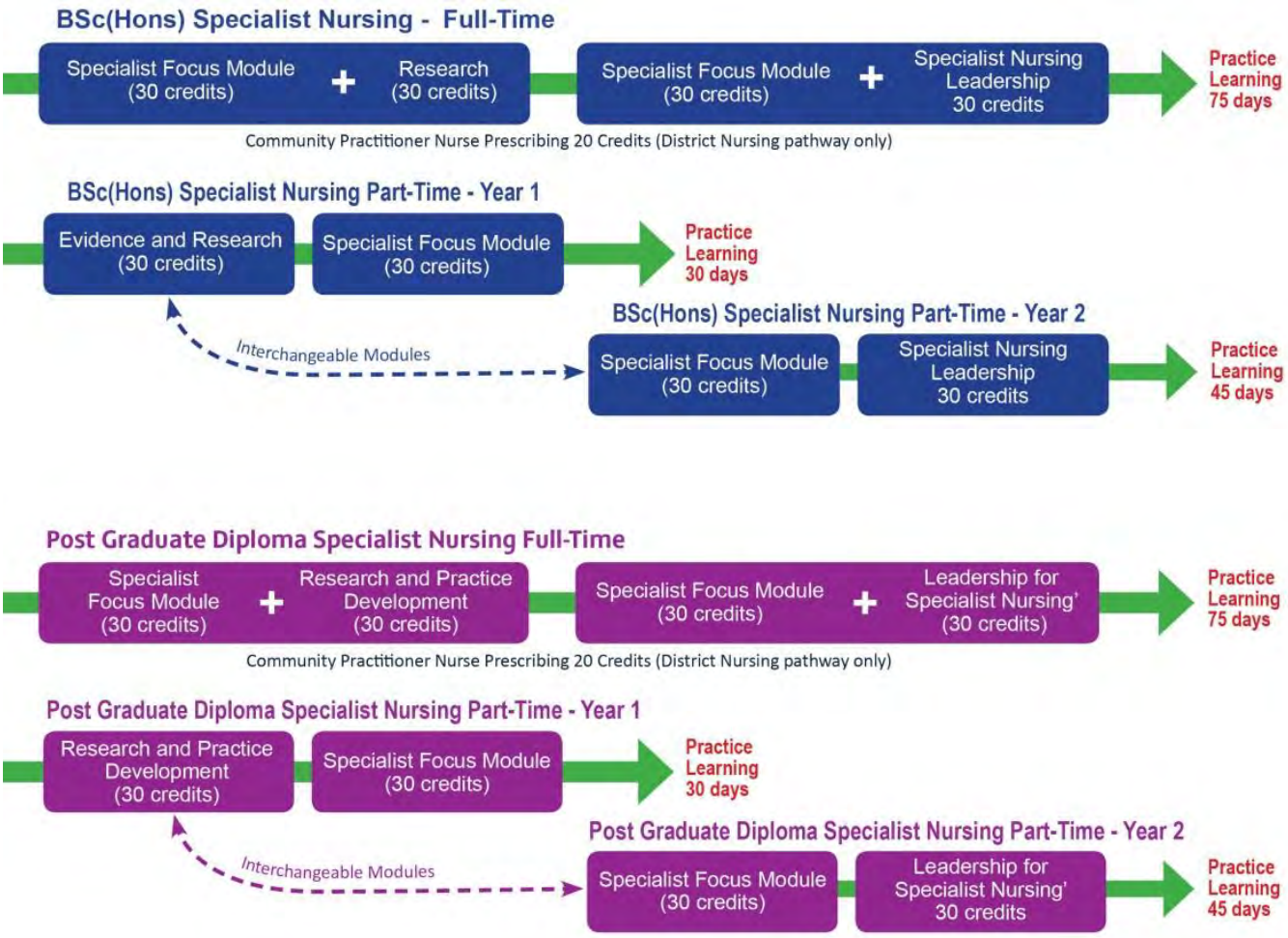
Nursing and Midwifery Council (NMC) (2001) *Standards for Specialist Education and Practice*. London: NMC.

Nursing and Midwifery Council (2018) *The code – Professional Standards of Practice and Behaviours for Nurses, Midwives and nursing associates.* London: NMC.

Nursing and Midwifery Council (NMC) (2018) *Future nurse: Standards of Proficiency for Registered Nurses* and *Standards for Education and Training.* London: NMC.

Department of Health (2018) *Career Framework for Specialist Nursing Roles – Supporting Specialist Nursing in Health and Social Care.* Belfast: DH.

Figure 1: Structure of the Specialist Nursing Programmes (Full-time and Part-Time)



Please note that the order of module provision of undergraduate and post graduate programmes may vary for individual pathways, depending on availability and student numbers. On the part-time programmes, the Research Module and Specialist Focus module are interchangeable, facilitating a student to complete two Specialist Focus Modules in Year 1 of the programme. The Leadership for Specialist Nursing module will normally be offered in Year 2 of part-time programmes.

Support and Resources for Practice Learning

You are expected to make use of the available support and resources to achieve the competencies for Specialist Practice as outlined by the NMC (2001). These resources include:

- Practice Supervisor(s)
- Practice Assessor
- Academic Assessor
- Course Director
- Module Teaching Team
- Other key staff across a range of practice settings
- Learning Resource Centre (LRC)
- Blackboard Learn (BBL)
- Trust Intranet
- Multi-Disciplinary Education Centres in the relevant practice settings

- Ulster University Policies and Procedures available at www.ulster.ac.uk
- School of Nursing website which can be accessed at http://www.science.ulster.ac.uk/nursing/placement/practice_learning.php

  This can be accessed using the following: username: nursing
  password: 1resource

Your Practice Supervisor

Prior to you starting this programme, in conjunction with your Practice Education Team, a practice assessor and a practice supervisor will be identified to support you as you embark on your learning journey. In each care setting that you access to further develop your specialist nursing competencies and skills, the allocation of additional practice supervisors will be guided by your learning needs. It is important that you ensure that the record of additional practice supervisors in your signature log in the Practice Assessment Document are kept up to data. Your practice assessor and supervisor(s) will have been prepared for their role, and will have up-to-date knowledge and experience relevant to your learning needs. It is likely that most of your Practice Assessor and Supervisors will be nurses, however in some learning experiences, it may be appropriate to allocate a Practice Supervisor from a profession other than nursing. In these situations, Practice Supervisors can be any health and social care professional registered with a professional regulator like the NMC, GMC or HCPC.

Your Practice Assessor

Prior to you starting this programme, in conjunction with your Practice Education Team, a nominated practice assessor will be identified to support your progression over a series of learning placements. It is the responsibility of the nominated Practice Assessor to identify the Practice Supervisor and ensure that that they are suitably prepared. Practice assessors for specialist nurse students are registered nurses that have been prepared and supported to take up their role, and have current knowledge and experience relevant for the proficiencies and programme outcomes they are assessing. A practice assessor will assess and confirm your achievement of practice learning, will work closely with the academic assessor to make recommendations regarding your progression through the programme.

Please note that in exceptional circumstances, the same person may fulfil the role of the practice supervisor and practice assessor for example, Prescribing Programmes, Specialist Practice and SCPHN. In such instances, the student, practice supervisor/assessor and the AEI will need to evidence why it is necessary for the practice supervisor and assessor role to be carried out by the same person.

Your Academic Assessor

Prior to commencement of your programme, the course director will identify an academic assessor that has current knowledge and expertise relevant to your specialist nursing programme proficiencies and outcomes. In most cases, this will be the School of Nursing Pathway Leader for your specialist nursing programme. Your academic assessor will liaise with you in capacity of Pathway Leader throughout your programme, and in a formal capacity with your practice assessor at mid-point in your practice learning for formative assessment, and towards end-point to confirm your academic outcomes and achievement across the programme in summative assessment. In addition, your academic assessor will be available to link with your practice assessor, when requested.

Figure 2: Schedule of Academic Assessor Visits on Practice Learning

Access NI Checks

Students on the District Nursing Pathway should have an Access NI check carried out prior to commencement of the programme. You should forward a copy of this to the Faculty Administrative Officer for commissioned programmes. Self-funding students will also be required to have an Access NI check carried out and they should present this to the Course Director prior to starting the programme.

Disability Services

Disability Services at Ulster University are committed to developing an inclusive environment for all students. The School of Nursing encourages you to disclose any disability or medical condition to ensure that appropriate support is arranged for you during practice learning experiences.

All applicants who have a disability are encouraged to make early contact with their Pathway Leader to discuss where they might need assistance in order to meet the programme requirements. Where reasonable adjustments are identified by Disability Services or Occupational Health, processes are in place within the School to apply agreed reasonable adjustments in both theoretical and practice learning components of the programme.

Discussions about how the requirements could be met, through making *'reasonable adjustments'* within the scope of the Disability Discrimination (Northern Ireland) Order (2006), enables both you, and the School to come to a realistic decision about progression and support. Practice learning providers would be involved in making such decisions because of the implications of making adjustments to practice environments where this may be required.

Quality Assurance

The School of Nursing aims to be responsive to health service needs, to feed forward from a wide range of sources, and to be innovative in continually improving quality. With reference to practice learning, a number of methods are used to obtain feedback and modify the programme accordingly:

- Staff/student consultation meetings involve Ulster staff and students. These enable you to raise any issues of concern related to your programme and to discuss ways of making improvements. Minutes of these meetings are forwarded to the Course Committee for consideration.

- Course Committee meetings are held each semester to which practice partners and student representatives are invited.
- Commissioning Manager Liaison meetings involving all partners are held regularly.
- Practice Assessment Documents are moderated and externally reviewed. This helps to ensure reliability and validity of assessment processes.
- External Examiners ensure that the quality and programme provision meets the required standards. Their key functions are to contribute to the assurance of the standards of the award and the fair treatment of students. They are involved in the moderation and approval of assessments both in the theoretical and practice modules, and in the moderation of the marking undertaken by internal examiners. External Examiners visit practice learning settings annually.
- Practice learning settings are audited prior to learning experiences to ensure a high quality of learning environment. This Educational Audit takes place collaboratively with the Manager, Pathway Assessor and Practice Education Facilitator, where relevant.
- Practice learning experiences will be evaluated annually by students.
- Practice Education Teams exist to support Practice Supervisors and Practice Assessors and ensure quality of supervision given to students during practice learning. In the Independent Sector this support is provided by the Academic Assessor.

Fitness for Practice

Where there are concerns about a student's attendance, health or behaviour in academic or practice learning settings, the matter shall initially be discussed between the Student, Practice Supervisor, Practice Assessor, Course Director and Academic Assessor. Referral to the Fitness for Professional Practice Committee (as specified in Ordinance XLIV, 2010-2011) may be necessary and this may result in the student being withdrawn from the programme. This process may be instigated at any time in the academic year.

If students are withdrawn from practice learning at the request of the practice learning provider, for example, due to unsafe practice, written evidence of the circumstances leading to this indicating clearly the grounds for withdrawal must be obtained. The 'Record of Discussions' – Additional Practice Assessor documentation from the Practice Assessment Document should be completed. If appropriate, the Formative or Summative Assessment (relevant to the stage of the programme) is completed. These documents may provide grounds for referral to the Faculty Fitness for Practice Committee or for failure in practice learning which will be dealt with through the normal examination processes.

Plagiarism in the Practice Assessment Document

Plagiarism is a recognised and growing issue across all levels of student work within the University and across other institutions in the UK. In an attempt to counteract this trend, it is important that you adher to School of Nursing policy on plagiarism. Key aspects of this are outlined in the Programme Handbook. You are reminded that plagiarism is defined as professional misconduct and all cases, including first time offences, will be automatically referred to the Faculty Fitness for Practice Committee. When you submit your Practice Assessment Document, you will be required to sign a declaration of originality. You are expected to adopt good academic practice in referencing your materials and sources throughout the Practice Assessment Document, and should adher to the Faculty Referencing Guidelines.

Signature Log

Any person who signs or authenticates the validity of work in your practice assessment document must enter their information into the Signature Log. This is essential to ensure that any signatures can be traced, and it is your responsibility to maintain this Log.

SECTION 2: INTRODUCTION TO PRACTICE LEARNING

Practice Learning Experiences

Practice learning experiences are required to meet educational standards as detailed in the Nursing and Midwifery Council (2018) *Future nurse: Standards of Proficiency for Registered Nurses* and *Standards for Education and Training,* and Department of Health (2018) *Career Framework for Specialist Nursing Roles – Supporting Specialist Nursing in Health and Social Care,* and therefore practice learning must take place within an audited and approved environment.

Your specialist nursing programme at Ulster University requires you to complete a 75-day practice learning period where you will work under the direct or indirect supervision of the Practice Supervisor(s). During these 75 days you are supernumerary. This period of practice learning will allow you to gain experience in achieving the competencies. Practice learning experiences will be parallel with your theoretical component. Your Practice Assessor will work closely with your Academic Assessor to ensure that your achievements are collated and confirmed. Following successful achievement at Summative Assessment, you will submit your Practice Assessment Document to Ulster University. The programme regulations stipulate that the academic award is wholly dependent on completion and submission of your Practice Assessment Document.

Aim

The aim of the 75-day practice learning period is to facilitate you in achieving your specialist nursing competencies for the award of a recordable qualification in one of the following:

- Adult Nursing
    - Emergency Care
    - Diabetes
    - Stroke
    - District Nursing (with integrated nurse prescribing)
    - Adult Specialist Nurse (previously Nurse Practitioner)
    - Palliative Care
- Learning Disability Nursing
- Community Learning Disability Nursing
- Community Children's Nursing
- Mental Health Nursing
- Community Mental Health Nursing.

Outcomes – Competencies for Specialist Education and Practice

During practice learning experiences you are expected to focus on learning in four broad areas as set out in the Standards for Specialist Education and Practice (NMC 2001), and these are clinical practice; care and programme management; clinical practice leadership; and clinical practice development. The 7 platforms of proficiency for Future Nurse (NMC, 2018) are mapped to the four areas in Table 1 below. Specific pathways may have additional key indicators, and these will be included in your Practice Assessment Document.

Table 1: The 7 platforms of Proficiency mapped to Competencies for Specialist Education and Practice

AREA	COMPETENCY
Clinical Practice Assessing needs and planning care Providing and evaluating care	C1.1 Assess health, health related and nursing needs of patients or clients, their families and other carers by identifying and initiating appropriate steps for effective care for individuals and groups. C1.2 Set, implement and evaluate standards and criteria of nursing intervention by planning and providing and evaluating specialist clinical nursing care across a range of care provision to meet the health needs of individuals and groups requiring specialist nursing. C1.3 Assess and manage critical and clinical events to ensure safe and effective care. C1.4 Support and empower patients and clients, their families and other carers to influence and participate in decisions concerning their care by providing information on a range of specialist nursing care and services. C1.5 Facilitate learning in relation to identified health needs for patients, clients and carers. C1.6 Provide counselling and psychological support for individuals and their carers. C1.7 Act independently within a multi-disciplinary/multi-agency context. C1.8 Support and empower patients, clients and their carers to influence and use available services, information and skills to the full and to participate in decisions concerning their care.
Care and Programme Management Promoting health and preventing ill health Being an accountable professional	C2.1 Supervise and manage clinical practice to ensure safe and effective holistic research-based care. C2.2 Initiate and contribute to strategies designed to promote and improve health and prevent disease in individuals and groups by identifying and selecting from a range of health and social agencies, those that will assist and improve care. C2.3 Recognise ethical and legal issues which have implications for nursing practice and take appropriate action.
Clinical Practice Leadership Leading and managing nursing care and working in teams Coordinating care	C3.1 Lead and direct the professional team clinically, to ensure the implementation and monitoring of quality assured standards of care by effective and efficient management of finite resources. C3.2 Identify individual potential in registered nurses and specialist practitioners, through effective appraisal systems. As a clinical expert, advise on educational opportunities that will facilitate the development and support of their specialist knowledge and skills to ensure they develop their clinical practice.

AREA	COMPETENCY	
	C3.3	Ensure effective learning experiences and opportunity to achieve learning outcomes for students through preceptorship, mentorship, counselling, clinical supervision and provision of an educational environment.
Clinical Practice Development Improving safety and quality of care	C4.1	Create an environment in which clinical practice development is fostered, evaluated and disseminated.
	C4.2	Identify specialist learning activities in a clinical setting that contribute to clinical teaching and assessment of learning in a multi-disciplinary environment within scope of expertise and knowledge base.
	C4.3	Initiate and lead practice developments to enhance the nursing contribution and quality of care.
	C4.4	Identify, apply and disseminate research findings relating to specialist nursing practice.
	C4.5	Explore and implement strategies for quality assurance and quality audit. Determine criteria against which they should be judged, how success might be measured and who should measure success.

References

Nursing and Midwifery Council (NMC) (2001) *Standards for Specialist Education and Practice*. London: NMC.
Nursing and Midwifery Council (NMC) (2018) *Future nurse: Standards of Proficiency for Registered Nurses* and *Standards for Education and Training.* London: NMC.

ROLES AND RESPONSIBILITIES

You, your practice assessor, practice supervisor(s) and your academic assessor each have specific roles and responsibilities and all should work collaboratively for the successful completion of this practice learning element of the programme. As this experience is focused on your learning, however, the main responsibilities lie with you – the student.

Your roles and responsibilities as a Student:

- With your practice assessor, undertake the baseline assessment of NMC competencies and then plan out your practice learning experiences and which competencies you aim to achieve.
- You should develop and maintain a learning log. This should be completed on a weekly basis, and together with evidence of learning and development, these will form the basis of discussions with your practice supervisor(s).
- It is your responsibility to complete the different components of the Practice Assessment Document as you progress through the programme. It is essential that all sections are completed correctly.
- You must ensure that you present a Practice Assessment Document that is an up to date record of your learning and development at formative and summative assessments.
- You should meet with your practice supervisor and your practice assessor if you are confronting challenge in gaining the necessary experience to develop the skills needed for the role of a specialist practitioner in your field of nursing.
- You should ensure that your experience is planned to cover the range of work that you will be undertaking on completion of the programme.
- You must ensure that as the programme progresses, you are developing evidence to support achievement of your competencies, and that these are signed off by your practice supervisor and verified as achieved by your practice assessor.
- You must ensure that your Practice Assessment Document and the evidence within it is kept safe. This document contains important information for you, your practice assessor, your practice supervisor and your academic assessor.
- At approximately 4-weekly intervals, review your progress, discuss the competencies to be achieved, and develop a Learning Contract as necessary with your practice supervisor.
- You must complete specified reflections, worksheets and learning activities to demonstrate evidence of proficiency in specified NMC specialist nursing competencies. These are available to you in the Practice Assessment Document, and pertain to:
  - Professional and Ethical Values
  - Communication and Relationship Management for optimising outcomes for people and their families/carers
  - Health Education
  - Leading and Coordinating Specialist Care Episodes
  - Reflective practice
  - Care Documentation
  - Leadership for Practice Development
  - Service User/Carer Feedback

- Ensure that evidence is authenticated by your practice supervisor, and compiled in Practice Assessment Document.

- Keep the log of the experience that you obtain, up-to-date. This will enable your practice assessor and academic assessor to review that you are making satisfactory progress and provide support where appropriate.

- Reflect on your practice throughout all your practice learning experiences as this will enhance your learning and your professional development.

- On successful completion of the Summative Assessment towards the end of the programme, you must ensure that your Practice Assessor and your Academic Assessor sign the Declaration of Competence. This is done through a tripartite process with you.

- Once the Declaration of Competence has been completed, you must retain the original for your records, and submit a copy of the signed Declaration of Competence to the Practice Learning Office.

- You must submit your completed Practice Assessment Document into the University within the time span agreed by with the Course Director.

Roles and responsibilities of the Practice Supervisor(s):

- To provide support and supervision to you as you develop your skills across the spectrum of competencies related to your field of practice.

- To act as a role model and provide teaching/learning opportunities as appropriate.

- To provide constructive feedback as appropriate and to identify areas for development through an agreed learning contract.

- To support and supervise you in the practice learning environment(s), with particular attention to public protection, equality and diversity needs.

- To familiarise herself/himself with, and understand, the requirements of the competencies.

- To participate in the negotiation of your learning contracts for the practice learning experience.

- To assess your competence and record your development in the different aspects of the competencies to be achieved through direct observation and scrutiny of the documentation.

- To help you increase your understanding of the way your new role is integrated into your practice setting and to help you resolve any challenges with the acceptance of the role by others in the team.

- To participate in pre-arranged meetings with you and your Practice Assessor to discuss and verify progress.

- To effectively inform and provide support for you if you are unable to achieve competence in certain skills and to indicate this to the Practice Assessor as early as possible.

Roles and responsibilities of the Practice Assessor:

- To undertake your initial baseline assessment.
- To review the learning contract(s) prepared by you and your Practice Supervisor and ensure that you are facilitated to meet the agreed outcomes.
- To keep up to date with your supervision support while on practice learning experience.
- To provide support and guidance necessary for you and your practice supervisor.
- To actively engage with you and your practice supervisor to support a process of continuous assessment.
- To ensure that the process of continuous assessment is evidence based, objective and fair, taking into account a variety of views and inputs, and student diversity, such as different learning styles, cultural backgrounds and communication styles.
- To feedback to you about your achievement(s), and collaborate with you, to review possible areas for improvement.
- To arrange dates for meetings with you and your practice supervisor to collate and verify evidence of achievement of specified competencies.
- To work closely with the academic assessor to make recommendations regarding your progression through the programme.
- To assess and confirm your achievement of practice learning, ensuring that assessment documentation is completed, and any issues of concern are escalated.
- To arrange dates for meetings with you and your academic assessor for your formative assessment and summative assessments.
- To work closely with the academic assessor to take into account your history of achievement across theory and practice.
- To assess your overall performance in practice learning in formative and summative assessment, taking account of whether or not the NMC specialist nursing competencies have been met, and if the evidence displays the required values of specialist nursing.

Roles and responsibilities of the Academic Assessor:

- To assess/reassess the suitability of the practice learning facility as a learning environment by completing an ‘Educational Audit for Practice Learning’ form in collaboration with the facility Manager and Practice Education Team (where relevant).
- To liaise with your identified Practice Assessor and ensure that he/she understands the programme, competencies to be achieved and the assessment strategy.
- To inform you, your practice supervisor and your practice assessor of the most effective means of contacting her/him if difficulties arise.
- To act as your Studies Adviser and correspondingly meet with you on a termly basis at Ulster University to discuss your academic as well as your practice learning progress.

- To monitor the Formative and Summative Assessments, and collate and verify academic achievement for the stage of the programme.

- To collate and confirm student achievement in the academic environment across the programme, ensuring that the process is based on continuous assessment and information which is objective and fair.

- To feedback to you about your achievement, and work with you to review possible areas for improvement, in line with Ulster University processes.

- To make a judgment about your achievement in academic learning, taking into account your history of achievement throughout the programme and across theory and practice.

- To sign the Declaration of Competence as a Specialist Practitioner when satisfied that there is authenticated evidence that demonstrates that you have achieved all the required competencies.

Your Course Director

The Course Director has overall responsibility for the management and delivery of the theoretical and practice learning components of the programme. This includes all aspects of quality assurance, management of the Course Committee, Staff-Student Liaison Committees, Programme Induction, annual Practice Assessor, Practice Supervisor updates, Accreditation for Prior Learning (APL) assessment, communication with the External Examiner, Examination Boards, decisions about student progress and awards including communication with the Nursing and Midwifery Council when required. The Course Director should be made aware of any difficulties you are experiencing so that swift action can be taken and your progress on the programme is not affected. Good communication with your Course Director throughout the programme is necessary.

Organisation and location of practice learning experiences

At the outset of the programme you will have an Initial Discussion with your practice assessor where you will complete a Baseline Assessment of competencies (these are at the back of your Practice Assessment Document). This will help you identify which competencies you will need to address during your practice learning experience. Along with your practice assessor, you will plan your 75 days of practice learning experience to meet these competencies. You must use the Practice Learning Planner in your Practice Assessment Document to identify these 75 days. An example of how to complete this is provided to you in the Document. Once you have planned your 75 days, you should consult with your Practice Education Team who will help you organise these days. Please note that 1 day of practice learning is 8 hours. That means that 75 days gives you a total of 8 hours x 75 = 600 hours of practice learning.

The majority of your practice learning experiences will take place within your own area of employment in your own Trust. However, if there is a specific learning experience that you need to acquire which is not available within your own Trust, then the Practice Partner Agreement facilitates Health and Social Care Trust staff to avail of practice learning experiences in other Health and Social Care Trusts across Northern Ireland. These experiences in other Trusts can only be arranged by the Practice Learning Office staff at Ulster University, on receipt of the completed Practice Learning Planner emailed by the student. The email address is at the front of this Handbook. Please note that there can be a delay from receipt of request to approval.

Self-funding students and staff from the Independent Sector ***must*** organise all their learning experiences in consultation with their practice assessor and the Practice Learning Office at Ulster University. In this case, once the Practice Learning Planner has been discussed with your Practice Assessor at your Initial Discussion, the completed Planner must be submitted to the Practice Learning Office where placement days are outside the employer setting. The e mail address is at the front of this Handbook. Practice Learning Office staff will then organise your practice learning experiences for you. Please note that there can be a delay from receipt of request to approval.

It is important that you clearly identify practice learning days and times so that you can specifically focus on ***your*** development within the programme. It is very easy when you are gaining your clinical experience within your own workplace to become caught up with the everyday demands and risk your own learning needs being set aside and thus, not met. For that reason, during your practice learning experiences ***you must be supernumerary***.

Recording your practice learning experiences

It is vitally important that you keep an up-to-date record of your 75 days of practice learning in order to demonstrate that you are achieving the necessary number of hours. You must record your experiences on the Record of Practice Learning Completed form in your Practice Assessment Document. See Figure 3 for an example of how to complete this form. On the final page, you should total these days to ensure you have completed your 75 required days.

Figure 3: Record of Practice Learning Completed

RECORD OF PRACTICE LEARNING COMPLETED

Please provide details of each of the 75 days of practice learning to confirm you have met the NMC requirements for Specialist Nursing (NMC 2001).

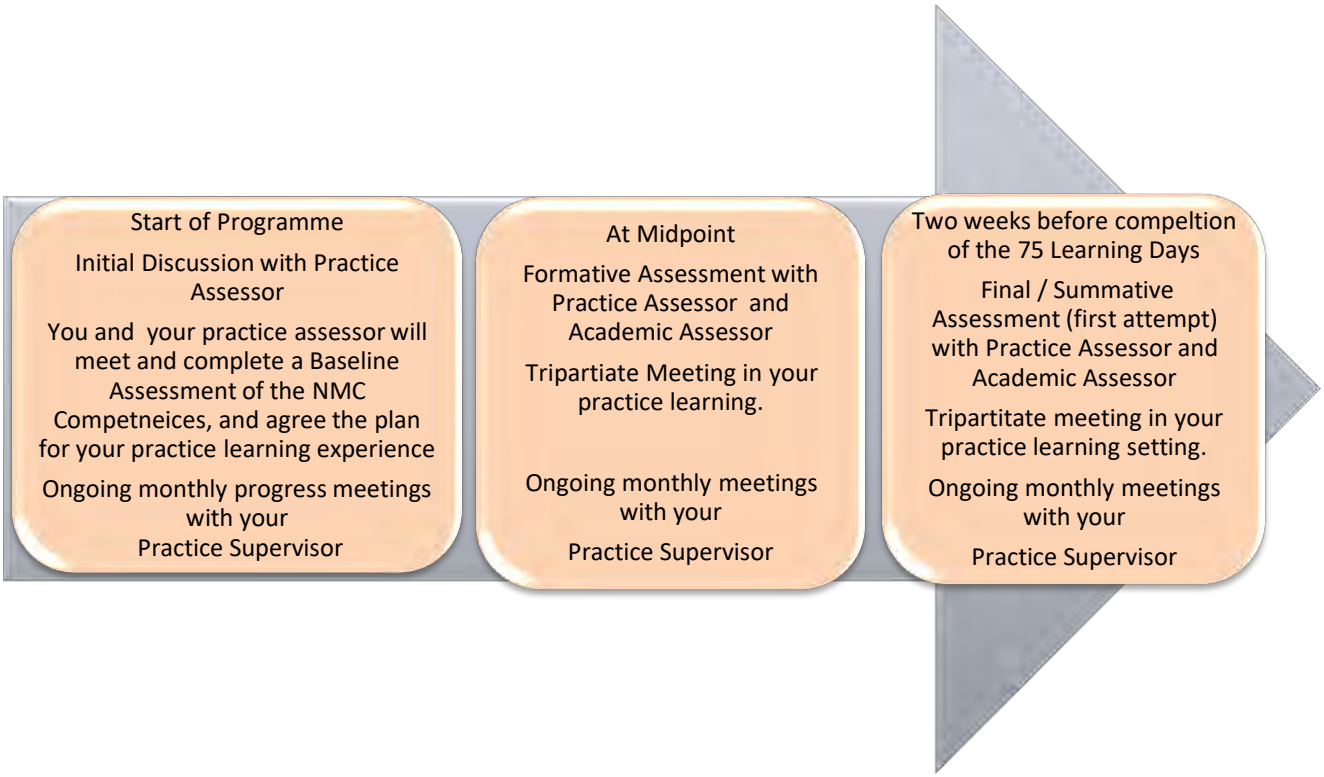
Number of days	Dates of practice learning	Practice learning experience	Competencies addressed during this experience
3	13, 14, 15 January 2015	Burns Unit, District Hospital	C1.1, C1.2
2	26, 27 January 2015	Sunnyvale Youth Unit	C1.10, C3.2
Overall total number of practice learning days: 75			

Your Practice Learning Journey

Your Practice Learning Journey begins with an Initial Discussion, which should take place between you and your practice assessor at the beginning of your programme. At this meeting you should complete the Baseline Assessment of NMC Competencies. You will also discuss and develop:

- Clarification of roles
- Expectations of your behaviour during practice learning experiences
- A plan for 75 days using the Practice Learning Planner
- Learning Contracts
- Clarification on collecting and authenticating evidence using the templates within the NIPAD
- Dates for your monthly progress meetings with your Practice Supervisor
- Approximate dates for your Formative Assessment at midpoint through the programme, and for your Summative Assessment towards endpoint of the programme.

Figure 4: Summary of meetings during your practice learning experience



SECTION 3: THE ASSESSMENT PROCESS

Assessment of Practice Learning Across the Programme

Assessment processes will be continuous, as guided by the NMC (2018) *Future nurse: Standards of Proficiency for Registered Nurses* and *Standards for Education and Training*. The Practice Assessment Document highlights the NMC competencies, including the additional specific competencies and indicators that are required for some pathways. Your monthly progress meetings with your practice supervisor are ideal opportunities to review what progress is being made, and for your practice supervisor to confirm supporting evidence and sign off competencies that have been achieved. You and your mentor at intervals may wish to invite your practice assessor to a progress meeting to enable her/him to keep informed about your progress. The Midpoint (Formative) Assessment is completed midway through your practice learning, and the Final (Summative) Assessment (towards end of practice learning) are tripartite formal meetings, with you, your practice assessor and academic assessor all being present, see Figure 5. Evidence of achievement to date must be signed, available and up to date, in your Practice Assessment Document, as it will be appraised and verified at these meetings.

Figure 5: Summary of The Assessment Process

Completing Your Tripartite Midpoint (Formative) Assessment

Your Tripartite Midpoint Assessment should be completed halfway through the 75 practice learning days, between days 35 and 40.

Stages of a Tripartite Midpoint Assessment

This is a formative assessment and should follow the process outlined below:

1. You, your Practice Assessor and Academic Assessor should agree a date and time to undertake the Formative Assessment. This will need commitment from all parties to dedicate time to undertake the process.

2. You are responsible for providing all of the Practice Assessment documentation to date, set out in a logical order.

3. You must liaise with your practice supervisor to ensure that supporting evidence to date is confirmed, signed and dated.

4. You, your Practice Assessor and Academic Assessor should:

a. Review your achievement towards the competencies and determine whether there is sufficient evidence to support their achievement.
b. Verify and record the competencies that you have achieved in the Formative Assessment Report.
c. Provide you with constructive feedback about your progress.
d. Record a summary of key areas for development in order for you to progress with achieving your competencies.
e. In collaboration with your practice supervisor, complete the Student Development Action Plan – if there are concerns about your performance. A review date should then be agreed.

Completing a Final (Summative) Assessment

The Final Assessment (First attempt) is completed two weeks prior to completion of the 75 days of practice learning.

Stages of a Final Assessment

The Summative Assessment should follow the process outlined below:

1. You, your Practice Assessor and the Academic Assessor should agree a date and time to undertake the Summative Assessment. This will need commitment from all parties to dedicate time to undertake the process.

2. You are responsible for providing all of the portfolio documentation to date, set out in a logical order.

3. You must liaise with your practice supervisor to ensure that supporting evidence to date is confirmed, signed and dated, and that all competencies achieved to date are signed off using the Summative Assessment of competencies documentation by your practice supervisor(s).

4. You, your Practice Assessor and the Academic Assessor should:

    a. Review your achievement towards **all** the competencies and determine whether there is sufficient evidence to support their achievement. All competencies must be achieved and have sufficient supporting evidence.
    b. Provide you with constructive feedback.
    c. Your Practice Assessor should collate and verify the Summative Competency Verification.
    d. Complete and sign all required documentation relating to the Summative Assessment.
    e. When satisfied that all competencies have been achieved, sign the Declaration of Competence.
    f. Report outcome of Summative Assessment (First Attempt and where necessary Final Attempt) to the course director.
    g. Have open communication regarding any failure to achieve all the competencies at Summative Assessment First Attempt. Document clearly the competencies that have not been achieved. In collaboration with your practice supervisor, complete a Student Development Action Plan, and agree a date for review of the plan, and for the Summative Assessment Final Attempt.
    h. Where there is failure to achieve all the competencies at the Summative Assessment Final Attempt, sign box 2 of the Declaration of Competence. It is important that you communicate with your course director following an unsuccessful Summative Assessment, and avail of University Student Support Services if this would be helpful to you.

Following Final Assessment

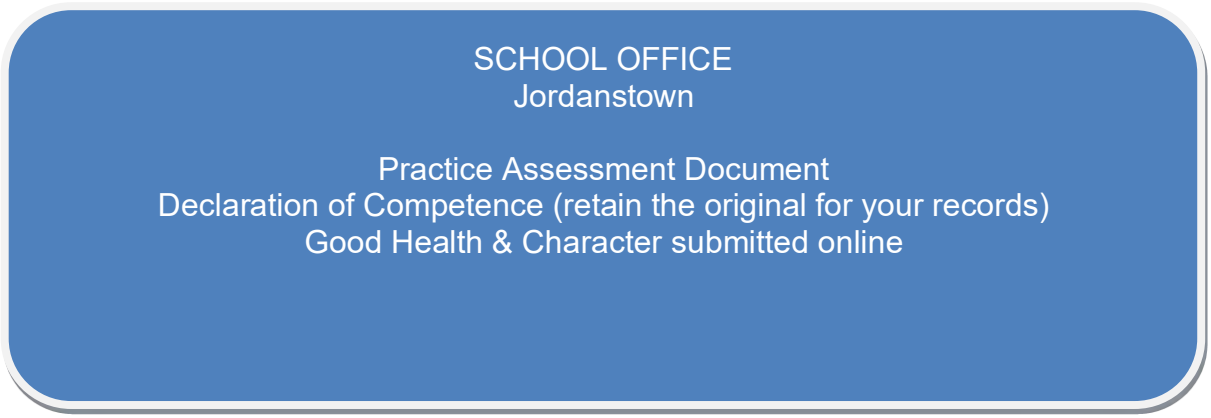
On completion of the summative assessment, you are required to submit the completed NIPAD to the Black Board NUS 530 within the deadline agreed by your Course Director:

1. Practice Assessment Document including the signed and completed Declaration of Competence (retain the original for your records)
2. The NMC Exit Self Declaration of Health and Character must also be submitted online at this time

Once your Practice Assessment Document is submitted, you will be given a receipt which you should carefully retain as proof of submission. Your Academic Assessor will then arrange for Practice Assessment Documents from your pathway to be moderated, and following this, to be reviewed by the External Examiner.

A summary of the submission expectations is given in Figure 6.

Figure 6: Summary of work to be submitted following the Summative Assessment



Board of Examiners

Following submission of your Practice Assessment Document, the result will be processed at the Board of Examiners at Ulster University. Should you not achieve the level of competency as indicated in the Practice Learning Handbook and Practice Assessment Document at Summative Assessment on Final Attempt, you will be required to withdraw from the programme following recommendation of the Board of Examiners.

SECTION 4: GUIDELINES FOR PRACTICE ASSESSMENT DOCUMENT DEVELOPMENT

Using the practice assessment document to structure learning in practice

Your Practice Assessment Document is a formal tool used by you, your practice assessor and practice supervisor to structure your learning as you progress towards competence in your area of specialist nursing. It has been developed to assist you in gaining the maximum benefit from practice learning through:

- *providing information and guidance about the activities you are expected to undertake in each practice learning experience;*
- *providing evidence of development in your ability to use reflection on practice to aid learning and enhance your practice;*
- *providing a record of developing competence in the practice of nursing through the use of learning contracts, and specified learning activities and worksheets, and other sources of evidence;*
- *maintaining a record of your achievement of the specific competencies required for your chosen Pathway.*

The following sections will outline how you can develop your Pathway Document in the following important areas:

- Competency development
- Collecting and developing a portfolio of evidence, that includes:
    - Learning contracts
    - Professional and Ethical Values
    - Communication and Relationship Management for optimising outcomes for people and their families/carers
    - Health Education
    - Leading and Coordinating Specialist Care Episodes
    - Reflective practice
    - Care Documentation
    - Leadership for Practice Development
    - Service User/Carer Feedback

Competency Development

The competencies are derived from NMC Standards for Specialist Education and Practice (2001). Each competency is to be applied in the specialist context, with evidence of achievement to be presented derived from an evidence-based application of knowledge and understanding. You will already be registered as a nurse on a particular field of practice. To progress to specialist level you are expected to evidence a higher level of decision making in your practice. Progress towards this goal must be frequently reviewed by you, and your practice supervisor, and also by your practice assessor.

At your Initial Discussion, you are required, in conjunction with your practice assessor, to complete a Baseline Competency Verification. This identifies your current level of proficiency for each competency. Based on this, you can determine your plan of experiences that will help you achieve your competencies over your 75 days practice learning.

If you and your practice assessor consider you already have proficiency for a particular competency which has been mapped against the NMC (2001) Specialist Nursing Standards, you need to produce evidence of this. You should include detail, both what the evidence is and where it can be found in

the Practice Assessment Document. Evidence should be clearly labelled and contained within the relevant Appendix at the back of the Practice Assessment Document.

In preparation for the Formative Assessment, and again at the Summative Assessment you should, in conjunction with your practice assessor and practice supervisor revisit your development in achieving your competencies. The specified worksheets and learning activities, that have been completed to date, must be discussed with and authenticated by your practice supervisor, and compiled in the Practice Assessment Document, as evidence of achievement of specified competencies.

Once your practice assessor is satisfied that the evidence is of a standard that demonstrates specialist competency, then she/he will sign off the Formative Competency Verification and finally, the Summative Competency Verification.

Collecting and developing a practice assessment document

Your Practice Assessment Document must demonstrate achievement of competency in specialist nursing. A range of sources of evidence can be used to illustrate this (see Figure 7), and these are integrated into the other records outlined in the Practice Assessment Document. Evidence should be discussed with, and agreed with your Practice Assessor and Practice Supervisor.

Presenting Your Evidence

The evidence to support achievement of competencies, is listed below. Please ensure that you label these evidence records according to the specified competencies and place at the end of the Practice Assessment Document.

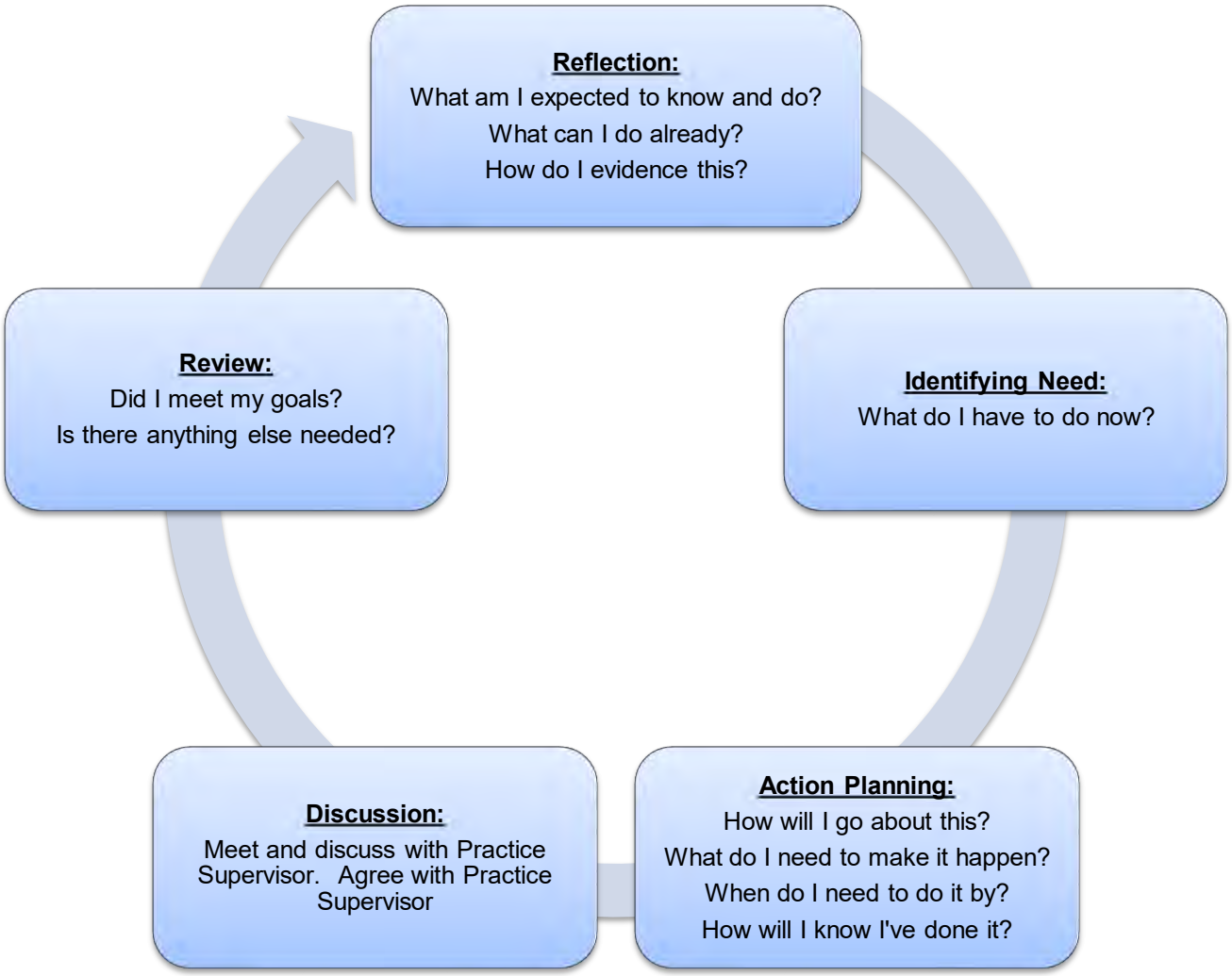
- **Professional and Ethical Values**
- **Communication and Relationship Management for optimising outcomes for people and their families/carers**
- **Health Education**
- **Leading and Coordinating Specialist Care Episodes**
- **Reflective practice**
- **Care Documentation**
- **Leadership for Practice Development**
- **Service User/Carer Feedback**

Learning Contracts

Practice learning is a key component of this programme and in order to identify your learning needs, you should complete a learning contract at intervals as you move through the programme. The use of such a contract also ensures that you, and your Practice Supervisor remain focused on your competencies while you are gaining this experience. If you will be gaining the required experience within your normal workplace, it is important to ensure that you have the necessary safeguarded time for your learning and the learning contract will help to facilitate this.

You should begin to prepare your learning contracts before starting any designated learning experience outside of your normal area of role or work setting. This will involve reflecting on your learning needs for that particular learning experience. As you move through the experience and develop your skills, the learning contracts will reflect your changing learning needs.

Figure 7: The Learning Contract Cycle



Sometimes you may need additional resources to help you achieve a specific competency, for example dedicated time with other members of the multidisciplinary team. All these requirements should be specified in your learning contract so that your practice assessor(s) can make the necessary arrangements. To ensure that you remain focused on your competencies, it is important that you set target dates and also specify the way in which your achievement of a particular competency will be evaluated. Figure 8 illustrates how a learning contract should be set out.

Figure 8: Example of a Learning Contract

Competency *What do I have to achieve?*	**Action Plan** *How will I achieve this?*	**Resources** *What do I need to achieve this competency?*	**Target Date** *When do I need to achieve this by?*	**Evidence of Achievement** *How do I know that I achieved this competency?*
Competency 1.7 **Act independently within a multi-disciplinary / multi-agency context** Work autonomously and demonstrate leadership within a multi-disciplinary / multi-agency teams, ensuring a person-centred approach to patient care is reflected in all decision making about care. In collaboration with the multi-disciplinary team, assess and manage hazards that affect patient flow within the emergency department and the wider organisation.	Identify and liaise with key members of the MDT Attend MDT meetings Identify key external agencies and explore their roles and responsibilities Contribute and ultimately organise and chair MDT meetings under supervision of Sign-off Mentor. Utilise external agencies in my daily role Engage with training in the patient flow system	Access to Practice Supervisor Access to multi-disciplinary team experiences Access to patient flow system Protected time for supervised practice Contact with relevant external agencies	31st May 2020	I have been deemed competent by my Practice Assessor I have completed a reflection on a MDT meeting that I chaired (see MDT Reflection) I now regularly play a key role in lead in MDT referrals and meetings I am aware of key external agencies and can refer patients when appropriate (see referral documentation) I am competent in managing patient flow within the emergency department

We have discussed the above Learning Contract and agree that the proposed actions are relevant to the expressed learning needs of the student and the required competencies.

Student Name:_____ Student ID:_____ Student Signature:_____ Date: _____

Practice Supervisor Name:_____ Practice Supervisor Signature:_____ Date: _____

Reflective Diary – Guidelines

The reflection process has developed over time and is used widely in nursing. It is recognised as a valuable learning method, providing fresh insights that enable nurses to enhance health care practice and thus improve the quality of care. The reflective diary is a personal account of your experiences. The information recorded will help you focus on your thoughts, feelings and actions in practice, with a view to improvement. There are no specific times for completing the diary, however, at the end of each day of practice learning take time to reflect on the following:

- How do you feel about the practice learning area in which you are working? Is it suited to your learning needs in the programme?
- This is a challenging programme, how do you feel about the progress you are making? If you feel you are not making progress please contact your Practice Supervisor, your Practice Assessor, your Academic Assessor / Course Director as soon as possible.
- Note any specific issues that have arisen from your practice learning experiences in relation to discussions in class.

You may find that you do not have any comments to make on these points but you are encouraged to keep using your diary as a learning tool to facilitate professional development, select events and situations which are of particular significance to you. The following criteria may assist this process:

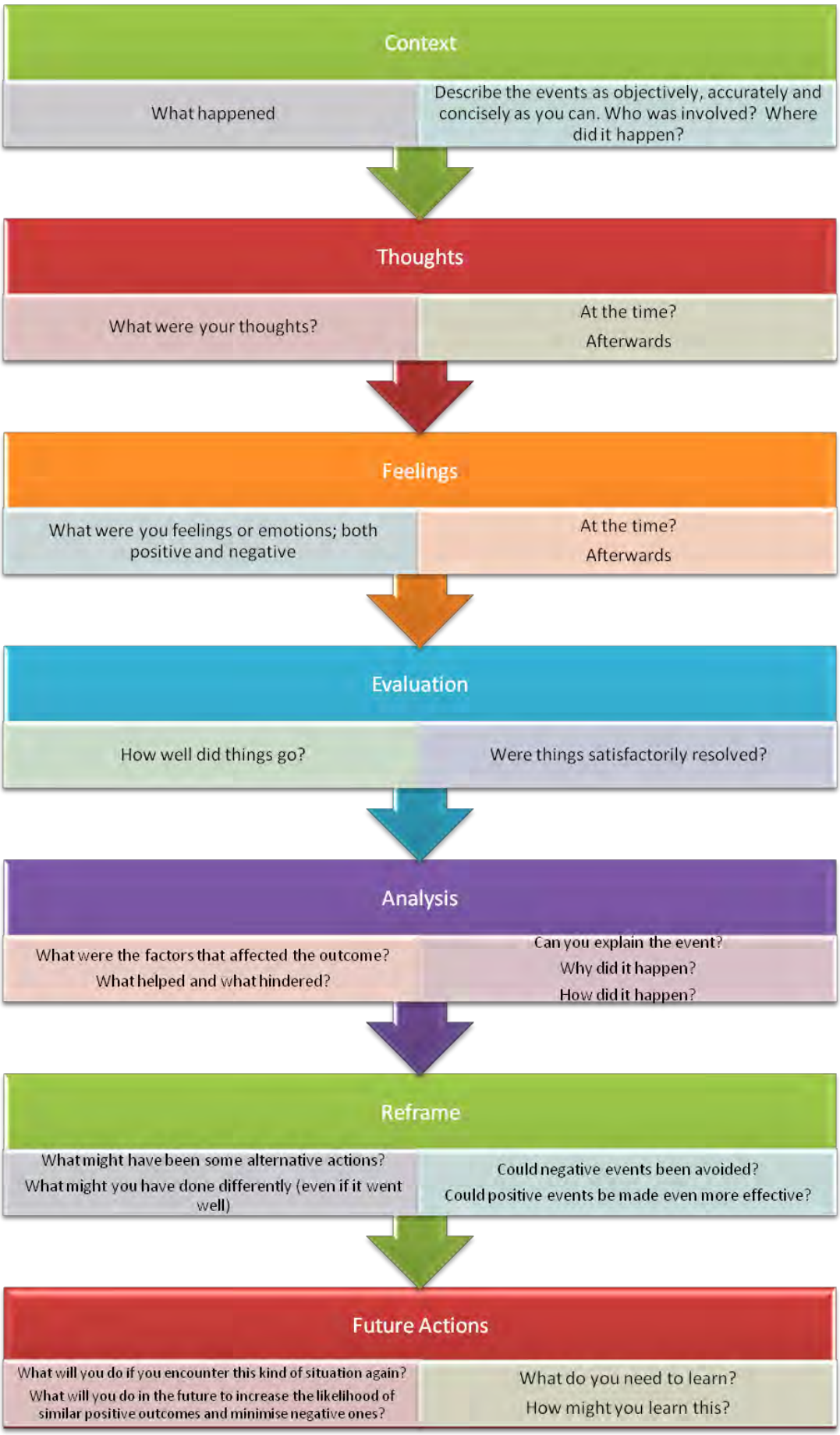
- Events which are a particularly good example of your practice, outlining reasons why you deem this to be so.
- Events that are meaningful, perhaps in terms of representing a key decision or dilemma.
- Events that have not gone well including an analysis of why this was so and what you feel could be developed in a similar event in the future.
- Situations where you feel frustrated by lack of knowledge, skill or resources and what solutions you feel may be possible.
- Events about which you feel unhappy - these might involve moral or ethical dilemmas and what actions you feel are appropriate for you to take.

Rather than describing events and situations, the focus needs to be on analysing the effect that the experience has had upon you. Be reasonably succinct in what you write. The following modified stages of Gibbs' (1988) model may be useful in writing your reflection on practice (Figure 10). Other models of reflection will be discussed during the Induction Programme.

Reference

Gibbs, G. 1998. *Learning by Doing: A Guide to Teaching and Learning Methods*. Oxford: EMU. Available free at: http://www2.glos.ac.uk/gdn/gibbs/index.htm

Figure 9: Gibbs' Reflective Cycle (1998)



Service User / Carer Feedback - Guidelines

As part of your ongoing development, it is important to consult service users and carers during your practice learning experiences. The NMC requires that service users / carers should contribute to the assessment of your performance during your programme.

The service user / carer feedback documentation has been designed to assist service users / carers to give feedback on your performance. It is suggested that you provide at least 2 of these forms as supporting evidence in your practice assessment documentation: One should be completed at approximately half way (around day 35) and prior to the Formative Assessment, the other towards the end of your 75 days' experience and before the Summative Assessment. This feedback can then be used to inform the discussions at these key points. One copy of this form is included in your Practice Assessment Document along with instructions for the service user / carer. You will need to print or photocopy this form for any subsequent occasions you wish to use it.

Once service user / carer feedback has been obtained, you and your practice supervisor should discuss the comments made and record this at the end of this form.

Note: *If there are any areas of concern, you should seek to address these in a reflection and obtain a further set of feedback comments to monitor development. Areas of concern should be notified to your Academic Assessor by your Practice Assessor.*

Safeguarding service users / carers

It is vital to remember that service users / carers are vulnerable and therefore obtaining feedback about student performance should be managed sensitively. The following principles are set out to guide this element of the practice learning experience:

- Consent for feedback should be sought by the practice supervisor, not the student.
- Participation of service users / carers is voluntary and they may decline involvement. This will not affect their care or treatment.
- Service users/carers should be encouraged to give open and honest feedback.
- Service users/carers should be reassured that any feedback they give will not detrimental to their normal plan of care.
- Service users / carers should be reassured that students will not fail solely as a result of their comments. This form is part of a wider assessment process.
- Service users should be informed that they retain the right to withdraw their feedback, should they wish to do so.
- The practice supervisor should facilitate the service user / carer in completing this form.

We hope you enjoy your experience.

Belfast Health and Social Care Trust

Reference No: SG 15/13

Title:	**Policy for the Management of the Nursing and Midwifery Council (NMC) Standards for Education and Training Parts 1, 2 and 3, and Standards of Proficiency for Registered Nurses (NMC 2018) and Midwives (NMC 2019)**			
Author(s)	Sheelagh O'Connor, Senior Manager Nursing, Education, Regulation and Informatics Carol Chambers, Lead Nurse, Practice Education Coordinator (Lead Author) Tel: [redacted] Olivia Gray, Practice Education Facilitator Rhonda Brown, Practice Education Facilitator			
Ownership:	Brenda Creaney, Executive Director of Nursing and User Experience			
Approval by:	Standards and Guidelines Policy Committee Executive Team Meeting		**Approval date:**	
Operational Date:	2020		**Next Review:**	2025
Version No.	3	Supersedes	V2 – December 2018	
Key words	Nominated person, practice supervisor, practice assessor, academic assessor, link lecturer, practice assessor database, practice learning environment, educational audit, transition training, new-to-role training, proficiency (appendix 1 - definitions).			
Links to other policies	• Assistance to Study Policy (June 2019). • Employment of People with Disabilities – Framework (Oct 2011). • Equality, Diversity and Inclusion Policy (August 2018). • Adverse Incident Reporting and Management Policy (April 2020). • Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments (May 2020). • Your Right to Raise a Concern (Whistleblowing) Policy (April 2018). • Belfast Health and Social Care Trust Capability Procedure (August 2015).			

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

The Nursing and Midwifery Council (NMC) is the regulator for two professions: Nursing and Midwifery. In 2018, the Nursing and Midwifery Council published updated Standards

for Education and Training, and Standards of Proficiency[1] for registered nurses and midwives. The critical focus of these standards is the provision of a practice learning environment where students are taught, supervised and assessed by practice supervisors and practice assessors who are trained for the role. The Standards require practice learning partners to establish systems and provide assurance to the NMC regarding the quality of practice learning for all nursing and midwifery students. The Belfast HSC Trust (BHSCT) is an approved practice learning partner of NMC programmes.

1.2 Purpose

The purpose and aim of this policy is to ensure:

Systems and processes are in place to meet NMC regulatory requirements to support student supervision and assessment in practice (NMC 2018).

The Trust has in place robust and standardised procedures for the identification, management and monitoring of the quality of practice learning opportunities which facilitate pre-registration and post-registration student nurses and midwives whilst completing NMC approved programmes.

All nursing and midwifery students are treated with equity and fairness whilst undertaking practice learning experiences within the Trust.

Evaluation of the practice learning experience by the student, the practice supervisors and practice assessors is used positively to continually improve the quality of practice-based learning in the Trust and impact positively on the care experience.

1.3 Objectives

To provide practice learning experiences which reflect the NMC requirements.

To ensure there are sufficient numbers of practice supervisors and practice assessors to support students undertaking NMC approved programmes.

To ensure the Trust maximises capacity to support pre-registration and post-registration student nurses and midwives who are undertaking NMC approved programmes.

To ensure practice supervisors and practice assessors are trained and supported in their role to meet the requirements of the Education Standards (NMC 2018, NMC 2019).

To ensure practice learning experiences are suitable to meet identified programme outcomes.

To ensure the Placement Learning Environment (PLE) responds to evaluation and feedback from students, practice supervisors and practice assessors to continually develop the learning environment.

[1] https://www.nmc.org.uk/standards/standards-for-nurses/
https://www.nmc.org.uk/standards/standards-for-midwives/

To ensure the Trust works in partnership with Approved Educational Institutes (AEI) to support students in practice**.**

2.0 SCOPE OF THE POLICY

This policy must be adhered to by all Trust staff who provide learning experiences to nursing and midwifery students on NMC approved programmes.

This policy will support partnership working ensuring that the practice learning experiences for student nurses and midwives meet the requirements of the NMC approved programmes.

This policy does not apply to any form of practice learning experience that is not planned as part of an NMC approved programme of study e.g. work experience.

3.0 ROLES/RESPONSIBILITIES

Executive Director of Nursing
As *'Accountable Officer'* has overall responsibility for ensuring the objectives of this policy are met and agreed.

Directors, Co-Directors, Divisional Nurses, Lead Midwife and Senior Managers
All Trust Directors, Co-Directors, Divisional Nurses, Lead Midwife and Senior Managers have responsibility for the implementation of this policy, and to ensure that:

- arrangements are in place within their directorates to facilitate the provision of practice learning experiences for students on NMC approved programmes
- staff have access to appropriate training, supervision and support to fulfil the role of practice supervisors and practice assessors.

Trust Staff
All staff involved in any aspect of assessing or supporting learning in practice have a responsibility to adhere to this policy.

The Practice Education Coordinator
The Practice Education Coordinator is responsible for the implementation and review of procedures, systems and processes across the Trust to ensure that the NMC requirements for assessment and support of students in practice are met in accordance with this policy.

Practice Education Facilitator
The Practice Education Facilitator provides professional support and facilitation to staff engaged in the support, supervision and assessment of student nurses and midwives to ensure adherence to this policy.

4.0 KEY POLICY PRINCIPLES

Key Policy Statements

The Nursing and Midwifery Council published Education Standards for both nurses and midwives (2018, 2019). In line with these Standards this policy supports the provision of suitable practice learning experiences for nursing and midwifery students on NMC approved programmes whilst developing and supporting a culture of person-centred care and embedding innovation and modernisation. Thus, pre-registration and post-registration nurses and midwives are prepared for entry onto the NMC register ensuring the safety and well-being of the service users and staff.

The policy takes cognisance of the Trust's responsibility for the provision of practice-based learning for nursing and midwifery students ensuring they are competent and flexible to respond to the modernisation of nursing and midwifery agendas; A Workforce Plan for Nursing and Midwifery in Northern Ireland 2015-2025 (Department of Health, Social Services and Public Safety (DHSSPS) 2016) and Midwifery 2020, Delivering Expectations (Department of Health (DOH) 2010).

The Trust provides education and training opportunities for pre-registration and post-registration nursing and midwifery students commissioned by the DOH in accordance with the provisions laid down in Schedule 1 of the Practice Placement Agreements (DHSPSSNI 2019). With respect to the status of students whilst on practice placements the agreement states:

> "8.1 The Trust shall take all reasonably practicable steps for securing the health, safety and welfare of all Students on Practice Learning to the same extent and in the same manner as an employer is required to take in relation to employees by or under the relevant legislation for the time being in force in Northern Ireland.
>
> 8.2 Whilst undertaking Practice Learning, but at no other time and for no other purposes than practice learning, and provided that Students have at all relevant times complied with the directions of Trust staff, Students shall be treated as if they are the employees of the Trust in which the Practice Learning is to be undertaken. The Trust shall be liable for the acts and omissions of such Students" (DHSPSSNI 2019).

To reflect the Trust's responsibility for the provision of practice-based learning policy writers must consider if their policies in any way relate to the preparation of nursing and midwifery students. If this is the case, the following statement must be included in the relevant policies:

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in (insert name of policy related practice/skill), where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct & indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

4.1 Policy Principles

The Trust aims to provide the highest standard of practice learning experiences for student nurses and midwives who are undertaking NMC approved courses. Through the governance arrangements of the Northern Ireland Practice Placement Collaborative the Trust will:

- Ensure that it maintains a current and up-to-date practice assessor database (appendix 2).
- Have in place a process to allocate students undertaking NMC approved programmes to practice assessors (appendices 3a, 3b and 4).
- Ensure that there are sufficient numbers of practice supervisors and practice assessors to support students undertaking NMC approved programmes. (appendices 5 and 6).
- Ensure that it maximises capacity to support pre and post-registration student nurses and midwives who are undertaking NMC approved programmes through a process of practice learning environment educational audit (appendix 5).
- Provide practice learning experiences to reflect the NMC requirements through a process of practice learning environment educational audit (appendix 5).
- Ensure practice supervisors and practice assessors are trained and supported in their role to meet the requirements of the NMC Education Standards (2018) (appendix 6).
- Ensure the Trust works in partnership with AEI's to support students in practice (appendices 7, 8 and 9).
- Respond to evaluations, feedback, compliments and complaints from nursing and midwifery students, practice supervisors and practice assessors to ensure that the PLE's continue to meet the requirements of the NMC (appendix 5, 10, 12).
- Provide guidance for students commencing commissioned courses that require current NI Access (appendix 11).
- Provide a process to ensure the supernumerary status for pre-registration nursing and midwifery students (appendix 13).

5.0 <u>IMPLEMENTATION OF POLICY</u>

5.1 Dissemination

This policy will be disseminated to all Trust staff who provide learning experiences for pre and post-registration nursing and midwifery students on NMC approved programmes.

This policy will be put in place with immediate effect.

5.2 Resources

All training and awareness with regards to this policy will be delivered by the Practice Education Team.

5.3 Exceptions

This policy must be adhered to by all Trust staff who provide learning experiences for NMC approved programmes.

6.0 MONITORING

The successful implementation of this policy is determined by adherence to The Northern Ireland Model (NIPEC 2019).

7.0 EVIDENCE BASE / REFERENCES

Staff must take cognisance of the relevant professional standards and guidance including BHSCT Policies and other Department of Health, Social Services and Public Safety (DHSSPS) publications including, but not exclusive to, the following:

DHSSPS (2009) Central Nursing Advisory Committee.
DHSSPSNI (2019) Practice Placement Agreements with Open University, Queens University Belfast and Ulster University.
Northern Ireland Practice Education Council (2019) Northern Ireland Model.
Nursing and Midwifery Council (2018) The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.
Northern Ireland Practice Education Council (2019) Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery.
Nursing and Midwifery Council (2020) Emergency Standards for Nursing and Midwifery Education.
Nursing and Midwifery Council (2018) Future Nurse: Standards of Proficiency for Registered Nurses.
Nursing and Midwifery Council (2019) Standards of Proficiency for Midwives.
Nursing and Midwifery Council (2018) Part 1: Standards framework for nursing and midwifery education.
Nursing and Midwifery Council (2018) Part 2: Standards for student supervision and assessment.
Nursing and Midwifery Council (2018) Part 3: Standards for pre-registration nursing programmes.
Nursing and Midwifery Council (2019) Part 3: Standards for pre-registration midwifery programmes.
Nursing and Midwifery Council (2019) Return to practice standards.
Nursing and Midwifery Council (2001) Standards for Specialist Education and Practice.

Nursing and Midwifery Council (2004) Standards for the Proficiency of Specialist Community Public Health Nurses.
Parliament of the United Kingdom (2001) Nursing and Midwifery Order.

8.0 CONSULTATION PROCESS

Practice Education Coordinators
Practice Education Facilitators
Executive Director of Nursing and User Experience
Lead Midwife
Co-Directors of Central Nursing and Midwifery
Divisional Nurses
Supervisors of Midwives
Ward Sisters/Charge Nurses/Team Leads
Service Managers
Practice supervisors, practice assessors, nominated persons
Northern Ireland Approved Education Institute's (Open University, Queens University Belfast, Ulster University)
BHSCT Human Resource Department

9.0 APPENDICES / ATTACHMENTS

- Appendix 1 – Explanation of terms within the policy.
- Appendix 2 – Guidance for maintenance of the BHSCT practice assessor database.
- Appendix 3a – Process for the allocation of students.
- Appendix 3b - Process for dealing with erroneous allocation of practice assessors.
- Appendix 4 – Internal process to confirm appropriate practice assessors for specialist practice and specialist community public health nursing programmes.
- Appendix 5 – Practice learning environment educational audit.
- Appendix 6 – Practice assessor role preparation.
- Appendix 7 – Guidelines for students who require reasonable adjustments during practice learning experiences.
- Appendix 8 – Students who have conduct issues which may potentially impact on their progress or public safety.
- Appendix 9 – Process for providing support to a student who has a previously identified developmental need.
- Appendix 10 – Students who are involved in incidents, accidents or near misses while in a practice learning environment.
- Appendix 11 – Guidance for students commencing commissioned courses that require AccessNI.
- Appendix 12 – Process for the management of complaints from nursing and midwifery students about the practice placement experience in the BHSCT.
- Appendix 13 – Guidance on supernumerary status for pre-registration nursing and midwifery students.

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability Discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:
Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES

Name: Brenda Creaney, **Signature:** _____
Title: Executive Director of Nursing and User Experience
Date: _____

Name: Carol Chambers **Signature:** _____
Title: Lead Nurse, Practice Education Coordinator
Date: _____

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 56/08

Title:	**Capability Procedure**		
Author(s)	Damian McAlister Cynthia Crutchley Regional HR Policy Group		
Ownership:	Human Resources & Organisational Development Directorate		
Approval by:	Regional Joint Negotiating Forum Workforce Governance and Policy Review Sub-Committee Trust Policy Committee Executive Team Meeting	**Approval date:**	09/03/2015 01/07/2015 5/08/2015 19/08/2015
Operational Date:	August 2015	**Next Review:**	~~August 2017~~ ~~September 2020~~ March 2022
Version No.	V2	**Supercedes**	V1 – August 2008-2011
Key words:	Capability		
Links to other policies			

Date	Version	Author	Comments
01/04/2015	1.1	D McAlister C Crutchley Regional Employment Law Team	Appendix 1 - Change in relation to level of panels for step 2 and 3. Other minor changes which were agreed regionally.
20/09/2019	2.1		Awaiting regional input – review extended 1 year
01/03/2021	2.2		Awaiting regional input – review extended 1 year

Director of Human Resources & OD

Chief Executive

CAPABILITY PROCEDURE

Author	Regional HR Policy Group
Directorate responsible	Human Resources & Organisational Development
Date	1st April 2015
Review date	1st April 2017

CAPABILITY PROCEDURE

1. INTRODUCTION

In order to deliver a high quality service, all employees are expected to perform the duties of their post to an acceptable standard in accordance with the nature and banding of their role. These standards may be laid down in the Job Description for the post and/or are determined in accordance with the employee's contractual obligations.

It is the aim of the <HSC Employer> to ensure that all employees are treated in a fair and equitable manner.

Capability in relation to this Procedure is defined by the Employment Rights (NI) Order 1996 as *'capability assessed by reference to skill, aptitude, health or any other physical or mental quality'.* Ignoring unsatisfactory performance can have an impact on the quality of service provided, the employee's own sense of satisfaction and enjoyment in their work and that of the team in which they work.

Where an employee is not performing in accordance with the required standards, they will be offered support, encouragement, guidance and, if necessary, training to improve their work performance.

The Procedure applies where there is a genuine lack of capability, rather than a deliberate failure on the part of the employee to perform to the required standard. In the event of deliberate failure by the employee to perform to the required standard the matter will be dealt with as a conduct matter under the <HSC Employer's> Disciplinary Procedure.

Nothing in this procedure is intended to prevent the normal process of supervision, allocation of work by management, monitoring of performance, drawing attention to errors and, as importantly, highlighting work done well.

This policy is not intended to cover concerns that arise in connection with an employee's ill health, which are addressed under the <HSC Employer's> <Sickness Absence Procedures>.

The Trust is also aware of its obligations under the Disability Discrimination Act 1995 (as amended) in the implementation of this procedure.

2. PURPOSE AND AIMS

This Procedure is intended to underpin the normal process of supervision, support and control where managers allocate work, monitor performance, draw attention to errors and poor quality and, as importantly, highlight work well done. This

continuing day-to-day process may include informal assistance in achieving improvement to the required standard, in addition to regular KSF development reviews.

This Procedure is designed to deal with those cases where the employee is lacking in some area of knowledge, skill or ability, resulting in a failure to be able to carry out the required duties of their role to an acceptable standard.

The aims of the procedure are to ensure that:

- the employee is assisted to improve their performance and that there is on-going monitoring and assistance afforded to them to support them to reach the expected performance standard
- the Trust operates effectively as an organisation
- there is guidance and a protocol through which managers can address employee capability concerns
- capability concerns are dealt with fairly, appropriately and consistently and all who are involved in the process are treated with dignity and respect
- managers, employees and their representatives are aware of their rights and obligations in dealing with matters of capability under this procedure.

3. SCOPE

This procedure applies to all Trust staff (excluding Medical & Dental Staff who are the subject of separate agreed procedures).

4. DEFINING CAPABILITY CONCERNS

Concerns about an employee's capability may arise from a number of factors, including:

- lack of competence, proficiency, poor organisation
- lack of aptitude, skill or experience
- the re-organisation or redefinition of the person's role, which causes performance / problems e.g. organisational change or technology changes
- changes in the nature or allocation of work, including changes to employment such as promotional position which the individual may not able to undertake to standards required
- an individual being unable to satisfactorily complete their probationary period
- external factors such as personal/family difficulties, work life balance

5. PRINCIPLES

- It is expected that if issues arise around an employee's performance, these should be addressed at the earliest opportunity by the employee's direct line manager. The employee should be issued with a copy of this Procedure at the time. Early intervention when poor performance is identified should be

encouraged enabling a supportive approach to be taken. In cases such as these the employee needs to be fully aware of the performance issues and the standards that need to be met. Line managers should seek to establish the type of support that can be offered to assist the employee in reaching the desired performance level. The following types of support may be considered useful:

- shadowing other members of staff
- training / development
- time out to concentrate on specific areas of work which require improvement
- mentoring
- increased supervision

- It is expected that in the first instance issues are dealt with between the line manager and the individual.

- It is expected that in many cases, informal discussions will resolve most difficulties.

- At all formal stages during this process the employee will have the right to be accompanied and/or represented by an employee representative.

- Accurate records should be kept of all meetings.

- The same principles of natural justice inherent in the Trust's Disciplinary Procedure should be demonstrated when dealing with an employee's capability.

6. PROCESS FOR ADDRESSING CAPABILITY CONCERNS

This process consists of three stages:

6.1 Informal Process
6.2 Formal Process – Stage One and Two Meetings with Employee
6.3 Appeal

6.1. INFORMAL PROCESS

6.1.1 Unsatisfactory performance should be discussed with the individual and line manager in an informal advisory session. The line manager will remind the employee of the expected standards of performance required.

6.1.2 It should be outlined by the line manager how the individuals performance is unsatisfactory and unacceptable in view of that standard. The problems being caused by the unacceptable performance should be referred to.

6.1.3 It is important that managers do not only focus on the performance concerns during these discussions but that areas of good performance should be highlighted and complimented.

6.1.4 At this session the line manager will try to identify any factors contributing to the poor performance and will identify assistance that may lead to improved performance including the provision of additional training or mentoring.

6.1.5 During the discussion an agreed action plan should be drawn up to include details of the improvements expected, with timescales and any support that is to be provided and to also include review periods to assess performance. The individual should be informed that their performance will continue to be monitored over a review period – normally one to three months.

6.1.6 Where an improvement is achieved the individual should be advised in writing by the line manager that required standards have now been met and should continue to be met. In cases of performance there should be a return to normal performance reviews in line with the Knowledge and Skills Framework process. The line manager should inform the employee that any lapse to previous unacceptable levels within six months from the date of the first informal meeting may result in further steps being taken in accordance with this procedure.

6.1.7 In the event that there has been insufficient improvement and there is evidence to support this then the employee should be advised in writing that the formal procedure will be used.

6.2 FORMAL PROCESS – STAGE 1

In cases where capability issues have not been resolved through the informal procedure, the line manager, following a discussion with an HR representative, will write to the employee inviting the employee to attend a formal meeting. This notification should include:

- Date, time and venue,
- Confirmation that this is a formal meeting in accordance with the formal steps within the Capability Procedure
- An outline of the issues to be discussed
- Advice that the employee has the right to be accompanied and / or represented by an employee representative and
- Who will be in attendance

This letter should give the employee at least seven days' notice of the meeting and should be sent to the employee as soon as practicable after the conclusion of the informal stage. The employee should be issued with a copy of the Capability Procedure with this letter.

6.2.1 FORMAL MEETING

6.2.1(a) The continued unacceptable performance should be discussed with the individual by the line manager, in a formal meeting. However, it should be made clear it is not a disciplinary interview. The individual should be informed that the continuation of unacceptable performance cannot be accepted.

6.2.1 (b) Reference should be made to the fact that there has been a failure to improve despite a previous informal meeting.

6.2.1 (c) The reasons attributing to the continued unacceptable performance along with any associated difficulties the individual may be experiencing should be discussed. The problems being caused by the unacceptable performance should be referred to.

6.2.1 (d) An indication of the improvement required should be given with an agreed action plan. This action plan should contain objectives, change of behaviour/agreed ways of working that is required, with timescales and clear measurable tasks that can be monitored against the action plan. The individual will also be informed of when this will be reviewed, how often and what the criteria for improvement are within the agreed timescales. Any additional support needed, such as further training or mentoring should be agreed.

6.2.1 (e) An indication should be given that further action will be taken if the improvement required is not forthcoming within the agreed timescales.

6.2.1 (f) A formal record will be made of the meeting. A copy of the record should also be issued to the employee.

6.2.1(g) Timescales will be agreed by all parties and they will not be longer than 3 months.

Review meeting:- The purpose of this will be to have a formal review meeting between manager and the employee to discuss progress and determine if the requirements and objectives have been fully achieved.

If after review and discussion the capability improves and is maintained this will be confirmed in writing to the employee, with no further requirements. In cases of improvement in performance there should be a return to normal performance reviews in line with the Knowledge and Skills Framework process. If there is a relapse within 6 months the matter will be dealt with at the appropriate point within the formal process.

If after review and discussion the capability concern remains and the objectives have not been achieved the employee would be informed of this and the need for the matter to be referred to step 2 in the process.

The outcome of the review meeting should be notified in writing to the employee.

6.2.2 TAGE 2

A formal hearing should be arranged with the next level manager as set out in Appendix 1 and in accordance with the guidance in 6.2 above. A member of HR staff may be in attendance. Furthermore the employee must receive notification in writing as to the purpose of the meeting, informed of the capability issues to be discussed, and of the possible outcomes of the hearing, e.g. redeployment/alternative employment, downgrading or termination of employment.

The purpose of this hearing will be to

a) Discuss the continuing capability concern and the failure to achieve agreed objectives.

b) Consider the employee's response to the capability concerns. (The individual's line manager may attend if required).

c) Reach a decision on appropriate action.
   - Redeployment / alternative employment
   - Downgrading
   - Termination of employment

The employee will be advised of the decision in writing within 7 days and their entitlement to seek an appeal.

6.2.3 STAGE 3 - APPEAL

If dissatisfied with the outcome the employee will be entitled to appeal against the decision. The purpose of any appeal would be to consider whether the decision reached was fair and reasonable under the circumstances.

The employee who wishes to lodge an appeal should write to Director of Human Resources stating the grounds of their appeal within 7 working days of receipt of the letter informing them of the decision.

The Appeals Panel, set up in accordance with Appendix 1, will comprise 2 members from the Trust who have had no previous involvement in the case.

The employee will be entitled to be represented at this appeal. The manager will be present during the appeal to advise on the management action taken to assist the employee reach the required standards of performance.

The decision of the appeal panel will be confirmed in writing to the individual within 7 days of the decision being taken.

7. REFERRAL TO PROFESSIONAL BODY / DISCLOSURE & BARRING SERVICE

Where appropriate, the employee will be advised that in accordance with the requirements of their regulatory body / Disclosure & Barring Service, a referral will be made by the relevant Director for consideration.

8. EQUALITY AND HUMAN RIGHTS

The <HSC Employer's> equality and human rights statutory obligations have been considered during the development of this procedure.

9. REVIEW OF THE PROCEDURE

This procedure should be reviewed periodically in consultation with recognised Trade Union side representatives via the HSC (NI) Joint Negotiation Forum.

Signed on behalf of Trade Union Side **Signed on behalf of Management**

Anne Speed
Joint Secretary

Damian McAlister
Director of HR & OD

Date

Date 19 August 2015

These procedures are effective from 1st April 2015

APPENDIX 1

MANAGEMENT LEVELS FOR STAGES 2 AND 3

	Step 2	**Step 3**
Staff below 5th level	Level 5	Level 4
Staff at 5th Level	Level 4	Level 3
Staff at 4th Level	Level 3	Level 2
Staff at 3rd Level	Level 2	Level 2
Staff at 2nd Level	Level 1 / Level 2	Chair / Level 1 / Level 2

Level 1 – Chief Executive
Level 2 – Director
Level 3 – Assistant / Co-Director
Level 4 – Senior Manager
Level 5 – Service Manager

Belfast Health and Social Care Trust

EMPLOYMENT OF PEOPLE WITH DISABILITIES - FRAMEWORK	
Summary	The policy has been developed to assist the Trust in complying with its statutory obligations under the Disability Discrimination Act and Section 75 of the Northern Ireland Act and ensure that appropriate support is provided for disabled staff and job applicants.
Operational date	April 2011
Review date	April 2014
Version Number	V 2.2
Director Responsible	Human Resources Director
Lead Author	Louise Beckett & Alison Kerr
Lead Author, Position	Senior Managers
Department / Service Group	Human Resources
Contact details	[redacted]
[redacted]	[redacted]
Reference Number	TP 18/08
Supersedes	V1 Belfast Trust Policy - Employment of People with Disabilities.

Version Record

Date	Version	Author	Comments
April 2007	1	Louise Beckett	Final BHSCT submitted for approval
30/03/2011	2	Louise Beckett	Final regional policy updated to Trust format and submitted for approval
September 2013	2.1	Susan Miller	Disability Etiquette updated
11/06/2019	2.2		Awaiting Input – review extended 1 year

Policy Record

		Date	Version
Author (s)	Approval	30/03/11	1.1
Director Responsible	Approval		

Approval Process – Trust Policies

Policy Committee	Approval	15.08.11	1.1
Executive Team	Authorise	17.08.11	1.1
Chief Executive	Sign Off	17.08.11	1.1

Approval Process – Clinical Standards and Guidelines1.1

Standards and Guidelines Committee	Approval		
Policy Committee	Ratify		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Local Approval Process

	Approval		

Dissemination

Areas :	

Equality and Human Rights screening carried out:
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.
Screening has been carried out by the Southern HSC Trust on behalf of all HSC Trusts as this is a regional Policy

x☐ Screening completed No action required.	☐ Full impact assessment to be carried out.

Summary
The Trust is committed to promoting equality of opportunity between both employees with and without disabilities. The policy has been developed to assist the Trust in complying with its statutory obligations under the Disability Discrimination Act and Section 75 of the Northern Ireland Act and ensure that appropriate support is provided for staff and job applicants with disabilities.
The policy outlines the Trust's responsibilities in ensuring that the rights of staff and job applicants with disabilities are protected and that appropriate support is provided for them when required. It also seeks to develop and extend work placement and volunteering opportunities for people with disabilities.

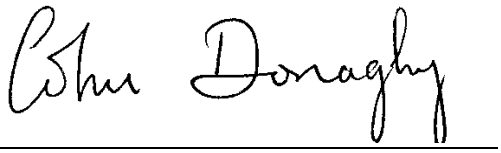
Title:
Regional Framework on the Employment of People with Disabilities.

Purpose:
To ensure that the Trust continues to due regard to the need to promote positive attitudes towards people with disabilities and to their participation in the workforce.

Objectives:
To ensure that the rights of staff and job applicants with disabilities are protected and that appropriate support is provided for them.

Policy Statement(s):
1 The Trust is committed to promoting equality of opportunity between both employees with and without disabilities in all aspects of employment.

2 By embracing and actively pursuing principles of good practice all people with disabilities will have a better opportunity to realise their fullest potential.



Director of Human Resources **Chief Executive**

Date: 17 August 2011 **Date: 17 August 2011**

Belfast Health and Social Care Trust

EMPLOYMENT OF PEOPLE WITH DISABILITIES- FRAMEWORK

April 2011

This document can be made available on request in alternative formats, e.g. plain English, Braille, disk, audiocassette and in other languages to meet the needs of those who are not fluent in English.

CONTENTS

1 Introduction

1.1 The Belfast Health and Social Care Trust (the Trust) has in place an Equal Opportunity Policy Statement which emphasises its continuing commitment to the provision of equality of opportunity. The scope of the current policy covers age, marital or civil partnership status, sex, sexual orientation, gender reassignment, religious belief, political opinion, race (including colour, nationality, ethnic or national origins, or being an Irish Traveller), disability, pregnancy or maternity leave and with/without dependants. The Trust recognises that attention needs to be given to the position of people with disabilities in the service and it is for this reason that this Policy has been developed.

1.2 This Policy takes account of the Disability Discrimination Act 1995 (the DDA), as amended.

1.3 In developing this policy, the Trust has taken account of its duty under Section 49A of the DDA (as amended), which requires the Trust, when carrying out its functions, to have due regard to the need to promote positive attitudes towards people with disabilities and the need to encourage their participation in public life. Further information about how the Trust will comply generally with the Section 49A duty is given in our S.49A Disability Action Plan.

1.4 In developing this policy the Trust has also taken account of its duty under Section 75 of the Northern Ireland Act 1998 which requires the Trust, when carrying out its functions, to have due regard to the need to promote equality of opportunity between a range of groups, including people with and without disabilities. Further information about how the Trust will comply generally with the Section 75 duty is given in its Section 75 Equality Scheme.

1.5 This policy should be read in conjunction with the Trust's 'Reasonable Adjustments Guidelines for Managers' and 'Disability Etiquette' booklet. The recently published ECNI document "Employing People with Autism: A brief Guide for employers" should also be taken into account and the recommendations implemented as appropriate.

2 Purpose and Aims

2.1 To assist the Trust in complying with its statutory obligations under the DDA and Section 75 of the NI Act.

2.2 To encourage people with disabilities to apply for jobs within the Trust.

2.3 To ensure that people with disabilities who apply for jobs in the Trust know that they will receive fair treatment and will not be subjected to unlawful disability discrimination and be considered solely on their ability to do the job.

2.4 To promote a supportive working environment for people with disabilities and for those staff who provide assistance to employees with disabilities.

2.5 To ensure that existing employees who become disabled are retained and supported in their current role, wherever possible, or in alternative suitable employment if available and provide retraining where necessary.

2.6 To develop and extend work placement programmes and volunteering opportunities to make sure that people with disabilities can gain real work experience within the Trust to improve their likelihood of securing future employment.

2.7 To ensure that buildings or premises will be made as accessible as possible to enable employees with disabilities to gain access. Further, information produced by the Trust will also be made available, on request, in accessible formats.

2.8 To be recognised by the community as an employer which provides good employment opportunities for people with disabilities.

It is the Trust's intention that the above aims will further the key objectives of its S49A Disability Action Plan i.e. to ensure that it continues to give due regard to the need to promote positive attitudes towards people with disabilities and to their participation in the workforce.

3 Policy Statement

3.1 The Trust is committed to promoting equality of opportunity between both employees with and without disabilities in all aspects of employment.

3.2 By embracing and actively pursuing principles of good practice all people with disabilities will have a better opportunity to realise their fullest potential.

4 Scope of Policy

4.1 This policy applies to people with disabilities applying to the Trust whether for temporary or permanent positions/work placements, work based training placements, work experience or volunteering opportunities. It also applies to staff with disabilities already employed by the Trust and former employees with disabilities when providing references.

4.2 For the purposes of this policy, a person is deemed to be 'disabled' if their impairment satisfies the definition of 'disability' as laid down in the DDA (as amended). See section 6 below for further information about this.

5 Responsibilities

5.1 Senior Management Team:-

- Is responsible for, and committed to, actively promoting the employment and retention of people with disabilities.
- In conjunction with Co-Directors/Heads of Service/Line Managers will ensure that all staff at all levels have received disability training appropriate to their role and responsibilities.

5.2 Staff

- All staff should be aware of the impact of their behaviour and attitudes to ensure a working environment in which the dignity of others is respected.
- Employees who have a disability are encouraged to discuss the implications of same with their line manager in the event that any reasonable adjustments may be required to ensure their full integration and participation in the workplace.

6 Definition of Disability

6.1 The DDA (as amended) defines disability as “a physical or mental impairment which has a substantial and long term adverse effect on a person’s ability to carry out normal day to day activities.”

The general rule is that a person is only deemed to be ‘disabled’ if they have an impairment which satisfies this definition.

NB: However there are some exceptions to this general rule so that people who have certain specified impairments will be deemed to be “disabled” regardless of whether they satisfy the above definition or not. The specified impairments are cancer, HIV infection, multiple sclerosis and severe disfigurements. Also a mental illness does not need to be a ‘clinically well recognised’ illness before it can count as an impairment for the purposes of the DDA (as amended).

6.2 **Physical impairment:** includes, for instance, a weakening of part of the body caused through illness by accident or from birth. Examples would be blindness, deafness, paralysis of a leg or heart disease.

6.3 **Mental impairment:** Mental health disabilities can occur at any time throughout a person’s life. Statistically, one in five people will suffer from mental illness during their lifetime. There are many different types of mental illness. These include depression, schizophrenia, bi-polar disorder, psychosis, anxiety and stress and they can vary in severity and in the way recovery takes place.

Learning disability is present from birth and is a lifelong condition that can prevent or hinder learning.

6.4 **Substantial:** this means the effect of the physical or mental impairment on ability to carry out normal day to day activities is more than minor or trivial. It does not have to be a severe effect.

6.5 **Long-term adverse effect:** the effect has to have, or be likely to last, overall for at least 12 months or which is likely to last for the rest of the life of the person affected.

6.6 **Normal day to day activity:** this is something which is carried out by most people on a fairly regular and frequent basis, such as

washing, eating, catching a bus or turning on a television. It does not mean something so individual as playing a musical instrument to a professional standard or doing everything involved in a particular job.

6.7 The person must be affected in at least one of the respects listed in the DDA:

- mobility
- manual dexterity
- physical co-ordination
- continence
- ability to lift, carry or otherwise move everyday objects
- speech, hearing or eyesight
- memory or ability to concentrate, learn or understand, or
- perception of the risk of physical danger.

6.8 There are certain conditions which do not count as impairments for the purposes of the DDA. These are:

- addiction to or dependency on alcohol, nicotine or any other substance (unless resulting from the substance being medically prescribed)
- seasonal allergic rhinitis (eg hay fever), unless it aggravates the effect of another condition
- tendency to set fires, or steal, or physically or sexually abuse other persons
- exhibitionism and voyeurism
- disfigurements consisting of tattoos, non-medical body piercing or attachments to such piercing.

A person with an excluded condition may nevertheless be protected as a person with a disability if he or she has an accompanying impairment which meets the requirements of the definition. For example, a person who is addicted to a substance such as alcohol may also have depression, or a physical impairment such as liver damage, arising from the alcohol addiction. While this person would not meet the definition simply on the basis of having an addiction, he or she may still meet the definition as a result of the effects of the depression or the liver damage.

7 Discrimination

7.1 Under the DDA, disability discrimination may occur in several different ways. These are as follows:

7.1.1 Direct Discrimination

Employers directly discriminate against a person with a disability if, on the grounds of the person's disability, they treat them less favourably than they treat or would treat a person not having that particular disability whose relevant circumstances including his/her abilities are the same as, or not materially different from, those of the person with the disability.

For example: An employer seeking a sales representative turns down a applicant with a severe facial disfigurement solely on the grounds that other employees would be uncomfortable working alongside the disabled person. This would amount to direct discrimination and would be unlawful.

7.1.2 Disability Related Discrimination

Employers discriminate if a person with a disability is treated less favourably, for reasons related to their disability, than they treat or would treat another person to whom those reasons do not apply, and the employer cannot justify that treatment.

7.1.3 Failure to make Reasonable Adjustments

When a person with a disability is substantially disadvantaged by the employer's provisions, criteria or practices or by the working environment, the employer discriminates if they fail to make any reasonable adjustments which would eliminate or alleviate that disadvantage.

Note: There is no justification for failing to make a reasonable adjustment.

This duty applies to all aspects and stages of employment including:

- recruitment and selection, including advertising
- induction

- promotion and transfer
- training/career development
- performance related pay and occupational pension schemes
- retention
- the dismissal process
- former employees

Please refer to the Reasonable Adjustment Guide for Managers for further information and examples.

7.1.4 Victimisation

This occurs when an employer treats someone less favourably than others because they have asserted their rights under the DDA, or have assisted a person with a disability in asserting their rights.

NB: Unlike the other forms of discrimination which are made unlawful by the DDA, victimisation may be claimed by people who do not have a disability as well as by those who have.

7.1.5 Harassment

This occurs where, for a reason related to a person's disability, another person engages in unwanted conduct which has the purpose or effect of violating the disabled person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person.

It covers many types of behaviour including physical, verbal, non-verbal, interfering with another's property, etc.

For example: A man with a learning disability is often called 'stupid' and 'slow' by a colleague at work. This is harassment, whether or not the man with the learning disability was present when these comments were made, because they were said with the intention of humiliating him.

The Trust has in place a Working Well Together Policy and Harassment Policy which have been agreed with Trade Unions and which outline the types of behaviours that are unacceptable in the work place e.g. harassment on grounds of disability, etc.

8 Employment Provisions

8.1 The DDA applies to all employers regardless of size.

8.2 It is unlawful for an employer to discriminate in:

- recruitment and selection including arrangements for deciding who should be offered employment, in the terms on which employment is offered, or by refusing or deliberately omitting to offer a person employment
- the terms and conditions of employment
- the opportunities afforded for promotion, transfer, training or any other benefits, or the refusal of those opportunities
- dismissing an employee or causing him/her any other detriment.

8.3 Contract workers with disabilities (i.e. agency and self employed) are also protected under the DDA and by this policy. So are people with disabilities on work experience and work placements.

8.4 Reasonable Adjustments in Employment

Reasonable adjustments have to be considered at every stage of employment. Where a provision, criterion or practice applied by or on behalf of an employer, or any physical feature of premises occupied by an employer, places a person with a disability at a substantial disadvantage compared with people who are not disabled, the employer is required to make a 'reasonable adjustment'. Please refer to the Reasonable Adjustment Guide for Managers which can be downloaded from the intranet for comprehensive information and clarification on reasonable adjustments or refer to the contact details given at paragraph 17.

8.4.1 Staff who cannot get exit of a building unaided should have a Personal Emergency Evacuation Plan (PEEP) completed by their manager with the necessary information to be able to manage their escape to a place of safety, and, to give departments the necessary information to ensure that the correct level of assistance is always available. This aim complies with the requirements of the Disability Discrimination Act (DDA). Information on PEEPs is included in Appendix B. Further information can be obtained from Fire Safety Officers or refer to the contact details in paragraph 17

8.5 Notifying the Trust of a Disability

Staff are actively encouraged to notify the Trust of a disability in order that reasonable adjustments may be made, where necessary, to assist an employee with a disability both in managing their disability and carrying out their job.

Whilst it is not compulsory for a member of staff to notify the Trust of a disability, if the Trust is not aware of a disability it cannot make any reasonable adjustments for the employee. For further information refer to the contact details in paragraph 17

8.6 Confidentiality

Sometimes a reasonable adjustment will not work without the co-operation of other employees and it may be necessary to tell one or more colleagues about a disability an employee has which is not obvious. However, the consent of the individual should always be sought before imparting information about their disability on a need to know basis.

When information about a disability is given in confidence to someone in the Trust e.g. Human Resources, Line Manager, or Occupational Health the Trust is deemed to know and therefore has an obligation to make reasonable adjustments where they are needed. The Trust must ensure this information is shared and dealt with by the relevant personnel in a confidential manner.

Further, if someone suspects that a person's behaviour, poor attendance and performance could be disability related, then they need to inform the relevant personnel (e.g. Human Resources Department or Occupational Health Department) and follow the appropriate procedure bearing in mind the duty to make reasonable adjustments for people with disabilities in areas such as absence management, the application of capability policies, performance management.

9 Recruitment

9.1 The Trust is committed to employing the best person for the job through the application of fair and objective recruitment & selection procedures and appointing solely on the basis of merit.

9.2 Generally the anti-discrimination laws make it unlawful to discriminate against an employee or job applicant on one of the equality grounds. However, there are some exceptions to the basic rule against discrimination. The Disability Discrimination Act 1995 does not prevent employers from treating persons with a disability more favourably than persons who are not disabled. Examples of this may include posts being advertised as open only to applicants with disabilities or the operation of a guaranteed interview scheme.

It is important to note that in the context of positive action, discrimination against other people with disabilities is not permitted.

9.3 As part of the Trust's commitment to ensure its recruitment and selection process is fair and objective, a person with a disability who does not meet the essential criteria stated in the Personnel Specification can request a reasonable adjustment which will be duly considered by the Trust. Where such an adjustment can be reasonably accommodated to allow the individual to move to the interview stage, it will. In instances where an adjustment cannot be made, the Trust will provide their decision in writing, clearly setting out the reasons why the request cannot be met in the circumstances.

9.4 The Trust will take every opportunity to engage in proactive approaches to the recruitment of people with disabilities and help break down employment barriers. This may include a range of options such as job trials, work experience, work based training placements, volunteering, ring-fencing jobs, availing of specialist Government programmes e.g. Workable NI, Work Preparation Programme etc. and using publicity to highlight that the Trust is an equal opportunity employer.

10.0 Retention/Dismissal

10.1 Under the DDA an employer must not discriminate against an employee who becomes disabled or whose disability becomes worse. If the arrangements or premises place the employee at a substantial disadvantage in their existing job the employer has a

duty to make reasonable adjustments to overcome the difficulties. This could involve:

- rearranging working methods
- allocating to another employee any minor tasks which the person with a disability can no longer do
- providing practical aids or equipment
- allowing employee to work at different times or places, eg to fit in with regular medical treatment.

10.2 The issue of job retention might also arise when an employee has a stable impairment but the nature of his or her job changes in a way which places him or her at a substantial disadvantage. Reasonable adjustments will have to be made if this occurs.

10.3 The person with a disability should be consulted at all times about what his or her needs are and, where the employee has a progressive condition, what effect the disability might have on future employment, so that reasonable adjustments may be planned. Therefore it is important to keep under review the needs of staff who have a progressive condition and the need for the ongoing involvement and support of the Occupational Health Department.

10.4 Support and advice will be provided by the Trust's Human Resources Department in conjunction with Occupational Health Department and, if appropriate, the Disablement Advisory Service which can:

- undertake employment assessments that are tailored to the individual;
- help to identify abilities and strengths;
- help to find out how disability or health conditions affect employment; and
- plan the steps needed to be taken to obtain or retain suitable employment.

These services can be accessed through a Personal Adviser at a local Jobs and Benefits Office/Job Centre or through the Employment Assessment and Occupational Psychology Services based in Belfast Tel: 02890 252175.

10.5 The cost of retaining an employee with a disability will frequently be less than the cost of recruiting and training a new member of staff and will prevent their knowledge and skills from being lost.

10.6 There are a number of Government Programmes which can assist people with disabilities to be retained in employment (see Appendix A) and the Trust will use these organisations as a source of support and advice to ensure people with disabilities have access to and can stay in employment. Further, in seeking to retain a person with a disability, there will be an expectation of both the Trust and the individual to be flexible in order to secure continued employment.

10.7 Deciding to terminate the employment of a person with a disability for a reason related to his or her disability (e.g. for capability or absence reasons) is a decision that should never be made before the employer has genuinely concluded that there are no alternatives to dismissal that can reasonably be implemented.

11 Former Employees

11.1 Under the DDA, where the employment of a person with a disability has come to an end it is unlawful for his or her former employer:

- to discriminate against him or her by subjecting him or her to a detriment, or
- to subject him or her to harassment, provided that the discrimination or harassment arises out of the employment which has come to an end and is closely related to it, eg provision of references.

12 Work Experience, Work Based Training Placements and Voluntary Work

12.1 In keeping with the Trust's Disability Action Plan, the Trust will work with external organisations to develop and extend structured work placement programmes to make sure that people with disabilities can gain real work opportunities and experience within the Trust to improve their opportunities of securing future employment.

12.2 A work placement is a planned period of work based learning or experience. The Trust recognises that for people with disabilities, work placements can be a key to access the world of work from which they might otherwise be excluded. Therefore work experience, work placement and vocational training are excellent interventions to provide opportunities for people with disabilities to gain experience and skills in work which may lead to employment. In addition, people with disabilities on work experience/work placement or vocational training are protected against discrimination and harassment under current legislation.

12.3 The Trust is committed to involving volunteers and a policy has been developed to promote and provide guidance on the appropriate involvement of volunteers throughout the Trust and to ensure that the interests of recipients, volunteers and staff are adequately protected. The Trust has adopted the following definition of volunteering:

"Volunteering is the commitment of time and energy for the benefit of society and the community, the environment, or individuals outside ones immediate family. It is undertaken freely and by choice without concern for financial gain"
(Making a Difference: the Government's Action Plan 1995)

12.4 The Trust supports the view that there is a very valuable and purposeful role for volunteers, which is separate and distinct from that of paid workers. It values the involvement of volunteers in its work because they reflect the interests, needs and resources of the community it aims to serve and bring a unique perspective to all its work. The Trust believes that volunteers, through a variety of interesting and satisfying tasks, enhance the quality of care or service provided to patients/clients/residents.

12.5 There are many benefits to involving volunteers with disabilities. People with disabilities can bring new ideas and fresh approaches, they can help to keep services relevant and present a more welcoming face to the public.

12.6 People with disabilities can experience exclusion from volunteering opportunities because of environmental, attitudinal and organisational barriers rather than as a result of the effects of their disability. However all volunteers bring with them their own skills

and talents, while increasing their own personal growth and development. Through appropriate support individuals who wish to volunteer should be supported to do so.

Support offered includes the provision of:

- A tailored volunteer role description with appropriate risk assessment
- Tailored support and supervision and identification of a key worker
- Volunteer expenses
- Volunteer induction and trial period
- Relevant training
- Partnerships with relevant volunteer supporting organisations

The Trust will continue to work with external volunteer supporting organisations to develop and support structured volunteer placements. These organisations include local volunteer centres, MENCAP, Action Mental Health, New Horizons and Cedar Foundation.

For further information on Volunteering refer to paragraph 17.

13 Indemnity

13.1 Children from schools and colleges on work placements with the Trusts are covered by Education Board indemnity.

13.2 Those on volunteering or work placements from the voluntary sector will be indemnified by the Trusts.

14 Awareness Raising/Education

14.1 The Trust will provide a programme of awareness raising and training on disability employment issues to provide managers and staff with information, training, support and advice so that they can achieve the objective of this policy.

14.2 This policy will be communicated to all staff and will be accessible via the Trust's Intranet and will be made available, on request, in alternative formats such as large print, Braille, audio cassette, plain language, easy read etc.

14.3 The Trust has developed a Disability Etiquette booklet which helps to identify and avoid inappropriate language and behaviour and offers practical advice about communicating with people with disabilities. This can be downloaded from the intranet or obtained from Equality and Improving Lives section of Human Resources – refer to paragraph 17.

14.4 The Trust is committed to seeking the views of staff with disabilities on issues that are important to them in the workplace and therefore a forum will be established in order to achieve this.

15 Review

15.1 Reviews of this policy will be undertaken at regular intervals and not later than three years following implementation.

16 Equality and Human Rights Considerations

16.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

16.2 The policy has significant equality implications for people with disabilities. However these are all positive implications because the policy has been specifically developed for the purpose of promoting equality of opportunity for people with disabilities. The policy will not therefore be subject to an equality impact assessment.

16.3 Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

17 Further Information

Employment Equality and Improving Working Lives.

If you wish to seek advice or receive further information on disability, policies, training, employee for a, or disability monitoring please contact Employment Equality Manager on (028) 90636082.

If you wish to seek advice or receive further information on reasonable adjustments, disability placements or employability initiatives please contact the Senior Human Resources Officer on (028) 90636081.

Occupational Health Department

(028) 90631300

DEL Personal Advisers

http://www.delni.gov.uk/index/finding-employment-finding-staff/fefs-help-to-find-employment/localoffices.htm

Volunteer Services Department

(028) 90903028.

Estates Services Department

(028) 90902633

Appendix A

Summary of DEL Employment Schemes for People with Disabilities

In addition to the full range of training and employment programmes delivered by DEL to assist people find and retain employment if you, an existing employee or potential employee need specific help because their disability or health condition significantly affects the kind of work they can do, or it affects their chances of finding or keeping work, you may wish to contact a Personal Adviser at your local Jobs & Benefits office / JobCentre.

Personal Advisers will:-

- discuss with you the difficulties you or your employee are encountering which make it difficult to work; and
- help you consider a range of choices which may provide the practical, health and financial supports you might need to make decisions about work .

- DEL is committed to helping employers recruit and retain employees with disabilities. It provides a range of practical and financial help so you can find the right person for your vacancy or organisation, including people with disabilities.

Disablement Advisory Services

The Department for Employment and Learning's DAS is an integral part of Preparation for Work Division. It is the main branch within the Department supporting people with health conditions and disabilities. DAS provides a range of programme to assist Departmental customers obtain and retain suitable employment while its staff have extensive experience of helping people with complex and serious conditions in employment and training. These programmes are listed below.

Job Introduction Scheme

The job Introduction Scheme is a job trial lasting 13 weeks. It offers both the employer and the person with the disability the opportunity to try work and to see if the requirements of the job and the skills of the disabled person match. Employers receive a grant of £75 per week for

the duration of the job trial while the employee with the disability is employed under the same terms and conditions as any other employee. Payment will be made in a lump sum at the end of the 13 week job trial period. The grant is available for people with all types of disability to start a job which is either full time or part time. The job should be permanent and expected to last at least 32 weeks.

Access To Work NI

Access To Work NI is available to overcome the practical problems caused by disability. It offers advice and help in a flexible way that can be tailored to suit the needs of an individual in a particular job, or getting to and from work. The programme can assist in a number of ways, for example:-

- Communication support at interview
- Special aids and equipment
- Adaptations to premises and equipment
- Travel to Work
- Support Worker
- Disability awareness training

Workable (NI)

This programme provides a flexible range of long term support to assist people with disabilities with substantial barriers to employment, find and keep work. The support needs of each individual are assessed and individually tailored support packages are developed to meet client needs. These support mechanisms can include:

- Job Coach to assist the disabled worker and their colleagues adapt to the needs of the particular job
- Developmental costs to the employer
- Extra training
- Disability Awareness Training

Work Preparation Programme

This programme is an important part of the 'Pathways to Work' initiative which aims to help people on an incapacity benefit return to work. The programme lasts up to 12 weeks and during this time, clients will benefit from in-house training from a provider organisation, as well as entering a real working environment through work placement with an employer.

Both in-house training and actual work experience will help identify and assess work abilities, as well as boosting self-confidence and updating existing or development new skills. Throughout work placements, clients will receive one-to-one support and will also be provided with professional advice on seeking new or returning to previous employment.

Condition Management Programme

This programme is a work-focused support and advice programme which lasts up to 12 weeks. It is delivered by health care professionals who will help clients understand and manage their conditions and assist in getting them back to work. They will provide support and advice to help clients management arthritic complaints, back and neck problems, chronic fatigue, depression, pain and stress, as well as heart, circulatory and respiratory disorders.

Occupational Psychology Services

Occupational Psychology Services service offer consultancy, advice and guidance in areas relating to work, disability and health. Their services are available to support clients with disabilities, employers and Personal Advisers and include;-

- Policy strategy
- Organisational development
- Training
- Employment assessment
- Advice, guidance and support on disability issues
- Programme design and management
- Recruitment
- Evaluation
- Research and development
- Consultancy

Workable (NI) Case Studies

- Please read the case studies for Workable (NI) Clients http://www.delni.gov.uk/index/publications/pubs-das/das-workableni-case-studies.htm

For further Details contact

Disablement Advisory Service
5th Floor Gloucester House
57-63 Chichester Street
Belfast BT1 4RA
Tel 028 9025 2268
Fax: 028 9025 2330
Textphone : 0800 0284716
E-mail: das@delni.gov.uk
Web: www.delni.gov.uk

Useful Contacts:

Disability Action
Portside Business Park
189 Airport Road West
Belfast, BT3 9ED
Tel: 028 9029 7880 Fax: 028 9029 7881
Text phone: 028 9029 7881
Email: hq@disabilityaction.org
Website: www.disabilityaction.org

Employers for Disability NI
Banbridge Enterprise Centre
Scarva Road Industrial Estate
Banbridge, BT32 3QD
Phone: 028 4062 4526 Fax: 028 4066 9665
Email: info@efdni.org
Website: www.efdni.org

Equality Commission for Northern Ireland
Disability Section, Equality House
7-9 Shaftesbury Square
Belfast, BT2 7DP
Phone: 028 9050 0600 Fax: 028 9032 8970
Email: information@equalityni.org
Website: www.equalityni.org

Northern Ireland Union of Supported Employment
58 Strand Road
Derry
Co Londonderry

BT48 7AJ
Phone; 028 71 377709
Fax: 028 71360125
Textphone: 028 71372077
Email: info@niuse.org.uk Website: www.niuse.org.uk

Ulster Supported Employment Ltd (USEL)
182-188 Cambrai Street
Belfast, BT13 3JH
Phone: 028 9035 6600
Fax: 028 9035 6611
Minicom: 028 9075 7012
Text Phone: 02890750625
Website: www.usel.co.uk

MENCAP
Segal House,
4 Annadale Avenue,
Belfast, BT7 3JH
Phone: 028 9069 1351
Fax: 028 9064 0121
Web: www.mencap.org.uk

AMH Action Mental Health (Central Office)
Mourne House
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9040 3726
E-Mail: info@amh.org.uk

Positive Futures
Head Office
2b Park Drive
Bangor
BT20 4JZ
Tel: 028 9147 5720
E-mail: info@positive-futures.net
Web: www.positive-futures.net/

ACET (Greater Belfast only)
Agencies in Consortium for Education & Training
Trust Headquarters
Knockbracken Healthcare Park
Saintfield Road
BELFAST
Northern Ireland
BT8 8BH
[redacted]

In each Health and Social Care Trust area there are a number of vocational training and supported employment organisations which can assist the Trusts to recruit and provide support to maintain and retain people with disabilities in employment. The Health Trust will also work in partnership with these organisations to develop interventions such as work experience, work placements, voluntary work and training which may progress into employment. Many of these organisations are funded under ESF and part funded by Health and Social Care Trusts –

Action Mental Health
5 Duncrue Place
Belfast
BT3 9BU
Tel: 028 90745015
E-mail: info@amh.org.uk
Web: www.actionmentalhealth.org.uk

Cedar Foundation (Regional organisation)
1 Upper Lisburn Road
Belfast
BT10 OGW
Tel: 028 9061 2424
Fax: 028 90614314
E-mail: info@cedar-foundation.org
Web: www.cedar-foundation.org

Dr B's Kitchen (Belfast)
9 Bridge Street
Belfast BT1 1LT
Tel: 028 90321213
Fax: 028 90313967

Web: www.barnardos.org.uk/drbsbelfast
E-mail: drbskitchen@barnardos.org.uk

NOW (Belfast)
428 Springfield Road
Belfast BT12 7DU
Tel: 028 90436400
E-mail: [redacted]
Web: www.nowproject.co.uk

Orchardville Society (Belfast Trust)
Lagan Village Tower
144-152 Ravenhill Road
Belfast BT6 8ED
Tel: 028 90732326
Fax: 028 90732328
Web: www.orchardville.com

RNIB (Regional)
40 Linenhall Street
Belfast
BT2 8BA
Tel: 028 9032 9373
E-mail: rnibni@**rnib**.org.uk
Web: www.rnib.org.uk/northernireland

RNID (Regional)
Wilton House
5-6 College Square North
Belfast, BT1 6AR
Tel: 028 90239619
E-mail: information.nireland@rnid.org.uk
Text phone: 028 9023 9619
Text answer phone 028 9031 2033
Web: www.rnid.org.uk

Stepping Stones
39 Seymour Street
Lisburn BT27 4SY
Tel: 028 92667124
Fax: 028 9266 8900
E-mail: **stepping.stones**@nireland.com

The Trust will also provide information to the Physical Disability/Sensory Impairment website www.OpportuntiesForAll.org which provides information on a range of subject areas including Supported Employment opportunities for the general public.

Disclaimer – This list is not exhaustive. For further information contact Northern Ireland Union of Supported Employment for Supported Employment organisations in your area.

Appendix B

Guidance on Preparation of a Personal Emergency Evacuation Plan (PEEP)

Background

Aim

The aim of a Personal Emergency Evacuation Plan (PEEP) is to provide people (who cannot get themselves out of a building unaided) with the necessary information to be able to manage their escape to a place of safety, and, to give departments the necessary information to ensure that the correct level of assistance is always available. This aim complies with the requirements of the Disability Discrimination Act (DDA).

Responsibilities

It is the responsibility of line Managers and Fire Wardens to talk to staff to identify whether they require any assistance in the event of an emergency. If a member of staff requires assistance the Emergency Egress Questionnaire should be completed (see section1). This should be completed in conjunction with the member of staff concerned and with appropriate support from the Estate Services Department (Fire Safety Officer).

Writing the PEEP

From the information gathered in the questionnaire, a written Personal Emergency Evacuation Plan (PEEP) should be developed (see section 2). Advice and support for writing the PEEP is available from the Estate Services Department via the Fire Safety Officer. Given the unique characteristics of buildings and the need for a PEEP to take account of the buildings capabilities, staff in question who regularly use different buildings may need a separate PEEP for each building.

If assistance with escape is required, the extent of such assistance should be identified in the PEEP and the number of assistants and the methods to be used should be recorded. The line Manager needs to ensure that there is cover for absences, and that assistants are trained as necessary.

Evacuation in an Emergency

Assisting wheelchair users on stairs

Where wheelchair users are located above the ground floor there are a number of considerations. In all the following cases the Fire Safety Officer will be able to give more advice with identifying Refuges and Evacuation Lifts.

a) Temporary Refuges

A refuge is a designated temporary safe space where disabled people can wait for assistance. It is an area that is both separated from a fire by fire resisting construction and provides a safe route to final exit e.g. the head of a protected stairway - where there is sufficient space. The provision of a refuge will permit a staged evacuation to be implemented. A refuge area must be clearly signed and should be of sufficient size to accommodate people using it as a refuge and also any people passing through on their way out of the building.

Refuges should only be defined after consultation with the Fire Safety Officer as the requirements for fire separation and structure are very specific.

b) Lifts

Most lifts cannot be used in an emergency. Any lift used for the evacuation of staff with disability should be either a “fire-fighting lift” or an “evacuation lift.” The Estate Services Department will be able to tell you if and in what circumstances a lift may be used in the event of a fire.

If you believe that there is a suitable lift then the Estate Services Department will advise on the correct procedure for using the lift as an evacuation lift and will also advise on the signage and training necessary.

c) Safe Routes

A PEEP should contain details of the escape route(s) the staff member will be expected to use. Clear unobstructed gangways and floor layouts should be considered at the planning stage.

It is especially important to ensure that locks, doors and other devices are all able to be operated by the evacuating persons.

It is also necessary to ensure that there are (as much as possible) alternative routes and that the routes are not excessively long. Further advice is available from the Fire Safety Officer on a Building by Building basis.

Deaf, Deafened and Hard of Hearing

Generally, most deaf people working alongside hearing colleagues will not require special equipment, providing they have been made aware of what to do in the event of a fire. They will be able to see and understand the behaviour of those around them.

However, people with who are deaf or hard of hearing working alone may need an alternative method of being alerted to an emergency. For example many alarm systems have visual indicators in the form of a flashing light, or vibrating pager systems can be used. If additional equipment is required then please consult with the Estate Services Department.

Blind and Partially Sighted

Staff should be offered orientation training and, where applicable this must include alternative ways out of the building. If a blind or partially sighted person uses a guide dog it is important that the dog is also given ample opportunity to learn these routes.

Training

To be effective, any egress plan depends on the ability of staff to respond efficiently. Staff will therefore receive instructions, practical demonstrations and training appropriate to their responsibilities. This may include some or all of the following elements:

- Fire drills for staff.
- Specific training for DNOF's/Fire Wardens
- Specific training in the use of Fire Extinguishers, etc.

Further advice is available in the first instance from the Fire Safety Officer.

Section 1: Emergency Egress Questionnaire for Disabled Person

This questionnaire is intended to be completed by a disabled person to assist the development of a Personal Emergency Evacuation Plan. Please provide as much information as possible to enable the Belfast Trust to develop a suitable plan.

Once developed, the Plan will be the intended means of escape in the event of an emergency (including drills). If the practice drills identify concerns in the implementation of the evacuation, then please contact your Line Manager for assistance in finding suitable solutions.

Why you should fill in the form

As your employer, the Belfast Trust has a legal responsibility to protect you from fire risks and ensure your health and safety at work. The PEEP will be developed based on the information you provide.

What will happen when you have completed the form?

You will be provided with any additional information necessary about the emergency egress procedures in the building(s) you attend.

If you need assistance, the "Personal Emergency Evacuation Plan" will specify what type of assistance you need.

Name

Job Title

Department

Brief Description of Duties

LOCATION

1. Where are you based for most of the time?

Please name: the building, the floor and the room number.

2. Do you routinely use more than one location in this building?

YES ❑ NO ❑

If you feel it is necessary please provide further details below. (Please list
the buildings and floors you use in each building)

AWARENESS OF EMERGENCY EVACUATION PROCEDURES

3. Are you aware of the emergency evacuation procedures which operate in the building(s) you attend?

YES ❑ NO ❑

4. Do you require written emergency evacuation procedures?

YES ❑ NO ❑

4a Do you require written emergency procedures to be supported by BSL interpretation?

YES ❑ NO ❑

4b Do you require the emergency evacuation procedures to be in Braille?

YES ❑ NO ❑

4c Do you require the emergency evacuation procedure to be on tape?

YES ❑ NO ❑

4d Do you require the emergency evacuation procedures to be in large print?

YES ❑ NO ❑

5. Are the signs which mark emergency routes and exits clear enough?

YES ❑ NO ❑

EMERGENCY ALARM

6. Can you hear the fire alarm(s) in your place(s) or work?

YES ❑ NO ❑ DON'T KNOW

7. Could you raise the alarm if you discovered a fire?

YES ❑ NO ❑ DON'T KNOW

ASSISTANCE

8. Do you need assistance to get out of your place of work in an emergency?

YES ❑ NO ❑ DON'T KNOW

If **NO** please go to Question 12

9. Is anyone designated to assist you to get out in an emergency?

YES ❑ NO ❑ DON'T KNOW

If **NO** please go to Question 11. If **YES** give name(s) and location(s)

10. Is the arrangement with your assistant(s) a formal arrangement?

(A formal arrangement is an arrangement specified for them by the Head of Department or written into their job description or by some other procedure.)

YES ❑ NO ❑ DON'T KNOW

10a Are you always in easy contact with those designated to help you?

YES ❑ NO ❑ DON'T KNOW

11. In an emergency, could you contact the person(s) in charge of evacuating the building(s) in which you work and tell them where you were located?

YES ❑ NO ❑ DON'T KNOW

GETTING OUT

12. Can you move quickly in the event of an emergency?

YES ❑ NO ❑ DON'T KNOW

13. Do you find stairs difficult to use?

YES ❑ NO ❑ DON'T KNOW

14. Are you a wheelchair user?

YES ❑ NO ❑

Thank you for completing this questionnaire. The information you have given us will help us to meet any needs for information or assistance you may have.

Please return the completed form to:

_____

Line Manager

Section 2: To be completed by the line Manager (may require development of more than one plan for more than one building)

Personal Emergency Evacuation Plan for

Name

Department

Building

Floor

Room Number

AWARENESS OF PROCEDURE

The person to be assisted is informed of a fire evacuation by:

existing alarm system ☐

pager device ☐

visual alarm system ☐

Other (please specify) ☐

DESIGNATED ASSISTANCE

(The following people have been designated to give me assistance to get out of the building in an emergency).

Name

Contact details

Name

Contact details

Name

Contact details

METHODS OF ASSISTANCE (e.g. Transfer procedures, methods of guidance, etc)

EQUIPMENT PROVIDED (including means of communication)

EVACUATION PROCEDURE (A step by step account beginning from the first alarm)

SAFE ROUTE(S)

Personal Emergency Egress Plan

1. PERSONAL DETAILS

Name:	

2. LOCATION

Building:	
Floor:	
Room Number:	
Times when the PEEP is applicable:	

3. AWARENESS OF PROCEDURES

I have received the emergency evacuation procedures:

In Braille		On Tape	
In BSL		In Print	
In Large Print		In SSE	

4. ALARM SYSTEM

I am informed of an emergency evacuation by:

Existing alarm system		Visual alarm system	
Vibrating pager		Other (please specify below)	

5. DESIGNATED ASSISTANCE

Where applicable, the following people have been designated to give assistance when I need to get out of the building in an emergency.

Name:	Location:

My designated assistants have been trained in the emergency procedures drafted to assure my safety:

Yes ☐ No ☐

6. EGRESS PROCEDURE (To be provided by the Assessor)

The details provided here should include a step by step account of how the Belfast Trust will ensure that the building user will reach a place of safety from first alarm actuation to final exit. A diagram should be provided, where necessary, highlighting the position of specific escape routes, refuges and any equipment provided to ensure the safety of the person under assessment.

7. ASSESSMENT SIGN-OFF

Signed (Assessor)	
Signed (Building User)	

February 2011

Disability Etiquette

February 2013

Contents

1. Alternative Formats

Please ask us if you would like a copy of this booklet in a different format, such as Braille, easy read, on disk or audiocassette, or in an alternative language.

If you require a copy of this booklet in a different format please contact the Improving Working Lives Team, Human Resources on 028 95 048913.

The HSC Trusts would like to acknowledge all of those who contributed to the development of this booklet.

2. Aims of this booklet

People with disabilities, and those who work on their behalf, are concerned that negative images of disability and incorrect assumptions can hamper their progress towards equal opportunities at work and within society. This booklet aims to widen understanding of the views and preferences of people with disabilities and will help employees identify and avoid inappropriate language and behaviour. The booklet offers practical advice about communicating with people with all disabilities both in daily life and in the workplace.

3. Did you know that in Northern Ireland ....

- 21% of the adult population has a disability which is higher than most of the UK
- 17% of people have multiple disabilities
- 6% of children and young people have a disability
- 1 in 4 families is directly affected by disability
- there are 52,000 people with a learning disability
- 1 in 7 people has some form of hearing loss
- mental health disability affects 1 in 5 of the population in some form in a person's lifetime.
- less than 5% of people with physical disabilities are wheelchair users.

Further, a person with a disability is more likely to:

- be unemployed – 66% of people with disabilities are unable to access employment opportunities
- have no qualifications
- live on or below the poverty line as benefits make up two-thirds of their income, compared to just over a fifth for the general population.

Approximately half of people with disabilities:

- have difficulty using everyday services like going to the cinema, eating out or going shopping
- of those 4 in 10 have problems getting there

- of those who find shopping difficult, 1 in 3 has problems getting around the shops.

In addition:-

- 80% of people with disabilities who encounter difficulties are offered no help by service providers.
- Disability should not be confused with illness. The general health of many people with disabilities is as good as that of anyone else.
- A sighted person is about four times more likely to be employed than a blind person is.
- 70% of people acquire disability during their working life and there are more females than males with disabilities
- People who have a mental health disability or a learning disability are five times more likely to be unemployed than people without these disabilities.

Sources: NI Survey of people with Activity Limitations and Disabilities; NI Census; Mental Health Foundation; Employer's for Disability NI.

People with disabilities are people first. Sometimes we, in most cases unknowingly, create barriers for people with disabilities. It's important that each one of us works to remove those barriers and concentrate on the person, not the disability.

The Trust is committed to good practice in the recruitment and career development of people with disabilities. Many of the barriers that people with a disability face are created by negative attitudes and misconceptions. These barriers are reinforced by small details of language and behaviour. These may seem insignificant but they can reinforce inaccurate assumptions and cause unnecessary offence.

By recognising this, and by understanding the feelings of people with disabilities, the Trust aims to ensure that employees with disabilities can compete and flourish on an equal basis in the workplace.

4. Terminology

Many terms used about disability go back to the medical model of disability from the 1960's. This model showed no consideration for the person – it focused on what was 'wrong' with the individual. The social model replaced the medical model and for the first time the 'person' was recognised. Even more enlightened is the new affirmation model, which recognises and celebrates disability and the individual differences of people.

Despite more enlightened thinking, many unacceptable terms are still used today. Appropriate use of written and oral language will make it easier to communicate and interact with people with disabilities.

Every member of staff can make an important difference to the way services are delivered to people with disabilities. It's estimated that around a third of our service users i.e. patients, their families and visitors have disabilities, that is, they have physical, sensory, learning or mental health difficulties or chronic and long term health conditions. Don't be daunted by 'rights' and 'wrongs'. Instead, always bear in mind that people with a disability, like everyone else, wish to be treated with respect and courtesy and in a friendly matter.

5. Improving the overall experience of patients

Below are some things to bear in mind when dealing with people, patients/clients and service users, whether or not they have a disability:

- Wear your name badge and, when possible, especially when helping a patient with a visual disability, give your name. Always give your name when answering the phone. Communicate directly with the patient, even if they have someone with them, unless informed otherwise.
- Offer help to a person with a disability but wait until your offer is accepted before you act. Do not assume you know the best way of helping – listen to any instructions you are given.
- Treat adults in a manner appropriate to adults. For example, call a person by their first name only when extending that familiarity to others present – all staff should ask service users how they would like to be addressed and it should not be assumed that people (especially older people) feel comfortable when being addressed by their first name by people who are not close friends or relatives.
- Use an everyday tone of voice. Do not shout at or patronise anyone.

- Make appropriate physical contact with people with disabilities like you would with anyone else – for example shake hands.
- Never lean on a person's wheelchair and, when talking to the person, try to ensure your eyes are at the same level as theirs, perhaps by sitting down.
- Ask the person how *they* wish to be communicated with and allow them to communicate in his or her own way, and in his or her own time. Don't finish sentences for anyone. Be patient, stay calm and respect the person's answer to your question.
- Try not to feel uncomfortable the first time you come across a person with a particular disability. It is perfectly acceptable to ask the person if they need any support or adjustment. Don't make assumptions that you know best.
- Take the time to explain what is going on and check that the person understands. For example, at outpatients, don't just say, "Put your card in the appointment box." People who are blind or have visual disabilities may not see the box. Explaining helps avoid unnecessary anxiety or stress.
- Don't make assumptions. For instance, avoid assuming that someone's disability is the cause of the symptoms he/she is experiencing. Often issues and problems have nothing to do with being disabled.
- Do not be embarrassed about using common expressions such as "see you later" if someone has a visual impairment, or "I'll be running along then" if they use a wheelchair.
- When planning an event, ask advice from people with disabilities and advertise accessibility. If access and facilities are not clearly described, people with disabilities may not come along if they have encountered difficulties in the past.
- It is estimated that 83% of people who have disabilities acquire the disability after birth. Many have hidden disabilities, that is, something that is not immediately obvious to the casual observer. Examples are post-accident trauma, arthritis, asthma, diabetes, diseases of the heart and circulatory system, dyslexia, epilepsy, learning difficulties or mental illness. Also, it may not be immediately obvious if someone has a hearing or visual disability.
- Ask patients, in appointment and admission letters, to let the hospital/clinic know in advance if they have any special requirements. Remember too that letters and leaflets for patients should be in Arial, size 14 font as per the Health

and Social Care corporate identity guidelines and should follow best practice regarding the provision of information and communication.

- Ensure you know how any communication aids work, for example, text phones, Typetalk, or induction loops. Remember that deaf patients/clients are entitled to be accompanied by a sign language interpreter or a person with a learning disability may have a friend or advocate to accompany them.
- When seeking consent for examination, care or treatment, remember that no-one has the right to consent on behalf of a competent adult. The Trust's policy on consent, available from line managers and on the intranet, provides further information.
- Ensure you attend disability training events, eg. Deaf awareness training, and, if you are a manager, allow your staff time to attend.
- If you have to give a diagnosis of a disability (diagnosis of condition that will or may result in the person acquiring a disability) to a patient or parent, be extremely sensitive to the fact that, often, how this news is given, can impact on how they deal with it for the rest of their lives. Make sure that all those who need to be told are told and that you have information available about support mechanisms for the patient and/or carer.

6. Language

It is important to have a general understanding of words and phrases that you should use when referring to someone with a disability. There are no hard and fast rules. Employers should be aware of the preferences of disabled people and respect these preferences, which may change over time.

The following is a helpful guide when talking to or writing about people with disabilities:

- The word 'handicapped' is offensive - instead say 'person with a disability'.
- Medical 'labels' are undesirable and often misleading, as no two people are alike. Medical labels say little about people as individuals, and tend to reinforce stereotypes of disabled people as 'patients', powerless and wholly dependent on the medical profession.
- It is dehumanising to refer to a person in terms of a condition. Therefore do not talk about 'a spastic' or 'an epileptic'. Instead say he or she 'has cerebal palsy' or refer to 'a person with epilepsy'.

The table overleaf has a list of terms that you should and shouldn't use.

Words to avoid

Do Say	Do not say
Person who has/person with/person who has experienced	Victim of/crippled by/suffering from/afflicted by etc. The anything: The Blind The Disabled
Wheelchair user or person who uses a wheelchair	Wheelchair bound or describe someone as 'confined' to a wheelchair
Person with a learning disability	Mental Handicap
Mental health disability or person who has/with a mental health disability	Mentally ill or 'Not all there'
Person with a disability	Invalid
He or she is deaf/hard of hearing/blind/has a visual disability	'deaf and dumb'
Person who has/with arthritis Person who has/with epilepsy Person who has/with diabetes	Arthritic Epileptic Diabetic
Non-disabled; Person without a disability.	Normal, healthy, (when speaking about people without disabilities as compared to people with disabilities)

7. Meeting and communicating with people with disabilities

People who are deaf or have a hearing impairment

- Do not make assumptions about a person's ability to communicate or the ways in which they do it. Ask how the person would prefer to communicate with hearing people.
- Deaf people who use sign language find this the easiest method of communication – but not all Deaf people use sign language.
- Don't shout – it is impolite, uncomfortable for a person wearing a hearing aid, makes lip reading more difficult and makes you look and feel irritable.
- Check that the person has understood you and that you have understood them by rephrasing your questions, repeating what has been said, and by summarising what has been agreed at the end of the conversation. In some situations written notes might be helpful.
- Pay attention to the person's facial expressions and gestures and if you don't understand what is said, ask for it to be repeated. If you pretend to understand when you don't, you will have problems later.

Lip-reading

Do not assume that everyone who is Deaf can lip-read. Always ask the person when you first meet them. If they do lip-read, remember that this skill is never wholly reliable. It requires intense concentration and is very tiring.

When meeting a person who is lip-reading:

- Look directly at them and speak clearly and slightly slower than normal speed.
- Speak with facial expressions, gestures and body movements which emphasise the words you use. (Only 3 out of 10 words are visible on the lips.)
- Face the light and keep hands, food and so on away from your face while speaking. Make sure there is enough light and that neither of you is silhouetted against a strong light.
- If necessary, attract the person's attention with a light touch on their shoulder or a wave of your hand or some other visible signal.

Using a sign language interpreter

Book an interpreter well in advance of the event or meeting (please refer to interpreter booking procedure on the intranet). In a one-to-one situation, talk to the person, not the interpreter. The interpreter normally sits or stands to the side of the hearing person to form a triangle.

In a group, arrange the seating in a circle or horseshoe so everyone can be seen. The interpreter can then point to the person speaking.

In all interpreting situations it's important to have adequate lighting. Make sure the background behind the interpreter is plain and not distracting. This means the deaf person can see the interpreter's facial expressions and lip patterns clearly.

People who use a wheelchair or have mobility problems

- Do not lean on a person's wheelchair. The chair is part of the body space of the person who uses it.
- When talking for more than a few moments to someone in a wheelchair, to avoid discomfort, for example a sore neck, try to put yourself at their eye level by sitting also.
- Wheelchair users usually prefer to move around under their own power or use powered wheelchairs. Do not push the chair unless you offer help and it is accepted.
- Never touch or move crutches or walking frames without the user's consent.

People who are blind or have serious sight loss

- Approach the person from the front and let them know you are there with a light touch on the hand or arm.
- Identify yourself clearly and introduce anyone else who is present. Try to indicate where they are placed in the room.
- When offering a handshake, say something like 'shall we shake hands?'.
- When help may be needed, for example on unfamiliar ground, say 'How may I assist?" The person will advise you. Generally speaking good practice involves standing by the person with your arm straight (known as the grip arm) and fingers pointing to the ground. He or she will firmly hold your arm just above your elbow. You should walk slightly in front, making it easier for the person to

understand the movement of your body. This will allow you to guide rather than propel or lead the person.

- When offering a seat, place the person's hand on the back or arm of the chair.
- To open a door, place the person's hand on the door handle and let him/her open it, then you go through the door first, allowing the person you are guiding to follow. Let them close the door themselves.
- Steps, stairs and slopes: When you approach steps or a slope say so and say whether they go up or down. The person with the sight problem should be on the side with the handrail. If you need to change sides, ask the person to stand still and let go of your guiding arm to allow you to change sides. Walk towards the handrail and show its position with your guiding arm. It's a good idea to practice these techniques with a colleague from time to time.
- When talking in a group identify yourself and remember to say the name of the person to whom you are speaking.
- Do not leave someone talking to an empty space. Say when you want to end a conversation or want to move away.
- Remember that a guide dog is a working dog, not a pet, and should never be distracted.
- Introduce other people for example, the ward sister and the ward clerk. It will make conversation easier if you also introduce a person with sight problems to the other patients. Say for example:

  "Mrs. Patel is on your right.
  Mrs. Anderson is just opposite and
  Mrs. Doherty is on your left.
  I'll introduce you to the Senior Nurse when they come on duty."

- The following points will also help make things easier:
  - If you move something around the person with a sight disability, always put it back in the same place.
  - When you serve a meal, say that you have done so, say what it is and ask if any help is needed.

- If the person has to go to x-ray, theatre, or somewhere else in the hospital, make sure the porter and whoever will be looking after the person, knows the person has a sight disability.

Deafblind people

A person may be regarded as deafblind if they have a combination of hearing and sight loss resulting in problems with communication, information and mobility. Most deafblind people do have some sight and/or hearing, so the advice in the two previous sections will also apply, but using touch methods for communication and access to information are more likely.

- If offering to guide, move their hand gently to your elbow; some deafblind people also have poor balance, take your cue on how to guide from them.
- You may be able to communicate by writing clear capital letters on their palm, using the whole palm.
- If the person asks for written information, use a thick black pen and write large letters – check the size is right for the person with one word before continuing.

People with speech difficulties

- Give your whole attention to a person with a speech difficulty. Be encouraging and patient. Do not correct or speak for the person. Wait quietly while the person talks, and resist the temptation to finish sentences.
- Where possible ask questions that just need short answers or a nod or shake of the head.
- If you have difficulty understanding, don't pretend. Repeat what you do understand, and the person's reactions will guide you.

Autistic Spectrum Disorders

It is widely recognised that individuals and groups prefer a variety of terms including autism spectrum disorder, autistic spectrum condition, autistic spectrum difference, Aspergers disorder. However in this guidance 'autism' refers to all 'autism spectrum disorders'.

Autism is a lifelong developmental disability that affects the way a person communicates and relates to other people. It is a spectrum disorder which means that it affects each person differently.

The main features of autism are;

• Having difficulties with communicating with other people. The person with autism may interpret language in a literal way, may have difficulty interpreting idiomatic terms, and may not know when someone is joking or being sarcastic.

• Finding it difficult to form or sustain relationships, to engage in a social situation and struggling to initiate conversation.

• Having narrow interests, repeated routines or finding it hard to prepare for change or plan for the future.

• Being over or under sensitive to sound, light, colour, smell and taste. A person with autism for example, may find the work environment too noisy.

Please also remember:

• Use clear and unambiguous language; avoid using figures of speech, sarcasm or metaphors.

• Give precise direction. Instructions should be given one at a time.

• If the person seems aloof or uninterested in talking to colleagues, e.g. avoids eye contact or often says the 'wrong' thing, remember (and, where appropriate, remind colleagues) that this is probably unintentional and is likely to be due to the person's communication difficulties

• Boundaries and 'unspoken or unwritten' rules of the workplace need to be explained clearly.

The Autism Act (NI) 2011 has amended the DDA (Disability Discrimination Act 1995) to remove any ambiguity as to whether the term "disability" applies to autism spectrum conditions. The effect of this amendment is to clarify that a condition which has a substantial and long-term adverse effect on someone's ability to "take part in normal social interaction" or in "forming social relationships" can constitute a "disability". Therefore, managers are asked to take note of this important change and of the need to consider reasonable adjustments for staff with an autism spectrum disorder.

People with Dyslexia or Dyspraxia

Dyslexia is more than just difficulty with reading and writing, it may include underlying problems of short-term memory, processing information and perceptual, spatial and motor skills. Associated literacy and numeracy problems may be obvious, or they may show as slowness rather than inaccuracy.

Dyspraxia impairs the organisation of movement and is associated with problems of language, perception and thought. It overlaps with dyslexia and the two conditions can co-exist in the same person, as can Asperger Syndrome (see page 18). Symptoms include poor short-term memory and concentration, literacy and organisational problems and problems with co-ordination, dexterity and social skills.

Forms can be difficult to fill in. Ask if support is required, as the person may feel embarrassed or awkward to ask you for assistance.

People with mental health problems

'Mental illness' covers all diagnosable mental health problems that become 'clinical', that is, they need a degree of professional intervention and treatment.

'Mental disorders' are health conditions characterised by alterations in thinking, mood or behaviour associated with distress or impaired functioning, or both, for example people in the early stages of dementia or who acquire a brain injury.

People with a past history of mental health problems can experience discrimination. Most people make a full recovery. However, someone experiencing the emotional distress and confusion caused by mental health problems may find everyday activities very hard.

Therefore you should:-

- be patient and non-judgemental and give the person time to make decisions
- ask what support, if any, is needed, and pay attention to the answer. Allow the person time to tell or show you what he/she wants.
- stay calm if the person seems over anxious or confused.

- take time to listen to someone who is mentally ill – and don't assume that he/she has no knowledge or opinions of value.
- keep your communication straightforward and clear. rephrase comments or questions for better clarity.
- not avoid a person with mental health difficulties. avoidance and rejection are among the most commonly upsetting things experienced by people who have mental health problems.

Mental ill health is 5 times more common than learning disabilities, is as common as heart disease and nearly 3 in every 10 employees will have a mental health problem each year.

People with learning disabilities

The Equal Lives document states that international definitions of what is known as a Learning Disability include three elements all of which must be present:-

- Significant impairment of intelligence that includes a reduced ability to understand new or complex information, and to learn new skills
- Deficits in social functioning or adaptive behaviour and a reduced ability to cope independently, and
- The disability started before adulthood and has a lasting effect on development.

Many people with learning disabilities live full and independent lives in the community making their own choices with varying levels of support. Here are some good practice tips:-

- When booking an appointment, it is important to be able to speak to a person – consider having a different telephone number for vulnerable groups if it is an automated system.
- Appointment letters must be in plain English and symbols should be used where appropriate.
- Emergency appointments should, where possible, be with the person's usual doctor as they will already know the person's health condition/history.

- In a GP clinic, take time to clarify and explain things and ensure there is a double appointment made for people with learning disabilities. Use pictures and images to show what is happening. Perhaps offer to tape a conversation so that the person can consider it later and keep a record.
- Watch the person and use gestures and facial expressions.
- If a person wants to take you to show you something, go with them.
- Explain information in a straightforward way what medication/tablets or treatment is for and if there are any side effects and what they should do if they experience side effects. Most people with a learning disability can understand information if plain English is used. However it may be necessary to put information in writing (including your name and phone number) or try using objects or drawings.
- Ask the individual if they have understood i.e. check their understanding, then explain again if necessary. Ask open questions.
- If there is a carer present, speak to the person first, not the carer. You can involve the carer if necessary to gain more information.
- Keep distractions (background noise and busy environments) to a minimum.
- In A&E Departments, check for medical documents.

People with facial disfigurement

- Some people are born with a disfigurement and others acquire it through an accident or illness. It does not mean the person is any different and certainly does not affect his or her intelligence. Most of the difficulties and discrimination people with facial disfigurement experience stem from other people's behaviour or reaction to them.
- If you are surprised by someone's appearance or feel uncomfortable by it, try not to show it.
- Make eye contact as you would with anyone else – try not to stare.
- Listen carefully and do not let the person's appearance distract you.
- Never ask 'what happened to you?' – restrain your curiosity.

Support workers and personal assistants

People with a disability may be accompanied by personal assistants or support workers. Personal assistants are paid workers who provide practical and personal support. Treat support workers with courtesy and respect but remember that they are present as an assistant, and your communication should be directed to the person with the disability.

Appointments/meetings/waiting areas

Always check the following when arranging meetings, interviews or appointments:

- Are there suitable parking arrangements? Ensure parking spaces dedicated to disabled people are not taken up by visitors or staff who do not need them.
- In all waiting areas at least one space or more depending on the type/size of area should be left free for a possible wheelchair user with a notice put on the wall identifying it as such.
- Is there a ramped or step-free entrance?
- Are there suitable toilet facilities?
- Is a lift required?
- Do the people on reception know they may need to provide assistance?
- Have you provided directions and/or a map to the hospital/clinic in an accessible format, eg large print, easy-read?

If there are potential access problems, contact the person in advance and discuss what can be done. Do everything you can to remove any barriers that might reduce the effectiveness of our service for people with disabilities. Managers and Supervisors should ensure that all aids (text phone, loop systems) are working, that all relevant staff know how to use them and that training is provided for all staff, including newly appointed staff.

Try to allow people enough time when checking or taking their details. A person with a learning disability may need more time. If you work in A&E reception, make sure you are aware of the 'fast track' arrangement for people with behavioural difficulties. And always, always, be discreet.

Try to be as helpful as possible to everyone. If a patient is very anxious, can you help in some way? Are the toilet areas clearly signposted? Be aware – and be discreet.

Remember, someone who has a hearing disability may not hear their name being called and people with visual disabilities may not be able to clearly see information they need, or find the seating area. If possible, seat visually and hearing impaired patients near and facing reception desks, to help reassure them that they won't be forgotten. If necessary, physically go to them to tell them when it is their time to be seen.

In waiting areas occasionally and discreetly check the comfort of requirements of service users with disabilities. If in doubt, it's always best to ask. If a person has a sight or hearing disability, keep them informed about what is happening.

Initial assessment or treatment areas

- At this stage you should already be aware if a patient has a disability. Bear in mind the following:
- Check how the patient wishes to be examined, for example, remaining in a wheelchair.
- Ensure that assistance, equipment and hoists are available and that you know how to use them.
- Avoid using complicated language or jargon when giving a diagnosis or explaining a treatment procedure and take time to explain it. Use plain English. Remember the patient's right to consent on his/her own behalf.
- Parents/carers of children/people with disabilities have useful knowledge and expertise about the child/person, as well as the patient him or herself. Listen to them and use that expertise to improve the care provided.
- If someone has to be left for any length of time, make sure they know why and occasionally check out if they are still ok. For example, check if they need a change of posture or personal care, or whether they are experiencing any anxiety – and do what you can to help.

Referral on to wards and other treatment/ diagnostic areas:

- Ensure that a person's requirements are passed on between departments. For example, information about a patient's personal preferences and any insight gained through earlier examination processes should be shared between departments in advance.
- It's important that the patient is kept fully informed of why and to where they are being sent, and how long they can expect to be there. Always let patients know about facilities such as nearby toilets.
- Ask if the patient would like someone to escort them to the next department.
- If they are going alone, ask if they want you to describe or write down locations and, if they do, use clear and straightforward language – avoid "up there" or "the next block".
- Avoid creating additional barriers for disabled service users. For example, a badly placed IV drip can prevent someone using sign language.
- Check that a patient's auxiliary aids are within reach.

At discharge

When a patient is sent home after treatment, discharge arrangements normally follow a standard procedure that may have to be amended to take account of the needs of a person who is disabled. For example, consider how a new mother who is a wheelchair user will change her baby, or if the patient needs you to book a taxi or needs help to the bus stop, etc. If a patient has a hearing disability, have a sign language interpreter available when they are being discharged so that there is clarity about medication, wound care, and follow-up care. Information on how to book Sign Language interpreters can be obtained from your Line Manager, Head of Department or Belfast Trust Hub.

Job interviews for people with disabilities

- With reasonable adjustments in place, if required, proceed with the interview process in the positive and friendly manner in which you would for all candidates. Please also refer to the Trust's Policy on the Employment of People with Disabilities and the Reasonable Adjustment Guidelines for Managers which provides further detailed guidance.
- Focus on the person's abilities, achievements and qualities against the tasks and the genuine requirements of the job. Remember that skills and abilities may have been acquired outside the working environment.
- Remember that questions about an interviewee's disability should be restricted to those relevant to work and should be asked positively in the context of 'reasonable adjustment'. Before asking a question about a person's life outside work, ask yourself whether you would put this question to any other interviewee.
- Do not make assumptions about an individual's ability to perform certain tasks. People with disabilities often develop innovative solutions to everyday challenges, with or without technical aids or personal support.
- Form your own opinions from discussion with the person, as you would with any interviewee.
- If a handwritten application form is required, ask the Recruitment and Selection Department on 028 950 49133 if it is necessary. Some people may need someone else to fill it in, or may need to use a computer or tape.

8. Towards a better service

These suggestions are just some of the approaches that will help you to improve the overall experience of patients who are disabled, their families, visitors and staff. They will help you comply with the relevant legislation. But most of all, they are, quite simply, about removing barriers and treating people equally.

Please note that in addition to this Disability Etiquette booklet the HSC Trusts have also developed guidance for staff on providing accessible information entitled "Making Communication Accessible for all". This guidance has been produced for HSC staff so that they can communicate effectively with people who may have a disability. This guidance is also available on the Intranet.

9. Useful Contacts

Improving Working Lives/ Employment Equality
4th Floor McKinney House
Musgrave Park Hospital
Belfast
BT9 7JB

(028) 950 48913
(028) 950 48667

Health and Social Inequalities
Graham House
Knockbracken Healthcare Park
Belfast

(028) 90 960070

Equality Commission for NI
Equality House
7-9 Shaftsbury Square
BELFAST
BT2 7DP

Phone: 028 9050 0600 Fax: 028 9032 8970
Email: information@equalityni.org
Website: www.equalityni.org

Disablement Advisory Service
Department for Employment & Learning
Gloucester House
Chichester Street
Belfast
BT1 4RA

Phone: 028 9025 2206 Fax: 028 9025 2213

Text phone: 028 9025 2363
Website: www.delni.gov.uk

Employers for Disability
Banbridge Enterprise Centre
Scarva Road Industrial Estate
Banbridge
BT32 3QD

Phone: 028 4062 4562 Fax: 028 4066 9665
Email: info@efdni.org
Website: www.efdni.org

Disability Action
Portside Business Park
189 Airport Road West
Belfast
BT3 9ED
Phone: 028 9029 7882 Fax: 028 9029 7881
Textphone: 028 9029 7882
Email: hq@disabilityaction.org
Website: www.disabilityaction.org

Belfast Health and Social Care Trust

REASONABLE ADJUSTMENT GUIDELINES FOR MANAGERS

April 2011

CONTENTS Page

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English

1. INTRODUCTION

The Belfast Health and Social Care Trust has in place a Policy on the Employment of People with Disabilities that should be read in conjunction with these Reasonable Adjustment Guidelines for Managers.

The Trust is committed to Equal Opportunities for applicants and employees with disabilities. The Disability Discrimination Act 1995 (as amended) (DDA) states that an employer has a statutory duty to make reasonable adjustments to prevent their practices or arrangements discriminating against a person with a disability. This duty is ongoing and reasonable adjustments should be reviewed on a regular basis to ensure they are effective.

Facts

- 21% of the Northern Ireland adult population has a disability.
- 1 in 4 families in Northern Ireland is directly affected by disability.
- A person with a disability is more likely:
  - To be unemployed – 66% of people with disabilities are unable to access employment opportunities
  - To have no qualifications
  - To have to live on, or below, the poverty line as a person without a disability
- Benefits make up two-thirds of the total income of people with disabilities, compared to just over a fifth for the general population.
- Around half have difficulty using everyday services like going to the cinema, eating out or going shopping.
- Of those, 4 in 10 have problems getting there.
- Of those who find shopping difficult, 1 in 3 has problems getting around the shops.
- 80% of people with disabilities who encounter difficulties are offered no help by service providers.

- Disability should not be confused with illness. The general health of many people with disabilities is as good as that of anyone else.
- Mental Health disability affects 1 in 4 of the population in some form in a person's lifetime.
- In NI 1 in 7 people has a hearing impairment.
- Less than 5% of people with physical disabilities are wheelchair users
- A sighted person is about four times more likely to be employed than a blind person is.
- It is estimated that 2% of the population or over 33,000 people in NI has a learning disability. These figures are people known to Social Services.
- 70% of people acquire disability during their working life.
- People who have a mental health disability or a learning disability are five times more likely to be unemployed than people without these disabilities.

Sources: NI Survey of people with Activity Limitations and Disabilities; NI Census; Mental Health Foundation; Employer's for Disability NI.

2. DEFINITION OF DISABILITY

The DDA defines disability as "a physical or mental impairment which has a substantial and long term adverse effect on a person's ability to carry out normal day-to-day activities".

What about people who have recovered from a disability?

People who have had a disability within the definition are protected from discrimination even if they have since recovered.

What does "impairment" cover?

It covers physical or mental impairments; this includes sensory impairments, such as those affecting sight or hearing.

Are all mental impairments covered?

The term "mental impairment" is intended to cover a wide range of impairments relating to mental functioning, including what are often known as learning disabilities. There is no longer a requirement that a mental health condition is 'clinically well recognised' before it can count as an impairment under disability discrimination law.

Substantial: a substantial adverse effect is something which is more than a minor or trivial effect. The requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people.

Long-term adverse effect: a long term effect of an impairment is one:

- which has lasted at least 12 months; or
- where the total period for which it lasts is likely to be at least 12 months; or
- which is likely to last for the rest of the life of the person affected.

What if the effects come and go over a period of time?

If an impairment has had a substantial adverse effect on normal day to day activities but that effect ceases, the substantial effect is treated as continuing if it is likely to recur: that is if it is more probable than not that the effect will recur.

Normal day to day activity: this is something which is carried out by most people on a fairly regular and frequent basis, such as washing, eating, catching a bus or turning on a television. It does not mean something so individual as playing a musical instrument to a professional standard or doing everything involved in a particular job.

The test of whether an impairment affects normal day to day activities is whether it affects one or more of the broad categories below:

- mobility
- manual dexterity

- physical co-ordination
- continence
- ability to lift, carry or otherwise move everyday objects
- speech, hearing or eyesight
- memory or ability to concentrate, learn or understand, or
- perception of the risk of physical danger

What about treatment?

Broadly speaking, the effects that matter are those that would be present if there was no medication or treatment taking place. The exception is people who wear spectacles or contact lenses when what matters are the effects that remain while the spectacles or contact lenses are being used.
Are there any types of condition covered by special provisions in the DDA?

Yes, because some people with particular conditions might otherwise not be counted as having a disability. These are provisions covering:

- recurring or fluctuating conditions such as arthritis, where the effects can sometimes be less than substantial, which are treated as continuing to have a substantial adverse effect so long as that effect is likely to recur.
- conditions which progressively deteriorate, such as motor neuron disease, which count as having a substantial adverse effect from the first time they have any effect at all on ability to carry out normal day to day activities even if it is not substantial, so long as there is eventually likely to be a substantial adverse effect.
- severe disfigurements which are treated as having substantial adverse effects on ability to carry out normal day to day activities, even if they have no actual effect at all.
- people with cancer, HIV, or multiple sclerosis are deemed to be disabled from the point of diagnosis, regardless of whether or not they have any symptoms.

Are any conditions not covered?

Yes, the following conditions specifically do not count as impairments:

- addiction to or dependency on alcohol, nicotine or any other substance (unless resulting from the substance being medically prescribed);
- seasonal allergic rhinitis (e.g. hay fever) unless it aggravates the effect of another condition;
- tendency to set fires, or steal, or physically or sexually abuse other persons;
- exhibitionism and voyeurism;
- disfigurements consisting of tattoos, non-medical body piercing or attachments to such piercing are not treated as having substantial adverse effects.

A person with an excluded condition may nevertheless be protected as a person with a disability if he or she has an accompanying impairment which meets the requirements of the definition. For example, a person who is addicted to a substance such as alcohol may also have depression, or a physical impairment such as liver damage, arising from the alcohol addiction. While this person would not meet the definition simply on the basis of having an addiction, he or she may still meet the definition as a result of the effects of the depression or the liver damage.

What is Discrimination?

The DDA describes five types of discrimination:

- Direct Discrimination
- Disability Related Discrimination
- Failure to make reasonable adjustments
- Victimisation
- Harassment.

3. WHAT ARE REASONABLE ADJUSTMENTS?

The DDA says that one way discrimination can occur is when an employer fails to comply with a duty of reasonable adjustment in relation to a person with a disability.

Reasonable adjustments are practical ways to remove certain disadvantages faced by a person with a disability and enable them to carry out the duties of their job. The DDA says that the duty to make reasonable adjustments applies where any physical feature of the employer's premises, or any practices, policies or criteria made by the employer, place a person with a disability at a substantial disadvantage compared to a person without a disability.

Each case will be individually assessed and reasonable adjustments made as appropriate. Failure to make reasonable adjustments is discrimination that can never be justified.

When to Make Reasonable Adjustments?

All employees who have a responsibility for staff management have a duty to make Reasonable Adjustments as soon as they know that someone defined as having a disability may need them. Not asking whether something is needed is no defence for not knowing, and it is your duty to take reasonable steps to find out whether adjustments are needed. Employers should not only seek reasonable adjustment information through formal processes e.g. Occupational Health, but also be alert to signs and symptoms that could have reasonably lead them to suspect that an individual may have a disability which they have not disclosed or which has not yet been diagnosed.

Any necessary adjustments should be implemented in a timely fashion, and it may also be necessary for an employer to make more than one adjustment. It is advisable to agree any proposed adjustments with the person with the disability in question before they are made.

Why Carry Out Reasonable Adjustments?

Carrying out reasonable adjustments is a legislative duty on employers under the DDA. Common misconceptions held about this requirement consider that measures are likely to be expensive and inconvenient, but this is not true. Often a very simple adjustment can make a huge difference to an individual and consequently enables them to remain in work, carrying out their job.

Aside from adhering to legislative requirements and duties placed under the legislation, there is a valid business case attached to accommodating and being proactive in the provision of reasonable adjustments. Often they are not costly to the organisation but can save a great deal by preventing a staff member needing to go off on long-term sickness. Also, taking this proactive approach will undoubtedly assist how staff carry out their duties and encourage positive morale in the workplace, as they will feel that their interests and well being are accommodated. Results can be the saving of money incurred through sickness pay and cover arrangements, as well as ensuring productivity and satisfaction.

4. REASONABLE ADJUSTMENTS IN RECRUITMENT AND SELECTION

In recruitment and selection it is unlawful to discriminate against a person with a disability in the arrangements for deciding who should get the job. All staff involved in recruitment and selection should undergo the Trust's Recruitment and Selection training course. Reasonable adjustments to the recruitment process may be required to enable an individual with a disability to compete on an equal basis and demonstrate their ability to do the job. Reasonable adjustments may be required at any stage of the recruitment and selection process.

Job Description and Personnel Specification

The job description should accurately reflect the duties and responsibilities of the job and the personnel specification must only contain criteria which is job related and can be fully justified.

However in the instance of a disabled applicant who indicates their need for a reasonable adjustment, the employer will be required to give such requests due consideration which may include provision for accepting a lesser level of qualification and/or experience unless such can be demonstrated as an element of the criteria which cannot be adjusted for justifiable reasons (for example if the qualification is required to practice). Panels should always seek advice from the Recruitment and Selection Department in such circumstances.

Disclosure of Disability on Application Form

Application forms contain a question on whether the candidate requires a reasonable adjustment for reasons related to a disability to allow them to attend for interview and undertake the duties of the post if successful. Where an applicant has indicated on the application form that they require a reasonable adjustment(s) the Human Resources Department (Recruitment Section) will contact the applicant and arrange for the appropriate adjustments to be put in place.

Examples of adjustments could include:

- A sign language interpreter at interview.
- Extended time to prepare a presentation.
- Interviews conducted in an accessible venue.
- Parking provided near the interview location.
- Criteria are reviewed for disabled candidates.
- A Support Worker can accompany the candidate to interview

Application forms will be made available on request in alternative formats.

Interviews/Tests and Assessments

It is necessary to prepare in advance for interviews. Applicants are given the opportunity to indicate in advance if they require reasonable adjustments and suggest adjustments to help overcome the disadvantage. The Chairperson should be aware of the situation and the panel members should also be briefed and consideration should then be given to individual cases and any advice received from the Recruitment & Selection Department.

It is important not to make assumptions about what a person with a disability can and cannot do. The majority of people with a disability need little or no special support for an interview and their disability may be irrelevant to their ability to do this job.

Interviews should be specific, examining the skills; training, experience and ability of the interviewees and questions should never focus on the details of the disability and instead should focus on how it affects ability to do the job.

Any tests/assessments should be relevant to the post and examples of reasonable adjustments required include; changes to the format, allowing a support worker to be present or allowing additional time to be given to complete the test.

Conditional Offer

As with all Trust appointments, the offer of employment will be conditional upon meeting all of the necessary pre-employment checks. In the instance of an appointee with a disability who has indicated their need for reasonable adjustment, this will incorporate a meeting to ensure that the individual's requirements are fully understood and to allow an assessment to ensure that their requirements can be met. The appointee will be invited to attend a meeting with the relevant line manager and Occupational Health Department and, where appropriate/necessary, a representative from the Equality/Improving Working Lives Section of HR. This will be co-ordinated through the Recruitment and Selection Team. Where reasonable adjustments are identified, an action plan for implementation will be agreed prior to the agreed commencement date.

5. REASONABLE ADJUSTMENTS IN EMPLOYMENT

It is the duty of the employer to make adjustments for employees with disabilities to the physical features of their premises or to any provisions, criteria or practice made by the employer. The duty of reasonable adjustment also applies to people with disabilities on work experience, work placement and vocational training.

Examples of Reasonable Adjustments include:

Work Environment

(1) Altering the height of a computer workstation so that an employee with a neck injury can work without aggravating the injury.

(2) Providing a stair lift to enable a wheelchair user to remain part of the team and enable them to get to their office on an upper floor or relocate them to a ground floor office.
(3) A consultant appoints a new secretary who is visually impaired. It would be an appropriate reasonable adjustment to paint part of an interior in contrasting colours to help the visually impaired person find their way around.

It is important that the work environment is considered when planning new services/builds and access audits are an important way of ensuring current premises are accessible.

Re-allocation of Duties

Re-allocating some of the duties carried out by the person with a disability to another employee. For example:

(1) A Clerical Officer with arthritis whose job may occasionally involve filing or photocopying. A possible reasonable adjustment might be to reallocate these duties to another member of staff.
(2) An employee who is deaf may be unable to use the phone could take on different duties while their colleagues have responsibility for answering all phone calls.

Job Transfer

For example, an employee who is no longer able to drive could be reallocated to a desk job or any other role where they are not required to drive. In these circumstances an employee does not need to undergo the interview process. However, redeployment should only take place when there are no more reasonable adjustments that can be made to an employee's existing role. Note that retraining may be required as a reasonable adjustment to facilitate redeployment.

Altering Hours of Work or Training

For example, an employee who has arthritis may find the effects of the condition are worse in the mornings, the Trust may allocate shifts that start later in the day. It could also include different working hours to avoid the need to travel in the rush hour if this is a problem related to impairment. A phased return to work with a gradual build-up of hours might also be appropriate in some circumstances.

Assigning a Disabled Employee to a Different Place of Work or Training

For example, this may include transferring to an existing vacancy. It could also include moving the employee to a ground floor office, or a different building depending on the nature of their disability. It could also mean moving an employee to a location closer to home or working from home. For example, an employee with Crohn's disease may find traveling for long periods difficult.

Time Off for Rehabilitation, Assessment or Treatment

For example, an employee who is undertaking a course of treatment for cancer may need to adjust their working hours to attend hospital appointments.

Providing Training or Mentoring

This may be linked to one of the other reasonable adjustments made for the employee.

For example, an employee who has been redeployed to an existing vacancy may require training to help them carry out that role. Another employee could act as a mentor to talk about aspects of the work, work patterns and work load and provide advice to the employee.

Additional support/supervision could be given to an employee with a learning disability via peer support or coaching.

Alternatively an employee who has been provided with a piece of equipment, for example voice recognition software, may also need to be trained in how to use it.

Refresher training may be necessary if the employee returns to work after a long period of absence.

A visually impaired person attending computer training may require the computer to have speech output software.

All staff should attend disability awareness training.

Acquiring or Modifying Equipment

For example:

(1) An employee who has dyslexia may benefit from voice-activated software, a spell checker or a Dictaphone to help record minutes or reports.
(2) An employee who is deaf may find a telephone with text display to be a useful aide

Modifying Instructions or Reference Manuals

For example:

(1) An employee with a learning disability may require their daily tasking to be repeated slowly in order for them to write them out, or they may require them to be provided in a written format by the line manager.
(2) An employee, suffering from a degenerative eye condition that leads to a sight-disability may benefit from the employer providing written materials in an enlarged format.

Modifying Procedures for Testing or Assessment

This could involve ensuring that particular tests do not adversely affect people with particular types of disability. For example, a person with

restricted manual dexterity would be disadvantaged by a written test, so the employer gives that person an oral test instead.

Providing a Reader or Interpreter

A colleague reads mail to a person with a visual impairment at particular times during the working day. Alternatively, the employer might hire a reader or sign language interpreter.

Providing Supervision/Other Support

An example of this is an employee who returns to work following a period of absence due to a disability such as clinical depression may need additional guidance and supervision especially in the short term to help them recover their skills and confidence. The Trust may seek support from Community and Voluntary organisation to provide support to the individual.

The Disablement Advisory Service programmes and services can also provide support to individuals who become disabled whilst in employment – please refer to the Trust's Policy on the Employment of People with Disabilities.

This list is not intended to be a comprehensive list of examples. There will be situations where adjustments can be made which do not fall under any of the above headings. The important point is to consider the requirements of the individual (which are best identified by consulting the employee concerned) in line with the needs of the service.

The DDA lists a number of factors, which may have a bearing on whether it will be reasonable for the Trust to have to make a particular adjustment. These are:

- The effectiveness of the particular adjustment in preventing the disadvantage
- The practicability of the adjustment.
- The financial and other costs of the adjustments and the extent of any disruption caused.

- The extent of the employer's financial or other resources
- The availability to the employer of financial or other assistance to help make an adjustment
- The nature of the employer's activities, and the size of its undertaking:
- In relation to private households, the extent to which taking the step would disrupt the household or disturb any person residing there.

The Trust must prove that it has explored all avenues and must present justifiable reasoning why a measure could not be taken, for example, a valid business reason or health and safety (this supersedes all else as the duty of care). The key word is reasonable. Stereotypical assumptions about the health and safety implications of disability should be avoided. Less favourable treatment based on such assumptions may itself amount to direct discrimination.

44% of Reasonable Adjustments cost less than £50 to implement (Source: Integrating Disabled Employees, Department for Education & Employment Research – Report 56). The employer's duty to make reasonable adjustments is ongoing. All arrangements should be monitored and reviewed regularly as it may be necessary to consider further or alternative adjustments.

Phased Return Guidance from the Chartered Institute of Personnel and Development (CIPD)

- Easier to retain through proactive recovery or retention schemes than waiting for long term sick to occur.
- Longer someone off, less likely to return. Rehabilitation should be initiated as soon as possible. This also sends positive messages and people appreciate being cared about.
- Effective case management for employees who require retention and rehabilitation, CIPD recommends dedicated case manager.
- Active involvement of supervisor/manager from beginning of recovery process.
- Mentoring to provide support on daily basis.
- Welcome person on their first day back to work – investment in this can reap huge returns.

- Set realistic targets for the rehabilitation programme, to get workers commitment to them. Consultation with worker imperative in discussion of options.
- Invite in to meet for coffee or outside work with colleagues to make the first day less daunting.

Please also refer to Appendix 1 for further guidance from the Central London Law Centre.

6. STEPS TO TAKE FOR APPLICANTS WITH A DISABILITY

Step 1

If applicant has stated on their application form that they require reasonable adjustment, consult with the applicant and ensure that reasonable adjustments are in place.

Step 2

If applicant is successful at interview, refer to Occupational Health for pre-employment medical assessment (as standard for all Trust employees).

Step 3

Where reasonable adjustments are required, a meeting should be arranged between, Human Resources, Occupational Health, line manager, new employee. This meeting will determine the necessary reasonable adjustments and action plan for implementation of same prior to commencement.

Step 4

If necessary, the new employee and Human Resources will meet with the Disablement Advisory Service (DAS) to further discuss reasonable adjustments to the workplace. The DAS provides advice, guidance, training and a placing service for people with disabilities and health issues. Community and voluntary organisations and Supported Employment organisations can also provide support and guidance to

people with disabilities in employment – please refer to the Trust's Policy on the Employment of People with Disabilities.

Step 5

Human Resources will advise new employee that they may contact them for help and support throughout the course of their employment with the Trust. It may be necessary for reasonable adjustments to be made to the new employee's induction to the Trust/Department. The Trust's Policy on the Employment of People with Disabilities recognises its ongoing duty with regard to reasonable adjustments.

7. STEPS TO TAKE IF AN EMPLOYEE DEVELOPS A DISABILITY

These are general principles. The position in any individual case will depend on the precise facts. Advice and guidance should always be sought from the Human Resources Department.

Step 1 – Gathering Information

An employer who becomes aware of an employee's disability or has reason to believe an employee may have a disability should first discuss the situation with the employee. Together the employer and the employee should agree a plan of action that could include conducting a risk assessment, obtaining medical reports and identifying reasonable adjustments.

Step 2 – Refer to Occupational Health

Refer employee to the Occupational Health Department if appropriate. Occupational Health will provide advice to management on the person's fitness for work, functional capabilities and on any adjustments which could be considered for example to premises or working duties/arrangements. If referral to Occupational Health is not appropriate go to step 3.

Some examples of when this may be appropriate include:

- suitable adjustments are difficult to identify or hard to provide

- a person has recently acquired the disability or has a fluctuating / progressive condition and is not sure what impact this may have or what would help them do the job
- you need to establish whether an underlying medical condition is the cause of workplace problems
- a medical opinion is required to ensure a safe and healthy working environment.

Provide Occupational Health with:

(a) objective and quantitative information about the employees job, for example:
- working hours/shift patterns
- job title, location and duties
- travel involved as part of their duties in work
- physical requirements of the job
- working environment
- intellectual and emotional demands.

(b) other relevant information which may include:
- records of sickness absence, time keeping
- details of adjustments that you may be considering or that are already in place
- any concerns you may have.

NB:
- managers do not need to know the medical diagnosis but should focus on the impact on the job and adjustments required
- further specialist medical advice may be appropriate
- Occupational Health must report back on any adverse constraints which could affect capacity to work.

Once the report is received back from Occupational Health the Manager and a representative from Human Resources should meet with the employee to determine course of action.

Step 3 – Reasonable Adjustments

Investigate and implement any reasonable adjustments in a timely manner. Where appropriate seek additional information and advice from statutory and voluntary bodies. It may be appropriate to contact Employers for Disability (EFD), the Disablement Employment Adviser, based at Jobs and Benefits Offices or JobCentres. The DAS provides advice, guidance and training for those who wish to obtain or retain employment. They also offer a range of practical and financial support to employers recruiting and retaining disabled employees.

Step 4 – Alternative Employment

Where no adjustment is possible to enable the employee to continue in their position redeployment should be considered in conjunction with the Human Resources Department and the individual. It is important to note that you should consider all available opportunities i.e. both redeployment opportunities where reasonable adjustments are not required and where reasonable adjustments are required.

At this point the individual's qualifications or relevant experience should be assessed and the Recruitment Section contacted to determine any suitable vacancies/redeployment opportunities.

NB: It is important to remember that a post cannot be created to accommodate a member of staff with a disability. Duty of care and providing employment will override, as the tribunal would pronounce the individual should be trained up for a role and slotted in. The Trust will seek in the first instance to redeploy an employee with a disability to a post at the same level.

Once a suitable vacancy has been determined, employees should meet with the appropriate manager and Human Resources to investigate the need for further reasonable adjustments in the workplace.

Step 5 – Where no adjustment or alternative employment is possible

If neither reasonable adjustments nor redeployment is possible, then retirement/termination on ill health grounds may be considered as the most appropriate course of action.

Step 6 – Monitoring

The Trust's Human Resources Department will monitor all known cases on an on-going basis, in conjunction with the employee, line manager, Occupational Health, the DAS and other relevant voluntary agencies, if appropriate.

8. AVAILABLE ASSISTANCE FOR DISABLED EMPLOYEES

Human Resources provide advice to both staff and management on statutory recommendations and best practice guidelines. They will ensure Trust compliance under the DDA and promote equality of access to employment opportunities throughout the Trust.

The Trust works in conjunction with the DAS within the Department of Education and Learning, which is a statutory body established to meet the needs of employees with disabilities to either secure employment or continue and develop within their current workplace. The DAS can provide financial assistance in the procurement of support and equipment and also, offer impartial advice to both employers and individual employees.

The Trust will also work in partnership with community and voluntary organisations i.e. Supported Employment organisations to provide assistance and support to people with disabilities and the Trust to access and maintain employment.

Definition of Equipment

The Trust defines equipment as any support or special equipment acquired specifically to assist a person with a disability to carry out their job. Special support is any item that a person with a disability needs to do a job that a person without a disability would not need to do that job. The list can include:

- Wheelchair
- Hearing aid
- Computer equipment
- Specialist chair
- Text Telephone
- Magnifying equipment
- Support worker

Contributions towards the cost of aids and equipment

Generally, when support and equipment are required for an employee to use in the workplace, the Access to Work Scheme will request that the Trust agree to contribute towards the costs. In certain cases the Access to Work Scheme will specify the required amount they wish the Trust to contribute i.e. first £500 of cost and 20% of remaining sum.

9. FURTHER INFORMATION

If you have a query on any aspect of this policy or require guidance, please contact:

Employment Equality Department/Improving Working Lives on (028) 90636105

Occupational Health Department on (028) 631300

Appendix 1

Central London Law Centre Good Practice to Consider in Policy and Management

- Before disciplining/dismissing consider if reasonable adjustments have been considered/exhausted (remember dismissal legislation and procedures too have impact on this area if avenue must be taken).
- Ensure staff understand meaning of disability.
- Counting days as sickness absence can have long-term repercussions – sick pay, bonuses, redundancy selection, capability, dismissal.
- Operations, regular medical checks and replacement of disability aids should not be taken as sickness absence or out of annual leave entitlements.
- Adjust appraisals and individual targets to take account of disability related leave.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 22/08

Title:	**Your right to raise a concern (Whistleblowing) Policy**		
Author(s)	Claire Cairns, Head of Office (Lead Author) [redacted] Joan Peden, Co Director, Human Resources [redacted] [redacted] [redacted] Robert Henry, Risk and Governance [redacted]		
Ownership:	Dr Cathy Jack, Medical Director		
Approval by:	Policy Committee Executive Team	**Approval date:**	11 January 2018 24 January 2018
Operational Date:	April 2018	**Next Review:**	April 2023
Version No.	3.2 **Supercedes**	3.1 - April 2018 – April 2023	
Key words:	Whistleblowing, whistle-blowing, whistle, blowing, raising a concern, concern, public interest, suspected wrongdoing, Public Concern at Work, PCaW, whistleblower		
Links to other policies	http://intranet.belfasttrust.local/policies/Pages/Policies/Finance.aspx		

Date	Version	Author	Comments
09/08/2012	0.1	Paul Ryan Joan Peden	
09/01/2013	1.1	June Champion	Initial Draft
14/02/2013	1.2	Nicola Williams	Bribery Act 2012
15/02/2013	1.3	Joan Peden	Revised Draft
15/02/2013	1.4	June Champion	Revised Draft
18/02/2013	1.5	Policy Committee	Comments
01/05/2013	1.5	Workforce, Governance and Policy Review Sub committee	No Comments
16/10/2014	2.1	Jill Shaw-O'Doherty	Revised details relating to the Head of Office and Medical Director.
28/11/2017	3.0	Robert Henry	Detail from Regional Framework lifted into BHSCT Policy
30/03/2018	3.1	Robert Henry	Additional line added on request from HR regarding Working Well Together Policy and Harassment Policy
16/02/2020	3.2	Claire Cairns	Policy advocates list updated

Contents

1.0 BACKGROUND & PURPOSE OF POLICY

Health and social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve.

Encouraging staff to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of services and patient safety. Many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. When concerns are raised and dealt with appropriately at an early stage, corrective action can be put in place to ensure safe, high quality and compassionate care.

The importance of raising concerns at work in the public interest (or "whistleblowing") is recognised by employers, workers, trade union and the general public. Working in partnership with Trade Unions, staff associations and employee representatives is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place.

1.1 Defining Whistleblowing

Whistleblowing is defined as "when a worker reports suspected wrongdoing at work".

The wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences.

Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:

- patient safety;
- health and safety at work;
- environmental damage; or
- a criminal offence (e.g. fraud).

Whistleblowing can also be broadly defined as simply 'raising a concern'. People outside the organisation, including stakeholders, suppliers and service users, can also raise concerns through the HSC Complaints Procedure. However, whistleblowing is different from making a complaint or raising a grievance.

Whistleblowers can often act out of a feeling of fairness or ethics rather than a personal complaint. As Public Concern at Work (PcAW) states, it is important to note that:
"*....the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequently, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not*

be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it".

1.2 Overview

This applies to **all staff** (employees, workers) involved in the work of BHSCT. It does not apply to patients and clients or members of the public who wish to complain or raise concerns about treatment and care provided by BHSCT or about issues relating to the provision of health and social care. These will be dealt with under the separate BHSCT Complaints Procedure.

This is for staff to raise issues where the interests of others or the organisation are at risk. If a member of staff is aggrieved about their personal position they must follow the local grievance procedure for making a complaint about Bullying and/or Harassment.

All cases of suspected, attempted or actual fraud raised under this policy should be handled promptly in line with the organisation's Fraud Response Plan

It is important that BHSCT, like all HSC organisations are committed to the principles set out in their whistleblowing arrangements and can ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their organisation.

Within BHSCT

- Head of Office has been identified to take responsibility for ensuring implementation of the whistleblowing arrangements.

- For each Directorate advisors/advocates have been identified to signpost and provide support to those wishing to raise a concern.**(Ref Appendix D)**

- A non-executive board member has been identified to have responsibility for oversight of the culture of raising concerns within their organisation.

As an employer, BHSCT must take all concerns raised seriously.
However, it may not be necessary to carry out a formal investigation in each case. BHSCT Head of Office / Directorate Advocate will consider a range of possibilities depending on the nature of each case:

- explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns
- minor concerns might be dealt with straightaway by line management
- a review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment
- there may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices
- there may be a clear need for a formal investigation.

Having considered the options it is important that the rationale for the way forward is clearly documented. If necessary, the BHSCT can also seek advice and guidance from the relevant prescribed person.

1.3 BHSCT Procedure for Whistleblowing

1.3.1 Introduction

All of us at one time or another may have concerns about what is happening at work. The BHSCT wants you to feel able to raise your concerns about any issue troubling you with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or BHSCT itself, it can be difficult to know what to do.

The BHSCT recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged.

This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof, raise the matter when it is still a concern. If something is troubling you of which you think we should know about or look into, please let us know. The BHSCT has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

1.3.2 Aims and Objectives

BHSCT is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

reassures you that it is safe and acceptable to speak up;
upholds patient confidentiality;
contributes towards improving services provided by the BHSCT;
assists in the prevention of fraud and mismanagement;
demonstrates to all staff and the public that the BHSCT is ensuring its affairs are carried out ethically, honestly and to high standards;
provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The BHSCT roles and responsibilities in the implementation of this policy are set out at **Appendix A** of this Policy.

2.0 SCOPE

The BHSCT recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Working Well Together, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the BHSCT, including permanent, temporary and bank staff, staff in training working within the BHSCT, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:
malpractice or ill treatment of a patient or client by a member of staff;
where a potential criminal offence has been committed, is being committed or is likely to be committed;
suspected fraud;
breach of Standing Financial Instructions;
disregard for legislation, particularly in relation to Health and Safety at Work;
the environment has been, or is likely to be, damaged;
a miscarriage of justice has occurred, is occurring, or is likely to occur;
showing undue favour over a contractual matter or to a job applicant;
research misconduct; or
information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think BHSCT should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the BHSCT's local grievance procedure, Working Well Together Policy or Harassment Policy which can be obtained from your manager. This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to

replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

3.0 ROLES & RESPONSIBILITIES

Refer **Appendix A**

4.0 KEY POLICY PRINCIPLES

4.1 Suspected Fraud

If your concern is about possible fraud or bribery BHSCT has a number of avenues available to report your concern. These are included in more detail in BHSCT Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Senior Manager
- Head of Department
- Director of Finance
- Fraud Liaison Office (FLO)

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The BHSCT's Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the BHSCT or under its control.

The BHSCT expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

4.2 BHSCT Commitment to you

4.2.1 Your Safety

The BHSCT, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The BHSCT will

not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The BHSCT expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the BHSCT reserves the right to take disciplinary action if appropriate.

4.2.2 Confidentiality

With these assurances, the BHSCT hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to initially a member of staff within your Directorate that has been identified to provide support in relation to Whistleblowing.

(Ref **Appendix D** for details of BHSCT Directorate Advocates)

The BHSCT is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

4.2.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Public Concern at Work (see contact details under Independent Advice 4.3.2).

4.3 Raising a concern

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in 4.4. You should also remember that you do not need to

have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

4.3.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager (or lead clinician or tutor). But where you do not think it is appropriate to do this, you can use any of the options set out below. If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact:

- the designated advisor/ advocate (**Ref Appendix D**)

If you still remain concerned after this, you can contact:

- Claire Cairns Head of Office **(Ref Appendix D)**

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see 4.4 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

4.3.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation. Advice is also available through the independent charity Public Concern at Work (PCaW) on 020 7404 6609.

4.3.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

4.4 Raising a concern externally

The BHSCT hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the BHSCT would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the BHSCT recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health;
- A prescribed person, such as:
  - o General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
  - o The Regulation and Quality Improvement Authority;
  - o The Health and Safety Executive;
  - o Serious Fraud Office,
  - o Her Majesty's Revenue and Customs,
  - o Comptroller and Auditor General;
  - o Information Commissioner
  - o Northern Ireland Commissioner for Children and Young People
  - o Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Public Concern at Work (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

4.5 The Media

You may consider going to the media in respect of their concerns if you feel the BHSCT has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The BHSCT reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by Corporate Communications on behalf of the BHSCT. Staff approached by the media should direct the media to this department in the first instance.

4.6 Conclusion

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the BHSCT listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

4.7 Equality, Human Rights & DDA

The BHSCT This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the BHSCT to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories.
The policy has been **screened out** without mitigation.

4.8 Alternative Formats

The document that this Policy is based on can be made available on request on disc, larger font, Braille, audiocassette and in other minority languages to meet the needs of those who are not fluent in English.

4.9 Sources of advice in relation to this document

The Policy Author, Head of Office or Directorate Advocates (as per Appendix D) should be contacted with regard to any queries on the content of this policy.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This is applicable to all staff. In addition to the Head of Office and Directorate Advocates, Senior Managers play a vital role in ensuring all staff are aware of the arrangements within the Trust.

5.2 Resources

Public Concern at Work (PCaW) have delivered training to key staff within the Trust

6.0 MONITORING

Details regarding Whistleblowing will be maintained by the Head of Office

7.0 EVIDENCE BASE / REFERENCES

- Your Right to raise a Concern (Whistleblowing) HSC Framework & Model Policy (02 Nov 2017)
- Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health & Social Care (NHS, 2014)
- Government Whistleblowing Policies National Audit Office (2014)
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
- Where's whistleblowing now? 10 years of legal protection for whistleblowers, PCaW, March 2010
- Whistleblowing in the Public Sector: A good practice guide for workers and employers, published jointly in November 2014 by Audit Scotland, the National Audit Office, the Northern Ireland Audit Office and the Wales Audit Office, with the support of Public Concern at Work
- Review of the Operation of Health and Social Care Whistleblowing Arrangements (RQIA, 2016)
- Definitions set out in Articles 3 (3) and 67K of the Employment Rights (Northern Ireland) Order 1996
- The Public Interest Disclosure (Northern Ireland) Order 1998
- Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014
- The Employment Rights (Northern Ireland) Order 1996 as amended by the Employment Act (Northern Ireland) 2016
- Department of Health. Correspondence from Health Minister Ref SUB/325/2012 (02 Mar 2012)

8.0 CONSULTATION PROCESS

This policy has been taken from the Regional framework that has been agreed after regional consultation including Northern Ireland HSC organisations and Trade union representation.

9.0 APPENDICES / ATTACHMENTS

Appendix	Details
A	Roles and Responsibilities
B	Procedure for raising a concern
C	Advice for Managers responding to a concern
D	Key contacts within BHSCT
E	Flowchart for raising concerns & whistleblowing process

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact. ☒

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

4 April 2017

_____ **Date:** _____

Dr Cathy Jack,
Deputy Chief Executive/Medical Director

4 April 2017

_____ **Date:** _____

Martin Dillon
Chief Executive

Appendix A Roles and Responsibilities

The BHSCT

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.
- To share learning, as appropriate, via organisations shared learning Procedures

The non executive director (NED)

- To have responsibility for oversight of the culture of raising concerns within their organisation

Senior Manager

- To take responsibility for ensuring the implementation of the whistleblowing arrangements

Managers

- To take any concerns reported to them seriously and consider them fully and fairly
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required
- To seek advice from other professionals within the BHSCT where appropriate
- To invoke the formal procedure and ensure the Head of Office is informed, if the issue is appropriate
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved

Whistleblowing adviser/ advocate

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations
- To work with managers and HR to address the culture in an organisation and tackle the obstacles to raising concerns

This list is not intended to be exhaustive or restrictiv

All Members of Staff

- To recognise that it is your duty to draw to the BHSCT attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain the duty of confidentiality to patients and the BHSCT and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of Trade Unions and other Organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

Appendix B Procedure for raising a Concern

Step one (Informal)

If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager (lead clinician or tutor). This may be done verbally or in writing.

You are entitled to representation from a trade union/ fellow worker or companion to assist you in raising your concern.

Step two (informal)

If you feel unable to raise the matter with your Line Manager (lead clinician or tutor), for whatever reason, please raise the matter with the designated adviser/ advocate for your Directorate (Ref **Appendix D** for further details)

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed;
- ensure you receive timely support to progress your concerns;
- escalate to the Head of Office any indications that you are being subjected to detriment for raising your concern;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;
- ensure you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three (formal)

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

Claire Cairns Head of Office directly (Ref **Appendix D** for details)

Step four (formal)

You can raise your concerns formally with the external bodies listed in 4.4

What will we do?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

We will advise you, where possible, and those identified as the subject of a concern, of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Where an Agency worker raises a concern then it is the responsibility of the BHSCT to take forward the investigation in conjunction with the Agency if appropriate.

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under the BHSCT Whistleblowing Policy.

Communicating with you

We welcome your concerns and will treat you with respect at all times. We will

discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

How we will learn from your concerns

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the relevant professional Executive Director will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

Board oversight

The BHSCT board and the Department of Health will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and want you to feel free to speak up. The Chair has nominated a non-executive director with responsibility for the oversight of the organisation's culture of raising concerns.

Review & Reporting

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate.

We will provide regular reports to senior management and to our Audit Committee on our whistleblowing caseload and an annual return to the Department of Health setting out the actions and outcomes.

Appendix C - Advice for managers responding to a concern

1. Thank the staff member for raising the concern, even if they may appear to be mistaken;

2. Respect and heed legitimate staff concerns about their own position or career;

3. Manage expectations and respect promises of confidentiality;

4. Discuss reasonable timeframes for feedback with the member of staff;

5. Remember there are different perspectives to every story;

6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;

7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager);

8. Managers should bear in mind that they may have to explain how they have handled the concern;

9. Feed back to the whistleblower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;

10. Consider reporting to the board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed; and

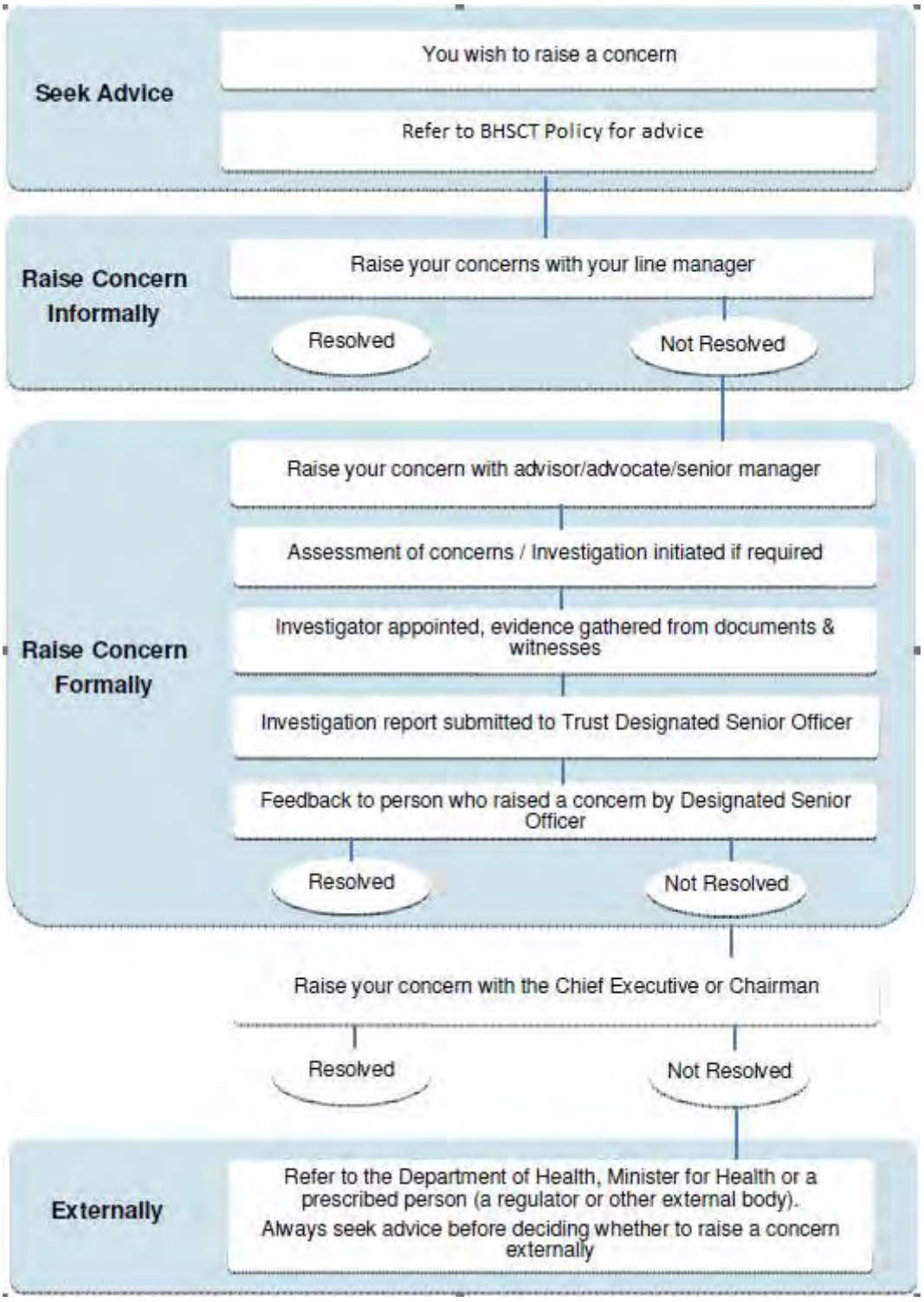
11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary.

Appendix D – Key contacts within BHSCT

The following table outlines staff within BHSCT that have been identified to provide further advice / guidance in relation to whistleblowing

	Name	Email Address	Phone Number
Head of Office	Claire Cairns	[redacted]	
Directorate	**Advocate**		
Adult Social & Primary Care	Ursula McCollam		
	Catherine Collins		
Children's Community Service	Nuala C Toner		
	Kerry Lee Weatherall		
	Cathy Curry		
Finance, Estates Services & Capital Redevelopment	Nicola Williams		
	Damian Horisk		
	Fiona Cotter		
Human Resources & Organisation Development	Joan Lowry		
	Martin McGrath		
	Marie Curran		
	Sally Thompson		
	Claire Nellis		
	Alison Kerr		
Nursing & User Experience	Seamus Trainor		
	Karen Devenney		
	Paula Forrest		
	Aisling Pelan		
	Tony McDonagh		
Specialist Hospitals and Women's Health	Patricia McKinney		
	Brenda Kelly		
Surgery & Specialist Services	Sharon ODonnell		
	Debbie Wightman		
	Clodagh Loughrey		
Unscheduled & Acute Care	Liz McAlea		
	Bernie Carey		
	Tara Clinton		
	Margaret Reid		
	Jane Sheridan		
Medical Directorate	Peter Watson		
	Robert Henry		
Performance, Planning & Informatics	Gillian Acheson		
	Stephen Best		

Appendix E Flowchart - Raising Concerns & Whistleblowing Process



Belfast Health and Social Care Trust

caring supporting improving together

Reference No: TP033/08

Title:	**Assistance to Study Policy**		
Author(s)	Marina McCarney, Learning and Development Manager		
Ownership:	Jacqui Kennedy, Director of Human Resources & Organisational Development		
Approval by:	Trust Policy Committee Executive Team Meeting	**Approval date:**	06/06/2019 12/06/2019
Operational Date:	June 2019	**Next Review:**	June 2024
Version No.	3.2 **Supercedes**	Version 3.1 – April 2014 - 2017	
Key words:	Study, placement, approval, development		
Links to other policies			

Date	Version	Author	Comments
20/03/2013	2.1	M McCarney	Initial draft considering impact of HRPTS
15/07/2013	2.2	M McCarney C Shannon J McAleer	Revised draft incorporating HRPTS screen input processes
15/08/2013	2.3	M McCarney S Dickey	Revised draft after input from Finance regards updates to 'Travel process'
26/09/2013	2.4	M McCarney C Shannon	Revised draft after consultation
24/03/2014	2.4	C Shannon	Trust Policy Committee approval
11/04/2014	3.0	C Shannon M McCarney	Final version issued
28/10/2014	3.1	M McCarney	Updated documents regards finance and travel paperwork – relating to shared service changes and requirements
06/06/2019	3.2	Peter Kane	Additional information on Travel

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the core values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

1.2 Purpose

To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance to study, or for any other learning and development activity where there is a direct financial cost to the Trust. This policy also deals with applications which require the individual to take leave in order to undertake learning and development activities.

1.3 Objectives

The policy aims to provide a mechanism to support staff in the acquisition of knowledge, skills and competence required to provide modern, efficient and safe health and social care.

2.0 SCOPE OF THE POLICY

This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3.0 ROLES/RESPONSIBILITIES

The specific responsibilities of Staff, Managers, Human Resources and Finance staff are outlined in the Policy.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

For the purposes of this policy, the following definitions should be followed:

4.1.1 Learning and development activity – any 'off-the-job' formal education or training programme, related to the individual's Personal Development Plan which carries a direct financial cost to the Trust or a requirement for leave to complete it.

4.1.2 Mandatory - this includes all learning and development activity which the Trust requires a member of staff to undertake to enable that person to fulfil the functions of their role. This type of learning and development activity will be required because it is a professional or statutory requirement to complete it or it is required by the Trust for the individual to undertake it. Further information is available in the BHSCT Statutory and Mandatory Training Policy.

4.2.3 Conferences - those which are either profession or discipline specific and will result in best practice or new learning to be brought back to the Trust. This will also include members of staff invited to present at a conference.

4.2.4 Professional Development - relates to a learning and development activity which is not a mandatory or essential requirement for a job, but is closely related to the individual's role and will add significant value to the service.

4.2.5 Personal Development - is a learning and development activity which is not related to the individual's role but will enhance the individual's long term career progression and personal growth.

4.2 Policy Principles

- All staff require learning and development in their roles
- All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan
- Access to learning and development opportunities is subject to service delivery requirements
- Funding and leave is provided at the discretion of the Trust and should not be regarded as a right
- Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust
- All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record
- All learning and development must be evaluated through the individual's Personal Development Plan and in line with the Trust's Evaluation Framework

- All staff should be treated equitably with regards applications for assistance to study

- Priority will be given to the completion of statutory and mandatory training

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

5.2 Resources

Applications for Assistance to Study are made via the new Training Request Form which can be accessed via HRPTS in the "Appraisals, Learning and Development" area of the ESS portal.

5.3 Exceptions

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

6.0 MONITORING

HR will monitor this Policy and its use.

7.0 EVIDENCE BASE / REFERENCES

The Policies comply with legislative requirements and good practice.

8.0 CONSULTATION PROCESS

Internal stake-holders such as Staff, Trade Unions and Professional Organisations were consulted in the development of this Policy. The Policy was tabled at the Policy Sub-Committee involving Management Side and Trade Unions Side representatives and approved.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 : Flow Chart Showing Summary of Procedure Applying for Assistance to Study
Appendix 2 : Guidance on the Completion of New Training Request Form
Appendix 3 : New Training Request Form - Manager Approval Guidance
Appendix 4 : Template for rejecting an application for assistance to study
Appendix 5 : Subsistence Rates
Appendix 6 : BHSCT Procedure for Booking Staff Travel
Appendix 7 : Central Travel Booking form
Appendix 8: Application for Approval (Charitable Funds)
Appendix 9: Privacy Notice

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact. x

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required X

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly

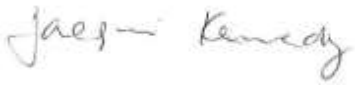
references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Date: __20/06/2019_____

HR Learning & Development / Author



12 June 2019

_____ **Date:** _____

Name: Jacqui Kennedy
Title: Director of Human Resources & Organisational Development

12 June 2019

_____ **Date:** _____

Name: Martin Dillon
Title: Chief Executive

Belfast Health and Social Care Trust

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ASSISTANCE TO STUDY POLICY

1 Introduction

1.1 Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the five values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

1.2 In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

2 Scope

2.1 This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3 Aim

3.1 Learning and development is critical to equip staff with the knowledge and skills required to provide the best possible service to the patients and clients of the Trust. The policy aims to provide a mechanism to support staff in this and in the delivery of the Trust's strategic objectives, namely: to provide safe, high quality effective care; to modernise and reform our health and social services; to improve health and wellbeing through partnerships with users and partners; to show leadership and excellence through organisation and workforce development; to make the best use of resources by improving performance and productivity. In addition to this, the policy underpins the Trust's core values of; treating everyone with respect and dignity, displaying openness and trust, being leading edge, maximising learning and development and being accountable. It is also the aim of this policy to support staff in both their professional and career development.

4 Decision Making Criteria

4.1 The following criteria are provided as guidance to both staff and managers as to the type of learning and development activities which are likely to be supported. They have been separated into two parts.

4.2 Part A: Applications must meet both of these requirements:

4.2.1 The learning and development need must have been identified on the individual's Personal Development Plan;

4.2.2 The learning and development need must be in line with at least one of the five Trust Strategic Objectives

4.3 Part B: The following criteria are provided to guide managers in the decision making process. Consideration should be given to:

4.3.1 How approval would impact on service delivery and ability to provide a safe and effective service to patients and clients.

4.3.2 The relevance of the proposed learning and development activity to the individual's job;

4.3.3 Other opportunities available which would gain the same learning outcomes but cost less or have a lesser time commitment;

4.3.4 Whether the staff member has completed all required mandatory training for their role, or is booked to attend the mandatory training and has made every effort to attend it, or if the need is part of the individual's mandatory training;

4.3.5 Any previous learning and development support provided to the individual and whether they have attended this activity previously;

4.3.6 The individual's capacity to commit to undertake the activity;

4.3.7 The numbers of staff applying for the same or similar activity;

4.3.8 If the member of staff had previously applied for the activity but had been rejected due to the number of places or funding available at that time;

4.3.9 The overall length and cost of the activity

4.4 The member of staff will be informed via the Human Resources Payroll Travel Subsistence (HRPTS) system of the manager’s decision to authorise or refuse their application. In cases where an application is refused, the manager should also detail the reasons as to why it has been refused (the template at Appendix 4 can be used for this purpose). The automated system responses should not remove the opportunity for face to face discussion between the manager and applicant (staff member) about the development activity and associated study leave requests. If a member of staff is unhappy with the decision they receive they should attempt to resolve it informally with their line manager and/or next level manager and if no resolution is achieved, the Grievance Procedure may be used.

4.5 When deciding to approve an application for assistance to study, managers should discuss with the member of staff how they will use the learning activity to enhance their work environment and how they will disseminate learning to other members of staff.

5 Continuing Professional Development (CPD)

5.1 In many professions, registering bodies require individual registrants to provide evidence of CPD activity they have undertaken within a defined timeframe. Some registering bodies require their registrants to demonstrate they have completed a certain amount of CPD usually expressed in hours per year. CPD consists of a wide range of activities including, but not exclusively limited to: reflective practice; mentoring; project work in the workplace; on-the-job training; reading; job shadowing; formal education and/or training programmes.

5.2 This policy aims to support staff undertaking learning and development where a formal education or training programme related to their role carries a cost or time implication as per the definitions and decision making criteria provided. Registrants should not expect to receive support for all CPD activity they undertake as it is expected that formal education and/or training will only be a small part of what a registrant would present to their registering body as CPD evidence. It is the responsibility of individual registrants to ensure their CPD evidence meets the requirements of their registering body.

6 Funding entitlements and leave

6.1 Depending on the type of activity applied for and approved by the manager, the following table sets out the maximum funding/entitlements available:

Type of development	Level of funding (registrations, course / exam / conference fees)	Time off to attend study	Costs for resources required e.g. books*	Excess mileage and subsistence
Mandatory	100%	100% Paid time off	All costs covered	100% excess mileage and subsistence rates
Conferences	100%	100% Paid time off	Not applicable (unless they are presenting)	100% excess mileage and subsistence rates
Professional	Up to a maximum of 75%**	100% Paid time off	Up to a maximum of £75	100% excess mileage and subsistence rates
Personal	Up to a maximum of 50%	50% Paid time off	50% of cost up to a maximum of £75	50% excess mileage and subsistence rates

**Please note: it is expected books/resources will be borrowed or bought 2nd hand where possible and where it does not present an infection control risk*
***With the exception of commissioned activity for registered nurses and midwives*

6.2 An application which has a direct cost implication or a requirement for leave from work must be authorised via the New Training Request Form on the HRPTS system by the appropriate level of management (See Appendices 2 & 3).

6.3 Reimbursement;

6.3.1 Except in exceptional circumstances, (for example extenuating personal circumstances which have been discussed with the line manager), staff who fail to complete a programme of study either by withdrawing from the course or failing examination or assessment, will be required to reimburse the Trust.

6.3.2 A member of staff who fails to attend a conference which has been paid for by the Trust will equally be liable to reimburse the Trust.

6.3.3 Staff who resign either during a period of study or within 2 years following the completion of study, will be required to reimburse the Trust. Managers will be expected to be responsible for ensuring staff are aware of this stipulation when approving an application for assistance to study and initiating the process if required. For staff transferring to another NHS, Health and Social Care, or other public or voluntary body or agency, the Trust will not seek reimbursement.

Examinations

6.4 For examinations, staff will be entitled to:

6.4.1 1 day off for preparation per exam up to a maximum of 3 days in any one academic year;

6.4.2 1 day off for an examination lasting more than 2 hours up to a maximum of 3 days in any one academic year;

6.4.3 Half day off for an examination lasting 2 hours or less or where the exam is taken at night/evening up to a maximum of 3 half days in any one academic year.

6.5 Applications for examination leave must be made using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Exam Leave” must be selected from the system drop down menu. Please also provide details of the exam leave in the text box labelled, “New Note”. The system will maintain records of leave granted and records can be accessed by managers and staff.

6.6 No financial aid will be provided for staff required to re-sit examinations unless there are exceptional and extenuating personal circumstances which have been discussed with the line manager. Time can only be granted for re-sit examinations where an individual has not exceeded the entitlements quoted above within the same academic year.

6.7 For Nursing and Midwifery staff who have accessed education or training through the Nursing & Midwifery Post-Registration Education Commissioning programme, programmes of education and training sometimes build examination leave into the

total time required to complete the programme. Where this is the case, staff should follow this rather than the provisions set out in 6.5.

Requirements for Applying for Study Leave in HRPTS

6.8 Once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Study Leave” must be selected from the system drop down menu. Please also provide details of the reason for the leave in the text box labelled, “New Note”.

This application process applies to all learning and education activities that require leave from work.

Time off in lieu which has been accrued as a result of attending learning and development activity outside of scheduled working hours, should be applied for in the same manner as study leave using the “Study Leave” drop down option. Please provide details of the leave and how it was accrued in the text box labelled, “New Note”.

As per table 6.1, requests for personal development carry an entitlement of up to 50% time off to attend study. In such cases, two leave requests must be made via HRPTS e.g. one for 50% of the time as study leave and the remaining 50% as another form of leave request which will be agreed between the individual and the manager, for example, holiday leave or unpaid leave.

As a result of the approved study leave application, a study leave record will be generated in HRPTS within individual’s overall leave record.

Studying outside of normal working hours

6.9 Where statutory or mandatory training critical to the individual's job or professional registration is scheduled outside of normal working hours the following guidance should be applied:

6.9.1 Part time staff attending training or education during hours they would not normally be working at the request of the Trust should receive time in lieu as per the table in 6.1.

6.9.2 Full time staff attending training or education outside of their normal working week at the request of the Trust should receive time in lieu as per the table in 6.1.

6.9.3 Shift workers or night staff attending training or education at the request of the Trust should be granted time in lieu for the hours attended at the education or training event.

6.10 Time in lieu should be taken within 3 months of the learning and development activity, provided the needs of the service can be met. If this is not possible then the hours must be paid. Where hours are paid, they will include any enhancements that would have been paid had the individual worked those hours.

6.11 If learning and development essential to the individual's role or professional registration is attended at the request of the Trust on the member of staff's rostered rest day, the rest day should be reallocated.

6.12 For personal development, study that is non-essential or where the Trust has not requested the member of staff to attend and where classes are held in the evening or at night, time in lieu will not normally be granted.

6.13 It is expected that staff undertaking a course of study will complete coursework in their own time. Where a course of study is based around research the manager may grant paid time consistent with taught courses of a similar academic level and in a way that does not advantage the member of staff against other staff. Where research time is granted, this must be requested through the HRPTS system as a study leave request (see paragraph 6.8)

Day and block release.

6.14 Day release should be agreed with the line manager and must not exceed one whole working day per week during the period of study.

6.15 Day and block release must be requested as a study leave request through the HRPTS system (see paragraph 6.8).

6.16 Block release should be agreed with the line manager and must not exceed 65 days in any leave year. Requests for paid leave in excess of 65 days should be approved by the appropriate Co-Director prior to the manager approving the leave request on the system.

Charitable funds and sponsorship

6.17 For any form of study which is to be funded by either charitable funds or sponsorship from a third party, managers should act in accordance with the Trust's Gifts and Hospitality Policy. Applications being made against charitable funds or sponsorship must be clearly identified on the Application for Approval of Expenditure from Charitable Funds form which is available from the Charitable Funds section, Finance Department, Glendinning House, Belfast.

NB: The principles of this policy apply regardless of funding source.

6.18 On approval of the Application for Expenditure from Charitable Funds form, the New Training Request Form in the L&D screen in HRPTS must be completed by the applicant referencing the details of the of the approval for expenditure from charitable funds. These details, including the approval date and reference numbers, should be entered in the “Description text box” of the New Training Request Form.

7 Travel

7.1 If travel is required (beyond mileage claims), a Central Travel Booking (Staff) form (see Appendix 7) should be completed and staff requiring travel should follow the procedures as indicated at Appendix 6. Staff will be required to sign a disclaimer section on the form to demonstrate and confirm management approval has been authorised on HRPTS.

7.2 Payment for courses/conferences will not be processed without the approved Central Travel Booking (CTB) application form. **Note:** Finance will not pay in excess of set subsistence rates without approval from an appropriate manager on the authorisation framework.

7.3 Managers must retain copies of CTB application forms for their own records.

7.4 The most economical mode of travel should be selected to will allow the member of staff to attend training/study and minimise the time spent away from their workplace.

7.5 Where possible, an overnight stay should only be booked if absolutely necessary to attend training/conference.

7.6 Unless there are exceptional circumstances and with Ministerial approval, no member of staff should travel outside of Ireland or Britain more than five times in a calendar year.

8 Procedure for applying for assistance to study on HRPTS

8.1 The member of staff (applicant) should complete the online 'New Training Request Form' in HRPTS. This form must always be completed *prior* to the learning or development activity being undertaken. Only in exceptional circumstances should this form be completed retrospectively, for example if the activity is required at short notice. The New Training Request Form can be located in the "Appraisals, Learning & Development" area of the Employee Self Service (ESS) screen. When all sections (fields) are fully completed, the applicant must click on the '*submit'* button to ensure the system processes the application to their line manager for consideration (see Appendix 2 for screen completion guidance).

8.2 The manager receives the online Training Request application on the HRPTS system and considers as per policy. The manager approves or rejects the application request by clicking on the appropriate button/icon on screen (see Appendices 2 & 3 for guidance).

8.3 The managers' decision to approve or reject the application will be communicated to the member of staff via a HRPTS system notification. Where an application is being rejected, this must be followed up by the manager in writing (see section 4.4 of this policy and Appendix 4 for further guidance). Where the manager does not agree with some of the details provided by the staff member on the New Training Request Form they should reject it and inform the employee to submit another New Training Request Form with the amended details.

8.4 On approval of the New Training Request Form, the member of staff should;

- book their own study/learning activity
- quote the appropriate Trust cost centre to the learning and development provider
- ask the learning and development provider to send the invoice to the BHSCT Finance department for payment
- ensure the learning and development provider is aware they must quote the cost centre code on the invoice

Directorates will meet the costs incurred from within their own budgets. The invoice will be forwarded to the appropriate manager for approval via the Finance Procurement and Logistics (FPL) system. Where a percentage of the total fees are rechargeable to the member of staff, the approving manager will be required to complete the recharging process using the FPM Invoice Request Form through the Trust FPL system (further guidance can be obtained from BHSCT Finance department). Please note;

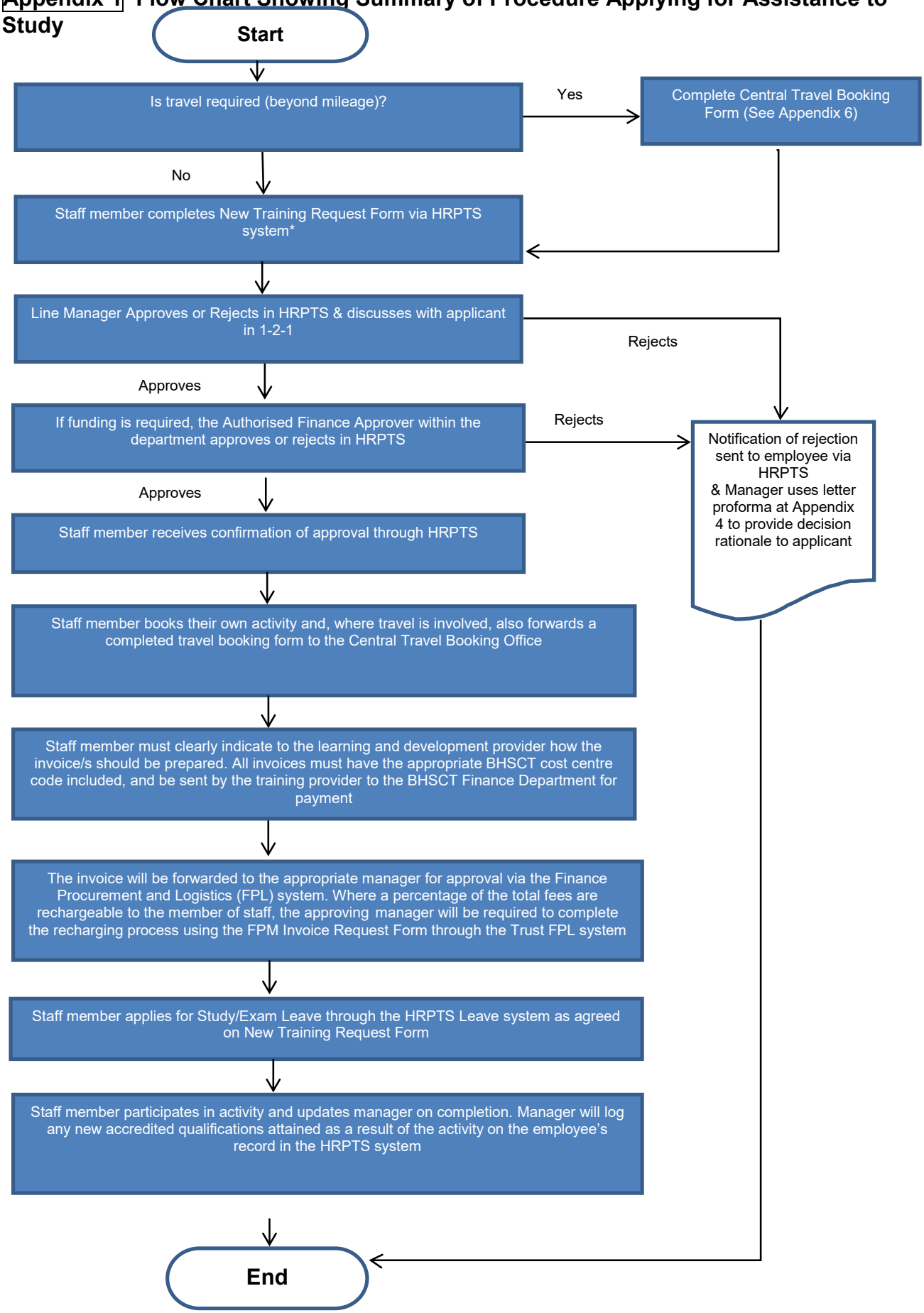
- all invoices relating to commissioned activity for registered nurses & midwives should continue to be sent to the Senior Manager Nursing: Learning, Regulation & Education
- all invoices relating to commissioned activity for AHP's need to be directed to the AHP Lead

8.5 As detailed in section 6.8, once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the 'Life and Work Events' area of the Employee Self Service screen) in the HRPTS system.

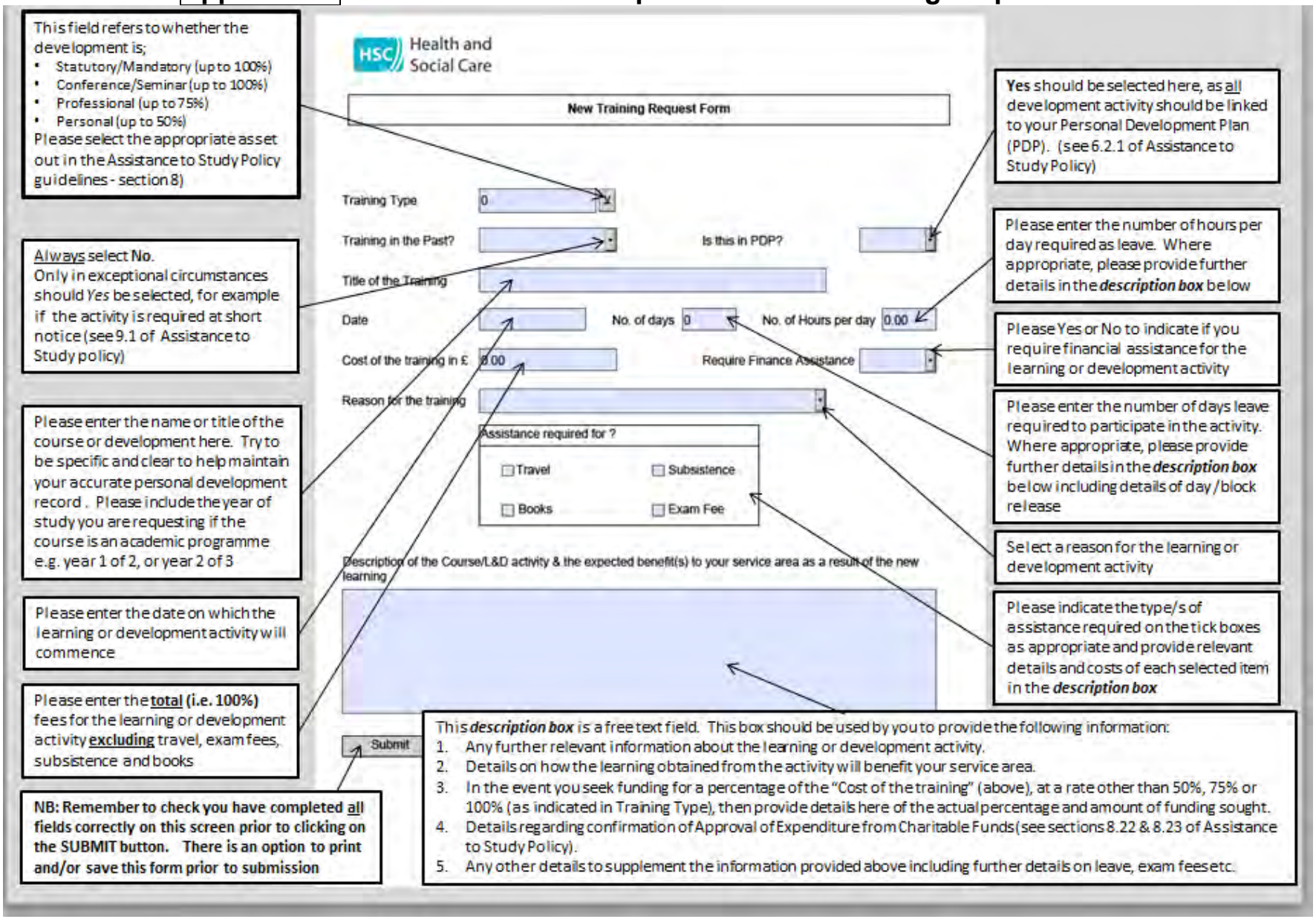
8.6 Managers should update the employee's development record on HRPTS on completion of any accredited qualifications acquired through the Assistance to Study Policy. <u>The record should only be updated by the manager on sight of the original certificates.</u>

8.7 Please refer to Appendix 1 for a flowchart summary of the procedure for applying for assistance to study. If staff have difficulty accessing HRPTS or computer access the manager should complete the request on their behalf.

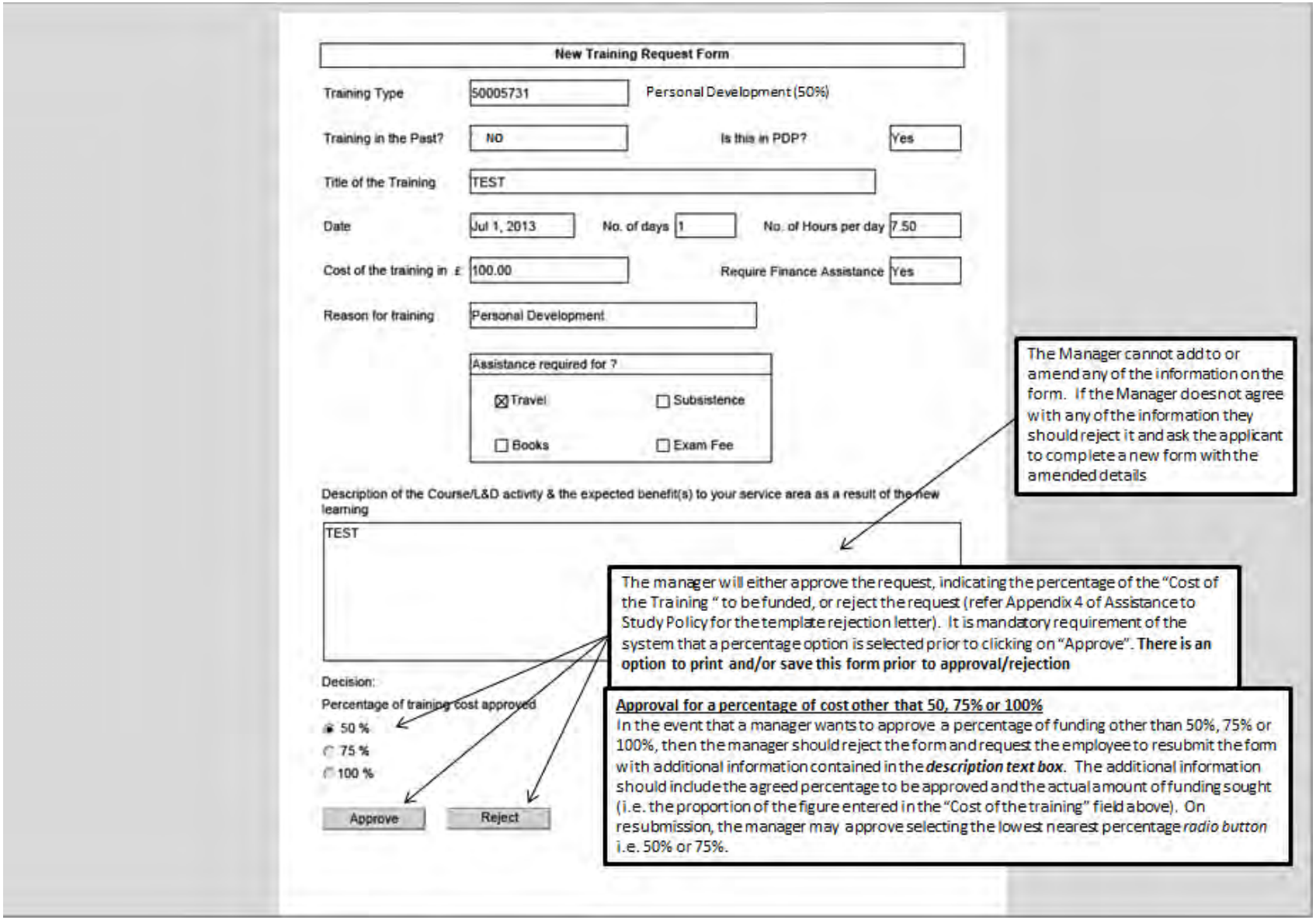
Appendix 1 **Flow Chart Showing Summary of Procedure Applying for Assistance to Study**



Appendix 2: Guidance on the Completion of New Training Request Form



Appendix 3: New Training Request Form - Manager Approval Guidance



Appendix 4

Template for rejecting an application for assistance to study

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APPLICATION FOR ASSISTANCE TO STUDY RESPONSE

Name: _____

Date application received by manager: _____

Dear _____

Thank you for your application for assistance to study, details of which are below;

Name of course/conference/event:
_____
_____

Date(s) of course/conference/event:
_____

Level of funding requested: _____

Travel/expenses applied for: _____
_____

Following consideration of this application, I regret to inform you that your request has been rejected for the following reasons in line with the Assistance to Study Policy;
_____
_____
_____
_____
_____
_____

Yours sincerely

Date: _____

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Subsistence Rates

Please refer to Section 18 and Annex N of the Agenda for Change Terms and Conditions.

Claims for mileage or subsistence should be made via the HRPTS system in the Travel & Expenses area of the Employee Self Service (ESS) screen. Staff should clearly note on their claim what learning and development activity the claim relates to e.g. course of study, conference. This will be considered and authorised online through the appropriate manager.

Where accommodation is required for the member of staff to attend the learning and development activity, this should be booked as per Trust procedure.

If meals are included as part of the learning and development activity (course or conference), staff should not include these in any claim for subsistence.

Please note, claims for mileage will only be payable as excess at the public transport rate.

Any approved application requiring authorised travel requisitions must be processed to Trust Finance Department.

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Appendix 6

BHSCT Procedure for Booking Staff Travel

Courses and Conferences – staff

Staff wishing to apply to attend courses or conferences must complete the online 'New Training Request Form' screen for assistance to study requests in line with the Belfast Health and Social Care Trust Assistance to Study Policy.

i. Staff requiring travel in connection with their approved application must complete a Central Travel Booking (Staff) form when approval has been received. Once completed the Central Travel Booking (Staff) form should be sent to Finance department as per paragraph vii below. The booking form (see Appendix 7), is available by contacting the email address in paragraph vii.

ii. An application for booking staff travel may be completed in one of two ways:
Either
- By contacting the Trust's contracted travel agent and then confirming details with the Central Travel Booking Office (CTBO) in Finance – please complete Section 2 of the form. Staff may find this option useful particularly where complex travel arrangements are being arranged. Travel will not be booked by the contracted travel agent until the CTBO have asked them to proceed – see (viii) below.

Or
- By providing all details to the CTBO to make arrangements on your behalf – please complete Section 3 of the form.

iii. Staff may contact the Trust's contracted travel agent to discuss travel and accommodation requirements. This information should be completed on the booking form in Section 2.

iv. Alternatively, staff must complete Section 3 to enable CTBO staff to arrange a booking with the travel agent on their behalf.

v. Where funding for attendance at courses/conferences is from the Trust Charitable Funds, staff must also have completed an Application for Approval of Expenditure from Charitable Funds form. A copy of both the Approval of Expenditure form and the Learning and Development activity form must be attached to the CTB booking form and sent to CTBO at the time of the booking. The CTBO staff cannot process/confirm travel bookings without this approval.

vi. **In all cases, the form must be approved by a level 3 or level 4 Manager in line with the Trust's Non Stock Authorisation Framework.** A booking/reservation cannot be made for staff if forms are submitted with incomplete information or without the appropriate authorisation. Staff in

CTBO will return forms to the applicant if information is incomplete / lacking appropriate authorisation

The fully completed and authorised booking form must be;

Posted to: **Finance Department Central Travel Booking Office**

Or

Scanned / emailed to: Travel.Helpdesk@belfasttrust.hscni.net

vii. CTBO staff will:

- Confirm to travel agent that arrangements already made by staff per Section 2 of the form may be booked (as per (ii) above)
- Make travel arrangements with travel agent based on requirements as specified in Section 3 of the CTB form. CTBO staff will confirm arrangements with staff prior to booking
- Send all travel details to staff named on the travel request form

Business travel

Where staff members are required to travel by the Trust on business rather than attending a course/conference, please consult the Finance area of the BHSCT Intranet HUB for further information and guidance

http://intranet.belfasttrust.local/directorates/finance/Pages/News/Changes-to-Travel-for-BSTP-Implementation.aspx

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Appendix 7

CENTRAL TRAVEL BOOKING OFFICE STAFF TRAVEL

SECTION 1 - *TO BE COMPLETED BY STAFF*

Name: _____

Grade: _____

Staff No: _____

Contact Phone No: _____

Email Address: _____

Cost Centre: _____

Please state purpose of travel:

Course / Conference / Business Travel / Escorting Client/Patient
(delete as applicable)

Please ensure all details are correct when submitting this form and it is aligned to the details completed online in your 'New Training Request Form' screen on HRPTS. Tickets booked may be non-refundable or non-changeable.

Please indicate if this is a new booking/amendment to a previous booking (*delete as applicable)*

If an amendment, please state previous booking ref and complete updated arrangements. ☐

SECTION 2 – TRAVEL ARRANGEMENTS *(arranged by applicant with Trust contracted travel agent)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Other travel and accommodation arrangements made (Please detail)

SECTION 3 – TRAVEL ARRANGEMENTS *(to be arranged by Central Travel Booking Office)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* What time are you available to make return journey?

Other travel arrangements required? (Please specify)

Is Accommodation required: Yes ☐ No ☐

No. of Nights: _____

City/Town: _____

Single/Twin/Double/Family (***delete as appropriate***)

Please indicate any special requirements (Dietary/Access etc.):

Source of Funding
(If other than service group funding, please detail source of funding e.g. Charitable Funds).

Employee Declaration

By signing this form, I confirm that:

My application to attend this course/conference has been approved by the appropriate manager through the HRPTS system in line with the Trust Assistance to Study policy.

I am responsible for ensuring that the correct level of approval has been obtained before submitting this Central Travel Booking Office form.

Signature:_____ Date:_____

Approved by:

_____ **(Service Group Level ¾ Manager)** _____

Please print **Signed**

_____

Date

This fully completed and authorised booking form must be:
Scanned / e-mailed to: travelbookingoffice@belfasttrust.hscni.net

---

OFFICIAL USE ONLY

Booked by: _____ **Booking Ref:** _____ **Date:** _____

Central file updated: _____

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Appendix 8

Belfast Health and Social Care Trust

No: 00000001

Application for Approval of Expenditure from Charitable Funds

Fund Name: _____ **Fund ref:** _____

All expenditure should be procured in line with Trust Policy. Include all costs e.g. installation
Explain how this use meets the charitable purposes

Expenditure details

Supporting documentation attached		Please tick
Goods & Services	Non Stock Requisition/Quotation Expenditure >£5,000 Business case proforma/Management approval	
Research Funding	Research project ref & Certificate of Indemnity	
Salary Recharge	Letters of authorisation	
Expenses Incurred	Original receipts	
Building & Maintenance	Works order	
Maintenance Costs	Supporting documentation inc. value, frequency & term	

Full details of proposed expenditure

Cheque should be made payable to:

If proposed expenditure does not exceed £100 and it is of no financial benefit to the Trust that an official order be raised, please attach original invoice to this document.

Amount applied for excl. VAT £_____ Total £_____

Are you aware of any future costs which may be incurred as a result of this expenditure? □ **YES** □ **NO**

If so, state source of funding for these future costs: Fund Ref: _____ Cost centre: _____

	Signature	Block caps	Band/Grade	Date
Applicant				

In supporting this request, I confirm that the nature of this expenditure meets the objectives of the fund and conforms with the Trust's expenditure criteria for Charitable Funds as stated in the Handbook

	Signature	Block caps	Band/Grade	Date
Advisor signatory				

Employee Declaration

Where applicable, by signing this form I confirm that:

My claim for expenditure from Charitable Funds has been approved by the appropriate manager through the HRPTS system in line with the assistance to study policy

I am responsible for ensuring that the correct level of approval has been obtained before submitting the Charitable Funds form.

Signature: _____ Date: _____

For finance use only	Signature	Block caps	Band/Grade	Date
Authorised by:				

Please note that failure to fully complete this application may result in delays

Registered Charity: No. XT1874

Blank copies of this form can be obtained by contacting: charitablefunds@belfasttrust.hscni.net

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Privacy Notice – Why and How HR Use Your Personal Data

The Trust as an employer, collects your personal data for a variety of employment related reasons described in this document. We treat the management of your data and personal information seriously and we therefore store and process it responsibly. Your privacy is extremely important to us and we manage your data securely and within the recommended guidelines and best practice. We will never use your data for any unauthorised purpose, other than those outlined in sections 4 and 5 of this document.

1. Introduction

The law around processing your personal data is set out in the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. For the purposes of Data Protection legislation, the Belfast Health & Social Care Trust is a “Data Controller” (the holder, user and processor) of staff information.
Belfast Health & Social Care Trust collects and processes personal data and sensitive personal data about its staff. This information is used mainly for employment related purposes.
This Privacy Notice has been drawn up in line with the Information Commissioner’s Office (ICO) Privacy Notices Code of Practice, to assist the Trust to comply with data protection principles and legislation. It aims to make staff aware of how the Trust processes and uses your personal data.
It should be noted that the Privacy Notice applies to all permanent, temporary, locum and agency staff, volunteers, students on placement and those staff engaged under external contract as sub-contractors. In addition, it applies to those individuals using a range of HR services including Occupational Health.

2. What Types of Information Do We Hold About You?

We hold and process a range of personal data and sensitive personal data mainly for employment related purposes, examples of this are: name, date of birth, address, telephone number, references from previous employers, proof of eligibility to work in the UK, staff number, national insurance number, remuneration details, pension details, Occupational Health information, qualifications, professional registration details and absence information. Data is also held on equality, health and wellbeing, disability, criminal conviction, disciplinary and grievance. This list is not exhaustive.

3. How Do We Collect your Personal Data?

We collect your personal information using computer systems, paper records, telephone calls and e-mails. This can include information you provide in person, on an official form (online or paper) and information that is recorded on CCTV cameras or other digital media in operation within the Trust.

4. What Do We Use Your Personal Data For?

We use the data for various employment purposes, including:

- Payment of salaries, travel, subsistence, sick pay, maternity pay, pension administration etc.;
- Her Majesty's Revenue & Customs (HMRC);
- Management information reports;
- Training and development;
- Staff engagement initiatives;
- Management of sickness absence;
- Management of leave types eg. term time, maternity, employment break;
- Appraisal and revalidation;
- Job Planning;
- Collation of information regarding conduct, health and performance;
- Occupational Health purposes;
- Compliance with legal obligations, for example Police investigations;
- We may also use your data in a way that does not identify you (ie. anonymised) for example for statistics relating to section 3 & 4 in this guide and Statutory Fair Employment Monitoring;

This list is not exhaustive.

5. Sharing Your Information

As an employer, we may need to share your information with certain other organisations: (there may be other occasions where we have a legal duty to share your personal information).

- Business Services Organisation (BSO) Payroll Shared Services Centre (PSSC) & Recruitment Shared Services Centre (RSSC);
- HSC Pensions (BSO);
- Her Majesty's Revenue and Customs (HMRC);
- National Fraud Initiative (NFI);
- Department of Health (DOH) and any relevant Arm's Length Bodies;
- HRPTS Systems Suppliers (HCL AXON);
- Professional Registration Bodies;
- Communication Companies;

- Accredited learning awarding bodies and learning providers (e.g. ProQual, Institute of Leadership & Management)

This list is not exhaustive.

There are a number of reasons why we need to share your information. Some of your information will be shared with BSO for payroll, pension or recruitment purposes. Sometimes we are bound by law to share your information for example for taxation, fraud or law enforcement purposes. Occasionally, we may share some personal information, such as name and address, with communication companies, for important staff communications and engagement purposes, pension changes, staff surveys and exit interviews. Any disclosure of your information will be carried out in a secure manner and in accordance with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

6. Security of Information

The Trust has a legal duty to ensure that all personal data relating to staff is held securely. Strict policies and procedures are in place regarding the management of and access to such data. These can be located on the Belfast Trust intranet HUB, or available on request through the Information Governance Department.

7. Retention and Disposal of Staff Information

Staff records are retained in line with the Department of Health's Good Management, Good Records' Retention and Disposal Schedule. This schedule can also be accessed on the Belfast Trust intranet HUB, or available on request through the Information Governance Department.
The Department of Health Retention and Disposal Schedule can be accessed online at:
https://www.gov.uk/government/publications/departmental-records-retention-and-disposals-policy

8. Keeping Your Information Up to Date

It is important that the information we hold about you is up to date. If your personal details change, or are currently inaccurate, it is important that you let us know. You can do this by contacting your Line Manager and or Your HR Team on 028 906 35678.
It is also possible for you to amend some of your personal details on the HRPTS system, through the Employee Self Service (ESS) facility. Please see additional guidance on the Your HR portal on the HUB.

9. The Right to be Forgotten

The General Data Protection Regulation enables individuals to request that the Trust remove certain pieces of information from their file if they feel it is out of date or incorrect. The Trust will consider each individual application on its own merit as

we continue to have a statutory obligation to retain information as per the Trust retention and disposal schedules.

10. Access to your Personal Data

The legislation gives you the right to access or request copies of the information the Trust holds about you. Requests must be made in writing (this can include by e-mail) and you will need to provide a copy of photographic identification such as a driving licence, electoral identity card or passport.
Please send your request to the Trust's Data Protection Office. Contact details can be found below. We will process your request as quickly as possible but you should be aware that the General Data Protection Regulation allows the Trust up to 30 days to respond to your request. This can be extended up to 90 days if your request is complex, however, you will be advised directly if this is the case.

11. Contacting us about your Personal Data

Please contact us if you have any questions about this Privacy Notice or the information we hold about you.
Information Governance Department
1st Floor, Administration Building
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH
Tel: 028 9504 6955

12. Who Can I Complain to?

If you are unhappy with any aspect about how we deal with your information, or how we comply with your request for a copy of your information, you can contact:
The Trust's Information Governance Department
or
The Information Commissioner's Office – Northern Ireland
3rd Floor, Cromac Place
Belfast
BT7 2JB

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 08/08

Title:	**Adverse Incident Reporting and Management Policy**		
Policy Author(s)	Regional Working Group on Adverse Incidents *Additional authors* Claire Cairns, Senior Manager, Corporate Governance [redacted] Robert Henry, Acting Corporate Governance Manager [redacted] Gillian Moore, Admin and Datix Manager [redacted]		
Responsible Director:	Chris Hagan, Medical Director		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☐	Non Clinical Trust Wide ☒
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			
Date:			
Approval process:	Trust Policy Committee Executive Team Meeting	**Approval date:**	04 June 2020 10 June 2020
Operational Date:	June 2020	**Review Date:**	June 2025
Version No.	5	**Supercedes**	V4 – January 2018 – January 2023
Key Words:	Incident, Adverse incident, Incident reporting, Datix		
Links to other policies	BHSCT Being Open policy – saying sorry when things go wrong (2020) TP 80/11 BHSCT Serious Adverse Incident (SAI) procedure (2016) TP 97/14 BHSCT Policy on Memorandum of Understanding (MOU) - Investigating Service User Safety Incidents (2020) TP 111/20 BHSCT Guidance on Actions to be Taken after a Patient's Death in Hospital (2018) SG 04/09 BHSCT Medical Devices Procedures and Guidelines (2017) TP 41/07 BHSCT The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Policy (2020) TP 42/08 BHSCT Procedure for Reporting and Managing Incidents (2018) TP 94/14 BHSCT Procedure for Grading an Incident (2018) TP 95/14 BHSCT Procedure for Investigating an Incident (2018) TP 93/14 BHSCT Guidance on Writing a Witness Statement (2018) TP 96/14 BHSCT Policy for Sharing Learning (2016) TP 98/14 BHSCT Policy and Procedure for the Management of Comments, Concerns, Complaints & Compliments (2020) TP 45/10 BHSCT Claims Management & Engagement of Legal Services Policy (2017) TP 27/08		

	BHSCT General Health and Safety Policy (2018) TP 50/08 BHSCT Policy on the Data Protection and Protection of Personal Information (2018) TP 26/08 BHSCT Risk Management Strategy (2020) TP 58/08 BHSCT Medicines Code Policy (2020) SG 09/11

Date	Version	Policy Author	Comments
25/02/2008	1.0	M Bardgett	Adverse Incident Reporting and Management Policy
19/04/2010	2.0	CR Cairns	Revised Adverse Incident Reporting and Management Policy
April 2014	3.0	CR Cairns	Revised Adverse Incident Reporting and Management Policy
29/11/2017	4.0	G Moore	Interim update pending regional policy
January 2020	4.1	Regional Group	After a period of Regional consultation Department of Health issued a template for the management of incidents and requested all Trust to update their existing Trust Policy to reflect Regional template
May 2020	4.2	G Moore R Henry	Adoption of Regional template customised to reflect BHSCT arrangements

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

Belfast Health & Social Care Trust has had a Trust Policy that covers Incident management from 2008. Following recommendations of the Regional Learning System Project Report (August 2015), it was agreed to develop a regional policy on the reporting and management of adverse incidents to be used by all Health & Social Care Trusts, the Northern Ireland Ambulance Service (NIAS) and the Health & Social Care Board (HSCB) hereinafter called ("the organisation").

1.2 Introduction

This policy provides the framework for reporting and managing all adverse incidents which affect service users[1], staff and visitors to its premises or have an impact on the Belfast Health and Social Care Trust[2] (BHSCT), its reputation or its legal duty of care.

The manner in which an organisation manages and learns from adverse incidents is one of the key markers of success in relation to risk management, corporate and clinical and social care governance standards. Consistent identification, monitoring and review of incidents is central to the

organisation's strategic and operational processes to ensure it can achieve its vision for safe and effective care.

It recognises that no health and social care environment will ever be absolutely safe and, on occasions, errors or incidents will occur. Equally, it recognises that when incidents do occur it is important to identify causes to ensure that lessons are learned to prevent recurrence.

The organisation is committed to an open, honest and just culture and reporting of adverse incidents is encouraged so that the organisation can learn from incidents and take actions including changes in practice to reduce the risk of recurrence. It also will ensure that staff learn and are supported in making changes to their practice, post incidents, as required.

1.3 Purpose of policy

This policy provides guidance on the reporting and managing of adverse incidents which affect service users, staff and visitors to its premises or have an impact on the organisation, its reputation or its legal duty of care. It will also enable a robust and systematic approach to the management of adverse incidents that will be consistently applied across the organisation ensuring that it meets all relevant statutory[3] or mandatory responsibilities and reporting requirements thereby safeguarding the wellbeing of service users, staff and visitors.

It has been developed to ensure organisational wide learning takes place within a structured framework and that any lessons learned are disseminated widely throughout the organisation and to external agencies, as appropriate.

1.4 Policy Aims and Objectives

Adverse incident management systems assist organisations to ensure that systems are in place to secure service user, staff and visitor safety; ensure internal accountability and safeguard the organisation's assets and reputation. Learning from adverse incidents enables the organisation to proactively reduce risk and improve services. It recognises that most incidents occur because of problems with systems rather than individuals but may also on occasions be multifactorial in nature.

The objectives of this policy are:-

- To promote and provide a unified regional organisational wide system for the reporting, recording, review and analysis of all adverse incidents;

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[1] The term service user also refers to patients, clients, children and young people under 18 years and carers
[2] "the Trust"
[3] Health & Safety at Work Order 1978, Management of Health and Safety at Work Regulations (Northern Ireland) 2000 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

- To improve the safety and quality of care through reporting, analysing and learning from incidents involving service users, staff and visitors (including contractors);
- To comply with relevant legislation and standards relating to the reporting of incidents;
- To ensure all adverse incidents are dealt with appropriately and in a timely and consistent manner;
- To provide a means of analysing trends in incidents and identification of factors contributing to incidents to assist in implementation of service improvement and risk reduction strategies, thereby minimising risk to service users, staff and visitors and the organisation; and
- To support staff when mistakes happen and encourage staff to review and reflect on their practice post review of incidents.

1.5 Legislative Requirements

The key legislative reporting requirements for organisations in respect of adverse incidents are as follows:-

- Health & Safety at Work (NI) Order 1978;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1997;
- Social Security Claims and Payments Regulations 1979; and
- The Public Interest Disclosure Act 1998.

2.0 SCOPE OF THE POLICY

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care.

This policy excludes detailed arrangements in respect of the following areas, which are covered by separate regionally agreed policies:-

- Policy for Reporting Early Alerts to Department of Health;
- Being Open Policy;
- Policy for Reporting Adverse Incidents under RIDDOR Regulations;
- Supporting Staff Involved in Incidents, Complaint, Claims and Coroner's Inquests;
- Policy on Memorandum of Understanding (MOU) - Investigating Service User Safety Incidents

3.0 ROLES AND RESPONSIBILITIES

3.1 **Trust Board:** is responsible for ensuring that a robust system is in place for the reporting and management of adverse incidents and will receive regular management reports on this subject matter.

3.2 **Chief Executive**:is the Accountable Officer for the organisation and is responsible for ensuring that it meets its statutory and legal requirements in respect of adverse incident reporting and management. He/she will ensure that the Trust adheres to, and responds appropriately to, circulars and guidance issued by the Department of Health (DoH) in respect of adverse incident management. The Chief Executive has delegated these executive functions to the Medical Director.

3.3 **Medical Director:** is the lead Director responsible for the reporting and management of adverse incidents within the Trust. He/she will ensure that systems, policies and procedures are developed and implemented on an organisational basis including the onward reporting of relevant incidents to external agencies for eg, Health & Social Care Board (HSCB), Heath & Safety Executive for Northern Ireland (HSENI) and the Regulation, Quality Improvement Authority (RQIA). On a daily basis this function is delegated to the Co-Director for Risk & Governance

3.4 **Co Director for Risk & Governance:** will support the Medical Director in meeting his/ her responsibility for the management of adverse incidents throughout the BHSCT.

3.5 **Director/s:** are responsible for ensuring that the Trust's policy on adverse incident reporting and management is widely disseminated, promoted and implemented within their areas of responsibility.

3.6 **Co-Directors and Senior Clinicians:** are responsible and accountable to their respective Directors for ensuring that this policy and any associated procedures are effectively implemented within their areas of responsibility. They should also promote an open, honest and just reporting culture and ensure that appropriate reviews are carried out.

3.7 **Senior Manager, Corporate Governance Services:** will support the Co-Director Risk and Governance in meeting his/her responsibility for adverse incident management.

3.8 **Senior Manager responsible for RIDDOR (Corporate Standards and Risk):** will support the Co-Director Risk and Governance in meeting his/her responsibility for adverse incident management and will ensure that systems are in place for the appropriate management and reporting of Health and Safety incidents including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR).

3.9 Head of Pharmacy and Medicines Management: as Controlled Drugs Accountable Officer must ensure there are safe systems in place for the management and use of controlled drugs. Adverse incidents and concerns involving controlled drugs are reported to the Accountable Officer.

3.10 Medicines Governance Pharmacist: is responsible for the expert review, quality assurance and identification of learning from reported medication incidents. In the event an adverse incident is categorised as a Serious Adverse Incident, they should be involved in the review. He /she is also responsible for submission of HSC Trust medication incident data for regional analysis by the Medicines Governance Teams.

3.11 Senior Information Risk Owner (SIRO): is the lead Director for ensuring that Information Governance (IG) incidents are reported and appropriately managed including reporting to Information Commissioner's Office, if necessary. He/she (or nominee) will provide advice and support to managers in respect of IG incidents, as appropriate.

3.12 Senior Managers, Heads of Departments/Services: are responsible for:

- ensuring that this policy and associated procedures are effectively implemented across their area of responsibility;
- promoting an open, honest and just reporting culture;
- ensuring that staff are appropriately trained in the reporting and management of adverse incidents;
- ensuring that appropriate review of adverse incidents is carried out;
- ensuring staff are given appropriate support following an adverse incident;
- ensuring communication with the service user and/or their relatives/carers as appropriate. (See Being Open Policy for guidance);
- trend analysis of incidents and identification of factors contributing to incidents to assist in service improvement and risk reduction strategies

3.13 Incident Approver

The Approver is responsible for reviewing, approving and/or escalation of incidents via DatixWeb, and for:

- ensuring that all possible remedial action is taken immediately following an adverse incident to prevent reoccurrence without compromising the investigation processes;
- ensuring the onward reporting of adverse incidents both internally and, where appropriate, externally and that their staff are aware of these particular local arrangements;
- securing all relevant evidence including materials, equipment, consumables, samples, records, witness details etc and ensuring that these are not compromised until appropriate investigation is complete. (See Procedure for Investigating an Incident);
- ensuring that where a death or a major injury has occurred, the security of the location and/or equipment/consumables, is maintained for inspection purposes by senior managers and/or statutory authorities (See Procedure

for Investigating an Incident);
- providing feedback and sharing learning with staff and ensuring that risk assessments and training needs are reviewed where relevant following adverse incident reviews.
- trend analysis of incidents and identification of factors contributing to incidents to assist in service improvement and risk reduction strategies

3.14 All staff: have a responsibility to:

- ensure the safety of individuals involved (service users, visitors and staff), the environment and equipment;
- avoid putting themselves and others in situations of danger;
- ensure their line manager/s and/or person in charge of the area is informed of the incident;
- record and report all adverse incidents using the organisation's reporting systems as soon as possible and ideally within 24 hours of the occurrence or becoming aware of the adverse incident; and
- co-operate with any review process including the provision of witness statements, if appropriate.

4.0 CONSULTATION

This policy was developed by the Regional Adverse Incident Work Group chaired by the Assistant Director, Risk Management & Governance, South Eastern Health & Social Care Trust. Consultation was completed via email with relevant Assistant/Co-Directors and staff within all organisations included in the working group. Further consultation within BHSCT was completed via email with relevant Co-Directors/Senior Managers.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Definitions

5.1.1 Adverse Incident: Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation/Special Agency or commissioned service[4]. A suggested list of broad categories of adverse incidents to be reported is listed in Appendix 1, for guidance purposes.

5.1.2 Harm is defined as: "injury (physical or psychological), disease, suffering, disability or death".[5] In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's/client's illness or underlying condition.

[4] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016
[5] Doing Less Harm, NHS, National Patient Safety Agency 2001

5.1.3 Serious Adverse Incident (SAI): is an adverse incident that must be reported to the Health and Social Care Board (HSCB) because it meets at least one of the criteria as defined by the HSCB within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAI's), Oct 2016[6].

5.1.4 Service User[7]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

5.2 Policy Statement

The Trust is committed to providing the best possible services for its service users, staff and visitors. It recognises that adverse incidents will occur and that it is important to identify causes to ensure that lessons are learnt to prevent recurrence. It is, therefore, essential that a responsive and effective incident recording, reporting and management system is in place to achieve this aim. Where learning from such adverse incidents is identified the necessary changes should be put in place to improve practice.

5.3 Policy Principles

5.3.1 The organisation's approach to Adverse Incident Reporting and Management: An open, honest and just culture[8]

As part of its proactive approach to risk management, the organisation promotes an open, honest and just culture in which errors or service failures can be admitted, reported and discussed without fear of reprisal. This will enable lessons to be identified and allow active learning to take place and the necessary changes made or reflected in policies, procedures and practices.

All staff must report and manage adverse incidents according to this policy (and any related operational procedures) for adverse incident reporting. Crucial to the effectiveness of adverse incident reporting and management is the organisation's commitment to the promotion of an open, honest and just culture where all staff can participate in reporting adverse incidents. Staff are encouraged to report incidents and to look critically at their own actions and those of their teams, to ensure the organisation can provide quality services for our service users, staff and visitors.

Ultimately, the organisation wants to encourage staff to report areas of concern and to foster a positive ethos around reporting. Staff who make a

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[6] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[7] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

[8] *a just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviours, while maintaining individual accountability by establishing zero tolerance for reckless behaviour. Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events. Just culture distinguishes between human error (e.g., mistakes), at-risk behaviour (e.g., taking shortcuts), and reckless behaviour (e.g., ignoring required safety steps), in contrast to an overarching 'no-blame' approach" (Agency for Healthcare Research and Quality; Patient Safety Network 2016, US Department of Health).*

prompt and honest report in relation to an adverse incident should not expect to be subject to disciplinary action except under the following circumstances:-

- A breach of law;
- Wilful or gross carelessness or professional misconduct;
- Repeated breaches of Trust policy and procedure;
- Where, in the view of the Trust, and/or any professional registration body, the action causing the incident is far removed from acceptable practice; or
- Where there is failure to report a serious incident in which a member of staff was involved or about which they were aware.

Completion of an adverse incident report does not discharge staff of their duty of care and their risk management responsibility. There should be timely and appropriate follow-up of adverse incidents. Where preventative measures and/or procedural changes are identified these should be put in place to minimise the risk of the adverse incident recurring.

All employees must be honest, open and truthful in all their dealings with patients/clients and the public, and organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.

5.3.2 External reporting arrangements in respect of other incidents not covered by this policy

Depending on the nature of the adverse incident the organisation may be required to report relevant details to other statutory agencies and external bodies, for example, HSCB, RQIA, HSENI and NIAIC. Staff should ensure that they are aware of their local reporting requirements to other statutory agencies and external bodies as per their local policy/procedures. These incidents must also be recorded on the organisation's incident reporting system.

With regard to Independent Service Providers (ISPs) and contractors, they will be required under their contractual arrangements to maintain a system of reporting and recording of adverse incidents related to service users referred to them by the Trust for assessment, treatment or care. ISPs are also required to submit monitoring information to the organisation as required. Both adverse incidents and SAIs are discussed at contract meetings between Trusts and ISPs. As per the HSCB procedure for reporting SAIs (November 2016), the Trust will decide whether an ISP adverse incident meets the criteria for reporting as a SAI and is, therefore, responsible for reporting the SAI to the HSCB.

~~5~~.3.3 Operational Procedures for Reporting of Adverse Incidents

A summary of the process for reporting, recording and reviewing adverse incidents is detailed below and also included in diagrammatic format in Appendix 1. Detailed procedures for reporting and managing, grading and

investigating incidents are available and should be read in conjunction with this policy. Key points to remember are listed below.

5.3.4 What to do when an adverse incident occurs – immediate actions

The injured person or damaged property should be assessed immediately to ascertain extent of injury/damage and identify emergency or urgent treatment/action required. The situation must be made safe. Communicate with the service user and their relatives/carers, as appropriate following an adverse event. Ensure appropriate discussion with the service user and/or relatives/carers and give consideration to any additional support which may be required. (See the *Being Open Policy*). Any equipment involved in the adverse incident, even if not directly implicated, should be removed from use and the following action taken:-

- Clearly label “Do Not Use” including a short description of the nature of the fault, if possible;
- Retain any related evidence such as packaging (for batch or serial numbers) or consumables/accessories (e.g. giving sets for pumps etc.);
- Decontaminate any device that can be decontaminated without destroying evidence and attach a decontamination certificate to that effect (See the *Medical Devices Policy & Procedures*); and
- For medication – where packaging or labelling of a medicine is an issue, retain or photograph to facilitate further review and follow up with the pharmaceutical company/MHRA.

You must also follow the *Guidance on Actions to be Taken after a Patient’s Death in Hospital* in relation to immediate actions to be taken when finding a person deceased following a suspected incident.

5.3.5 Who should report?

Any member of staff can report an adverse incident. It is the responsibility of **ALL** staff who are involved in, witness to, or become aware of an adverse incident, to ensure it is reported using the organisation’s adverse incident reporting system. If the incident involves another area within the Trust, this area must be made aware of it and remedial actions agreed.

5.3.6 When to report?

It is important that all adverse incidents are reported as soon as possible and ideally within 24 hours of occurrence or becoming aware of the adverse incident. This supports effective review and timely learning, and ensures compliance with responsibilities for external reporting.

5.3.7 What types of incidents to report?

Any event which meets the definition in section 4.1.1 involving service users, staff and visitors must be reported promptly and action instigated, where necessary. Appendix 2 provides a list of broad categories of possible adverse

incidents which may assist reporters. This is not an exhaustive list but gives a broad indication of the types of adverse incidents to be reported.

5.3.8 How to report?

All incidents should be reported using the organisation's adverse incident reporting system (DatixWeb). This is accessed via the Hub (Trust Intranet).

In respect of incidents involving service users, please note that adverse incident reports are NOT health records and copies of any electronic reports (or paper forms) should NOT be filed in the service users' records. However, details of the incident (including the incident reference number, if available) that are relevant to the treatment and care being provided to the service user should be added separately within the service user's healthcare record.

5.3.9 Other Reporting Systems

Some departments have additional error and incident monitoring arrangements (e.g. Laboratories) as part of specific legal, accreditation or quality assurance framework requirements for these services. Staff using these systems must ensure that incidents which meet the organisation's definition of adverse incidents are also reported via the organisation's adverse incident reporting system.

5.3.10 Staff Support directly following an incident

The organisation recognises that it has a responsibility to support all staff following adverse incidents. All staff involved in an adverse incident will need an appropriate level of support consistent with the outcome of the incident. It is the line manager's responsibility to ensure that individuals are supported appropriately. Support can be provided by Occupational Health, Trade Unions and Staff Care. Staff involved should be kept informed of the progress of a review at all stages.

In addition, individuals who have been absent from work may require additional support and supervision to aid confidence when returning to work. Staff involved in the incident should also be involved in the review where appropriate, with feedback, when complete. Further guidance can be obtained via the Trust's policy on *Supporting Staff Involved in Incidents, Complaint, Claims and Coroner's Inquests*.

5.3.11 Arrangements for Incident Review & Grading

Deciding the level of review

Many organisations typically report thousands of incidents each year. It is therefore unrealistic to suggest that all incidents should be reviewed to the same degree, or at the same level, within the organisation. Furthermore, the outcome of an incident, including a 'near miss', at the time of occurrence is

sometimes a poor indicator of the level of review required. The application of a simple risk assessment process to incidents at the time of occurrence can enable the organisation to implement a much more structured approach to its incident management.

Organisations should grade all incidents in DatixWeb for severity (actual impact) at the time of reporting the incident. This is completed by the reporter of the incident using the Regional Risk Matrix (Impact Assessment Table) (see Appendix 3).

In addition, it is important to complete the potential risk grading also using the Regional Risk Matrix (Impact Assessment Table/ Likelihood Descriptors) on DatixWeb (See *Procedure for Grading an Incident*)

The Regional Risk Matrix is also used by a range of specialist advisers for grading of incidents. Not all incidents fit discreetly into individual categories within the matrix and therefore the grading/coding of incidents will be at the discretion of the relevant adviser.

5.3.12 Communication with Service Users and/or relatives

Harming a service user can have devastating emotional and physical consequences for the individuals, their families and carers, and can be distressing for the professionals involved. ***'Being Open'***[9] is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident. **"Saying sorry is not an admission of liability".**

'*Being Open'* involves:

- acknowledging, apologising and explaining when things go wrong;
- keeping service users and carers fully informed when an incident has occurred;
- conducting a thorough review into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident reoccurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened; and
- recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff. Staff are encouraged to seek emotional support.

The organisation is committed to improving the safety and quality of the care we deliver to the public. Our '*Being Open'* policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance

by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven Steps to Patient Safety'*.

The main focus of the Being Open policy is for incidents with a severity of moderate and above. However, it is good practice to follow the principles for any incidents where service users have suffered harm.

Further guidance on communicating with service users and their relatives is available in the *Being Open* and/or *Serious Adverse Incident Policy*.

5.3.13 Communication with the Media

All media queries should be directed, in the first instance, to the Corporate Communications Dept.

5.3.14 Debriefing of Staff after Adverse Incidents

Co-Directors/Senior Managers and Heads of Department should ensure that local procedures are in place for the debriefing of staff after incidents. Agreed timescales for debriefing should be specified. The Line Manager should ensure that the staff member has access to appropriate help immediately post incident as necessary eg, referral for medical opinion in case of assault, counselling etc. Line managers should, where appropriate, seek medical advice as to whether it is advisable for the staff member to return to (or stay in) the workplace.

It should be standard practice at all debriefing sessions with staff to consider the contributing factors, which may have led to an incident. This should assist staff in reviewing practice and updating care plans, risk assessments etc. in order to minimise the risk of recurrence. Details of debriefing offered/arranged should be documented and retained in the staff member's local personnel file.

In the case of assaults on staff, line managers should discuss with the staff member whether or not they wish the police to be involved. Line managers should make staff aware of the availability of the services of Occupational Health Services and Staff Care.

5.3.15 Review, Monitoring and Analysis of Adverse Incidents

The organisation has in place mechanisms for the review, monitoring and analysis of adverse incidents both at Corporate and Divisional level. This involves production of reports for consideration and discussion at relevant governance related committees/sub committees and externally as required. Incidents should also be used with other sources of information to help inform the management of risks and effectiveness of actions taken following incident reviews, Quality Improvement projects and other quality and safety initiatives.

The Medicines Governance Pharmacist will lead on the multidisciplinary review, monitoring and analysis of medication related incidents and will link in

with the Regional Medicines Governance Team in respect of the production of regional Medication related governance reports.

5.3.16 Learning and Feedback

Learning from adverse incidents can only take place when they are reported and investigated in a positive, open and structured way. Where learning from such adverse incidents is identified the organisation will ensure that the necessary changes will be put in place to improve practice. Where learning from incidents is relevant to other areas across the organisation, and/or externally, the learning should be shared as per current organisational arrangements, e.g. established sub committees and groups. (See *Policy for Sharing Learning*)

Feedback to staff is vital in respect of incidents they report. Managers should ensure it occurs in their respective areas. This can be on a one to one basis or feedback can be given to all staff at regular Incident, Staff or Assurance / Governance Meetings.

5.4 Dissemination

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care. All staff employed by the Trust should be provided with access to this policy. The latest version of this policy (and related documents) is available on the Trust's intranet.

5.5 Resources

5.5.1 Training

Adverse Incident Training is mandatory for all staff and appropriate training and guidance will be provided by the Corporate Governance Dept, to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to report adverse incidents. The organisation's training administration system should be used appropriately to record staff training. Senior Managers/Heads of Departments are responsible for ensuring that training on Incident Reporting is covered in local Directorate induction programmes.

5.6 Exceptions

There are no exceptions to this policy and to the organisation's commitment to learn from adverse incidents.

6.0 MONITORING AND REVIEW

An audit of the policy will be undertaken post implementation to ensure adherence to the principles and procedures outlined in this policy document. Changes will be made to the policy, as required. This policy will be reviewed on a regular basis in the light of best practice, changing legislation or new/updated policy guidance.

7.0 EVIDENCE BASE/REFERENCES

- Health & Safety at Work (Northern Ireland) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997;
- HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016;
- Six steps to Root Cause Analysis, 2002, Consequence UK Limited;
- National Patient Safety Agency;
- Seven Steps to Patient Safety (2004); and
- Being Open, Patient Safety Alert, November 2009.

8.0 APPENDICES

Appendix 1 – Incident reporting and review process flowchart
Appendix 2 – Examples of Adverse Incidents
Appendix 3 – Regional Risk Matrix

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient **in Adverse Incident Reporting and Management Policy** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

04/06/2020

_____ **Date:** _____

Chris Hagan
Medical Director

10/06/2020

_____ **Date:** _____

Cathy Jack
Chief Executive

Appendix 1 – Process for Reporting and Managing an Adverse Incident (including level of review based on severity and potential risk grading)

NOTE: For detailed guidance see the Procedures for Reporting and Managing, Grading and Investigating Incidents

INCIDENT →

IMMEDIATE ACTION

1. Make person(s) / area safe.
2. Obtain medical aid if required.
3. Inform manager on duty ASAP.
4. Complete an incident form.
5. Consider level of communication with the patient.
6. Consider level of review required and action accordingly. If incident meets SAI criteria, follow relevant procedures.

GREEN INCIDENT (INSIGNIFICANT OR MINOR SEVERITY/LOW RISK)

Green incidents – Should normally be reviewed locally in the ward or department in which the event occurred. The review lead will normally be the Ward/Team/Department manager. It is the local team's responsibility to identify learning points, or safety improvement measures that are within the department's control, and ensure that those safety measures identified that are not within the control of the department are appropriately communicated to the relevant Management Team for consideration.

Incident types frequently falling into this grading should also be subject to aggregate analysis by the Ward/Team/Departmental Manager to identify any need for more targeted data collection. It is acceptable for the ward/departmental manager to close such incidents following review and recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 5 working days**.

YELLOW INCIDENT (MODERATE SEVERITY/MEDIUM RISK)

Yellow Incidents – These should also be reviewed locally, as for Green Incidents, but overseen by the Service Manager/Asst Service Manager for that area. It is the local team's responsibility to identify learning points, or safety improvement measures within the departments control and ensure that those which are not, are appropriately communicated to the relevant Management Team for consideration. Frequently occurring events of this grading should also undergo Trust-wide aggregate review to identify any need for more targeted data collection.

It is acceptable for the Ward/Team/Departmental Manager to close such incidents following review and proper recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 4 weeks**.

AMBER INCIDENT (MAJOR SEVERITY/HIGH RISK)

Amber Incidents – The Co-Director is accountable for ensuring that all investigations are carried out appropriately. The incident should be investigated and reviewed locally by more than one person and the team may include someone independent from the specialty, if required. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this.

It is the responsibility of the relevant management team to ensure that all learning points and safety improvements are appropriately identified and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate. Improvement strategies arising out of this group of events should be monitored as part of the Division's Governance arrangements.

Advice can be sought from Directorate Governance staff.

Review of this grade of incident should normally be completed and **closed within 12 weeks**.

RED INCIDENT (CATASTROPHIC SEVERITY/EXTREME RISK)

Red Incidents – The Co-Director is accountable for ensuring that all reviews are carried out appropriately. The incident should be investigated and reviewed locally by more than one person and the team may include someone independent from the specialty, if required. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this.

It is the responsibility of the relevant management team to ensure that all learning points and safety improvements are appropriately identified and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate. All of the resulting reports and improvement strategies arising from these events should be monitored through Division/Trust Governance arrangements.

Advice can be sought from Directorate Governance staff.

Review of this grade of incident should normally be completed and **closed within 12 weeks.**

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR)
Report all RIDDOR reportable incidents to the Health & Safety team on 02895048722.

For advice on Medical Device incidents contact the Medical Devices Coordinator on 02895048840 or email [redacted]

Open, Honest and Just Culture

This Trust welcomes knowledge of adverse events as an opportunity to learn for the benefit of our service users, staff and visitors. Unless there is clear evidence of flagrant malpractice, a complete disregard for the safety of others, maliciousness, intent to harm, theft or fraud, the disciplinary policy will not be used for review purposes. Incidents will be investigated for the purposes of learning and change and staff are required to engage as active participants of this.

Appendix 2 – Examples of Adverse Incidents that should be reported

Broad categories of possible adverse incidents are shown below and may assist reporters. This list is not comprehensive but gives a broad indication of what should be reported

- Violence, aggression, behavioural issues
- Delays or difficulties during appointments, admissions, transfers or discharges
- Accidents e.g. falls, medical sharps injuries, manual handling, exposure to hazardous substance, burn or scalds
- Cardiac arrests involving CPR and/or Defib
- Issues with clinical investigations, scans, x-rays, lab tests etc.
- Communication breakdowns between staff and/or with service users, issues with consent and confidentiality
- Event which caused the dignity and respect of a service user to be compromised
- Diagnosis, missed or delayed
- Financial loss to the Trust
- Infrastructure or Resources (staffing, facilities, environment) – for example, unsafe environment, waste issues, misuse, failure or theft of IT equipment or systems, lack of facilities, equipment or supplies, inadequate staffing levels
- Infection control issues, pressure sores, fluid maintenance, pain management, any other issues relating to implementation of care or ongoing monitoring / review
- Labour or delivery adverse incidents
- Medical device/equipment related Incidents – any preventable equipment related event that could have or did lead to patient harm, loss or damage. Includes incidents related to training, servicing, storage, disposal and suitability of the device, as well as failure of the equipment itself
- Medication incident (ie, any preventable medication related event that could have or did lead to patient harm, loss or damage).
- Patient Information issues e.g. records, documents, test results, scans. This may also include any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
- Treatment, procedure – any adverse incident immediately before, during or immediately after
- Security – for example, fires and fire risks, theft or damage to personal property, premises or vehicles, intruders or break-ins

Appendix 3 – Regional Risk Matrix

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid. • Non-permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration). • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest > 3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

SET Risk Matrix – April 2013 (based on HSC Regional Risk Matrix - April 2013, updated June 2016) - Clean

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Risk Matrix/Consequence (Severity Levels)				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 45/10

Title:	**Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments**		
Author(s)	Rachel Maxwell, Senior Manager, Licensing and Regulations, Complaints, [redacted]		
Ownership:	Dr Chris Hagan, Medical Director		
Approval by:	Trust Policy Committee Executive Team Meeting	Approval date:	2 April 2020 8 April 2020
Operational Date:	April 2020	**Next Review:**	April 2025
Version No.	4	**Supersedes**	V3 – March 2017
Key words:	Complaint, comment, concern, compliment, investigation, learning, action plan, shared learning, professional assurance, Ombudsman		
Links to other policies	BHSCT Adverse Incident Reporting and Management Policy TP 08/08 (2018) BHSCT Policy for Sharing Learning TP 98/14 (2016) BHSCT Being Open policy – saying sorry when things go wrong SG 56/11 (2018) DoH Complaints Standards and Guidelines		

Date	Version	Author	Comments
25/06/2019	3.1	Rachel Maxwell	Initial Draft
20/09/2019	3.2	Rachel Maxwell	Amendments / Comments
08/01/2020	3.3	Rachel Maxwell	Amendments to reflect Medical Director's Comments

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CONTENTS

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

In the patient-centred environment of the Belfast Trust, patients, relatives and carers are encouraged to express their views about the treatment and services that they receive.

We recognise the need to have an effective process for managing comments, concerns, complaints and compliments about any aspect of care or treatment provided or commissioned by the Belfast Trust in hospital or community settings. The purpose of the complaint investigation process is to establish the facts, to identify areas for improvement, and gain 'resolution' for the complainant. On occasion this process may identify areas of individual concern that will then be investigated separately.

It is essential that all concerns and complaints are received positively, investigated promptly and thoroughly, and responded to sympathetically. Timely and effective action should be taken where appropriate to prevent recurrence when services provided have fallen below acceptable standards.

1.2 Purpose:

The purpose of this document is to ensure that:

- complaints are dealt with in line with the DoH Guidance in relation to the Health and Social Care Complaints Procedure

- complaint management processes comply with the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration

- complaints are handled in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame

- staff are provided with a greater understanding and guidance on Complaint Management procedures within the Belfast Trust to ensure complaints are managed in a positive manner and that learning can take place

The policy promotes local, prompt resolution with involvement of the complainant at the core of the process, and encourages continuous learning and identification of improvements in the quality and safety of services throughout the Trust.

1.3 Objectives

- To ensure that patients/relatives/carers are encouraged to provide feedback about their experiences of treatment and services - to tell us what is working, help identify any potential service improvements, and help identify problems and risk – and that individuals will not be treated differently as a result of making a complaint.

- To learn from comments, concerns, complaints and compliments and use feedback effectively to improve the quality of our services, prevent recurrence of factors giving rise to a concern or complaint, and inform professional assurance processes including identifying areas of individual concern that need separate investigation.

- To ensure that Trust staff are aware of their roles and responsibilities in good customer care and complaints handling, including responding positively to complaints, actively listening, acknowledging, assessing, resolving and investigating concerns / complaints quickly as possible.

- To ensure the Trust promotes a culture of openness, honesty and fairness when investigating all concerns and complaints.

- To ensure complainants receive open, honest and proportionate responses to their complaints where mistakes are acknowledged, explanations provided for what went wrong and appropriate and proportionate measures are considered to put things right.

2.0 SCOPE OF POLICY

This Policy is applicable to all staff providing services within the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency staff and volunteers, and includes services that are commissioned or provided by the Independent Sector.

The Formal Complaints Procedure applies only to complaints about care or treatment, or about issues relating to the provision of health and social care.

Comments, concerns, complaints and compliments may be received from patients; patient relatives, carers, visitors and other service users. The concerns and complaints excluded from the scope of this policy are identified in **5.3.**

3.0 ROLES/RESPONSIBILITIES

Chief Executive

As Accountable Officer, the Chief Executive has overall accountability for ensuring compliance with statutory and legal requirements and with relevant complaint guidance.

The Chief Executive will:

- promote an open, honest and just culture for complaints management

- ensure that the Trust takes the necessary action to ensure that lessons are learned and where appropriate, improvements are made to the service.

- ensure a Committee structure is in place to monitor and review the organisation's performance in complaints management.

Trust Board

The Trust Board has a monitoring and assurance role to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

- promote an open, honest and just culture for complaints management, and ensure that the arrangements contained within the policy and procedures are implemented

- monitor and review the overall reporting performance and receive regular reports

- ensure complaints management is integrated within the Trust's Performance and Assurance Framework

Medical Director

The Medical Director (or their deputy) is the lead Director on behalf of the Trust Board and Executive Team for the management of complaints. The Medical Director has a shared responsibility with the Director of Nursing and User Experience for clinical quality.

The Medical Director will:

- develop suitable organisational arrangements for the management of complaints and promote an open, honest and just culture for complaints management
- develop and maintain professional assurance systems, and processes to monitor and disseminate learning from complaints across the organisation
- put systems in place to ensure reporting of complaints to external agencies as required e.g. DoH, Regional HSC Board, RQIA
- regularly review a representative sample of complaint responses for assurance purposes

Co-Director Risk and Governance

The Co-Director will support the Medical Director in meeting their responsibility for complaints management.

The Co-Director has Trust-wide lead for the co-ordination, implementation, and evaluation of risk management systems and the Trust Risk Management Strategy.

The Co-Director will:

- promote an open, honest and just culture for complaints management
- maintain systems for the reporting, recording and analysing of complaints including in relation to professional assurance
- ensure that subsequent learning from complaints is shared across the Trust, through appropriate management structures
- take account of relevant complaints when reviewing Service Directorate risk registers and ensure appropriate linkage to the corporate risk register

Directors

Directors are responsible for ensuring that the standards and processes referred to in this policy are followed within their Service Areas, thus ensuring that the Trust does not suffer reputational damage due to maladministration of complaints.

Directors will:

- disseminate and promote this policy and procedure within their areas of responsibility and ensure its implementation by providing support and advice to managers and staff and promoting an open, honest and just culture for complaints management

- ensure complaints are investigated thoroughly and in a timely manner in accordance with existing policy and procedure, including approving extensions to timescales as appropriate upon request from Service Areas

- review and amend draft complaint responses and sign off on behalf of the Chief Executive

- ensure that appropriate actions are taken, where required, in response to professional assurance issues identified through complaints

- ensure that learning from complaints is shared across Service Areas, in keeping with the Shared Learning Policy through appropriate management structures

- ensure that learning with relevance beyond the Directorate is appropriately formulated and progressed for sharing in line with the shared learning procedure

- ensure that complaints are monitored and reviewed within their Service Areas

- implement action plans as required to ensure recommendations made as a result of investigations are implemented and monitored, and provide assurance to the Service User Experience Feedback Group and subsequently to the Assurance Committee

- take account of relevant complaints when reviewing their Risk Register and ensure that this is linked appropriately to the Corporate Risk Register

- ensure staff have access to appropriate training on complaint management and, where appropriate, investigation of complaints.

- ensure identification of key issues and actions regarding the management of complaints for progression via the Service User Experience Feedback Group and onward reporting to the Trust Board

Chairs of Division, Clinical Directors and Professional Leads

Chairs of Division, Clinical Directors and Professional Leads (ie Divisional Nurses, Divisional Social Workers etc) will review all complaints correspondence sent to them in relation to named staff members and will initiate appropriate actions / review mechanisms as required to ensure effective Professional Assurance governance systems are being robustly implemented within their respective areas.

Clinical Directors and Professional Leads will maintain oversight of Clinical Record Reviews and other assurance systems and reports regarding staff named in complaints, and will escalate to Directors and Chairs of Division as necessary to advise of any concerns and of progress with associated actions.

Co- Directors

Co-Directors are responsible for ensuring that all complaints are managed efficiently and effectively in their Service Areas and all complaint responses are provided in a timely way

Co-Directors will:

- agree the grading of the complaint in conjunction with the Investigating and Complaints Managers

- ensure any complaint identified as high risk is assessed, reported to the Director and appropriately managed and investigated using Root Cause Analysis methodology. Consideration should be given to undertaking independent investigations into high risk complaints that do not meet the SAI criteria.

- ensure that Clinical Record Reviews are conducted for complaints relating to Quality of Treatment and Care and that Chairs of Division and relevant Clinical Directors are informed of the review outcomes

- deal with any queries Investigating Managers might have, including the need to contact or meet with the service user who raised the complaint or concern.

- maintain oversight of and implement effective performance management systems to ensure the quality and timeliness of responses provided by their Service Areas, reviewing complaints management data on an ongoing basis and prioritising actions to address issues identified regarding outstanding responses and any trends of excessive response times

- where a complaint relates to the actions of more than one Directorate the Co-Directors will liaise with the relevant Complaints Manager to identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.

- agree the draft response with the Investigating Manager (ensuring that all aspects of the complaint are addressed, and that the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling are reflected in the response) and forward this to the relevant Complaints Manager within identified timescales

- where appropriate, ensure action plans arising out of investigations (including Ombudsman's recommendations) are agreed, progressed, monitored and evaluated.

- ensure that the Directorate fosters an ethos of learning in order to minimise future occurrences of issues identified through complaints

- where serious allegations regarding staff performance and behaviour arise through the Complaints Procedure, ensure this is appropriately followed up.

Service Directorate Managers (Investigating Managers)

Service Directorate Managers are responsible and accountable to their Director to ensure that complaints are thoroughly investigated within their clinical and managerial teams and responded to within the given timescales.

Service Directorate Managers will:

- ensure that complaints investigations are conducted thoroughly in a manner that is supportive to those involved and takes place in a blame free atmosphere

- ensure that complaint responses are provided within agreed time scales, including ensuring that their teams review and approve draft responses in a timely manner and promptly escalating obstacles that may cause delays to Co-Directors as required

- work in conjunction with relevant Clinical Directors (or deputies) to initiate the Clinical Record Review process for all complaints relating to quality of treatment and care

- ensure appropriate action is taken when a health professional is identified in a concern or complaint. Where more than one concern or complaint raised about an individual, ensure there is appropriate escalation to the relevant professional lead

- ensure that comprehensive records are maintained throughout all complaint investigation and management processes

- ensure that upon closure of each complaint the Complaints Department is provided with details of any staff members where the complaint investigation process has identified potential concerns (in order to facilitate effective implementation of the Trust's Professional Assurance mechanisms)

The Investigating Manager will:

- agree grading of the complaint in conjunction with the relevant Complaints Manager

- undertake a preliminary assessment of how best to investigate the complaint (scoping process to take place within 48 hours of receipt of complaint where possible) including consideration of Independent Review where appropriate

- liaise regularly with the relevant Complaints Manager

- ensure the investigation is carried out in a timely manner and notify the relevant Complaints Manager at the earliest opportunity of any delays

- ensure that panels interviewing staff members as part of the complaints investigation process include suitable professionals with similar expertise to the individual being interviewed

- provide support to staff during an investigation and ensure that staff named in the complaint are made aware of the content of both the complaint and the response. If a named member of staff has left the Trust, all reasonable efforts must be made by the Investigating Manager to contact them to obtain all relevant information.

- keep comprehensive records of all relevant supporting information arising throughout investigation of the complaint

- ensure response letters are compiled and fully address all issues raised by the complainant

- ensure that agreed action plans arising out of investigations are completed and any recommendations implemented across appropriate teams/departments

Senior Complaints Manager

The Senior Complaints Manager will support the Co-Director of Risk and Governance in executing those duties relating to the management of complaints.

The Senior Complaints Manager will:

- ensure implementation of audit and quality assurance mechanisms to support effective and high functioning complaints management processes within the complaints department

- ensure provision of data at corporate and Directorate level to support oversight of complaints and shared learning

- ensure appropriate systems are in place for the identification and escalation of professional assurance issues arising from complaint investigations

Complaints Managers

Complaints Managers will:

- acknowledge complaints within 2 working days of receipt

- agree grading of complaints in conjunction with the Investigating Manager

- contact complainants to confirm and agree areas for investigation and expected outcomes

- ensure all complaints involving a sudden unexpected death, serious harm or potential safeguarding issues, are escalated to the relevant Director and Senior Complaints Manager immediately for consideration of independent investigation and to facilitate communication with the complainant

- where a complaint relates to issues across more than one Directorate the Complaints Manager and / or Service Manager will liaise with the complainant to clarify the main issues of concern to assist identification of who should take the lead in investigating the complaint and co-ordinating the response for the complaint

- obtain consent where required in the case of third party complaints or enquiries

- notify the relevant Investigating Manager within 2 working days of receiving complaint

- record all relevant information about each complaint on Datix and set up the agreed response timescales

- track complaints and send reminders to Service Areas to facilitate the meeting of deadlines, including informing the Investigating manager *10 working days* before the final response deadline, and escalating delayed responses to Co-Director and Director-level as required

- ensure that the preferred mode of contacting the complainant is agreed and ensure that the complainant is kept informed about progress with his/her response

- ensure that the relevant Executive Director is notified where a health professional has been identified in a complaint or has subsequently been identified during the complaint investigation process (including notification of the Medical Director's Office where a complaint involves medical staff)

- ensure that the relevant Divisional professional lead (ie Divisional Nurse, Divisional Social Worker etc) is notified where a health professional has been identified in a complaint or has subsequently been identified during the complaint investigation process

- detail the specific points in the complaint that require to be answered and subsequently quality assure that all points have been fully addressed by the Directorate before forwarding for signature (in addition to quality assurance checks ensuring accuracy of dates, names/titles and address of complainant etc)

- ensure final complaint responses are sent to Investigating Managers and Co-Directors for checking with contributing staff and final approval prior to being sent to the relevant Director

- provide service user feedback, related analyses and reports to services and Committees within the Governance Accountability Framework

- thematically review complaints for learning locally and across the Trust

- provide information as requested to external sources including RQIA, Department of Health and HSC Board.

- provide guidance and support to relevant managers, supervisors and staff to enable them to carry out their duties and responsibilities relating to complaint prevention and management

- provide training in relation to complaints investigation and management

All staff

A complaint can be made orally or in writing to any member of Trust staff. The most satisfactory outcome from complaints often comes when the issues identified are dealt with fully and effectively on the frontline within the Service Area. As such the Trust expects all staff to attempt to resolve issues on the front line speedily and to the complainant's satisfaction, with the assistance of a more senior member of staff when necessary.

The first responsibility of the recipient of a complaint is to ensure that patients' immediate healthcare needs are being met. This may require urgent action before any matters relating to the complaint are tackled.

Complainants should be listened to and treated courteously with dignity and respect, and should be approached in a non-defensive manner to ascertain their concerns.

Reassurance should be given to the complainant that their concern is being taken seriously, that it will be dealt with confidentially and will not in any way adversely affect their or their relative's treatment.

Where the issue raised is about a specific member of staff, the local manager should appoint another staff member with appropriate expertise to carry out an initial investigation and seek to resolve the matter speedily.

Staff will:

- work to put things right and help resolve issues or concerns raised by complainants in an open, compassionate, constructive, non-judgemental and timely manner
- refer as soon as possible to their line manager if unable to deal with complaints raised directly with them or seek advice from complaints staff on how to proceed
- keep their line manager updated on complaints and enquiries they are currently dealing with, and complaint outcomes (including resultant service improvements)
- provide patients, patient relatives, carers, visitors and other service users with appropriate information regarding how to give feedback and how to raise concerns or a complaint (this includes ensuring that information relating to service user feedback is displayed in facilities accessed by service users)
- co-operate fully with the investigation of complaints within the service/team particularly by returning statements, reports and other information to Investigating Officers in a timely manner – even where staff members have left the Trust (for example due to retirement) since the events of the complaint.
- enable the process of organisational learning following a complaint
- release staff for relevant complaints awareness/ customer satisfaction training.
- maintain good record keeping (including updating Datix with relevant details as require
- inform their line manager and other team members (if appropriate) when they receive a written compliment from service users

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

A **complaint** is an expression of dissatisfaction about care or services provided by the Trust, which requires a response. It can be made by a patient, relative, carer or representative acting on behalf of a patient. Complainants may not always use the word complaint.

A **complainant** is the person making the complaint, on behalf of themselves or another.

A **concern** is usually where an individual remarks, expresses an opinion or makes an observation about a patient's treatment/care that can be defined as a matter of interest, importance or anxiety.

An **enquiry** is a request for further information such as waiting times for appointments

A **compliment** is an expression of praise, commendation, or admiration.

4.2 Key Policy statements:

This policy has been developed and set within the Legal Framework for Complaints Management within Health and Social Care Services.

The Belfast Trust is committed to providing safe, effective and high quality services and welcomes feedback from patients/relatives/carers/visitors and other service users about their

experience of care to improve quality. This policy provides the opportunity to put things right for service users as well as improving services.

It is recognised that there may be times when treatment and or services do not meet expectations particularly when something has gone wrong or fallen below standard. By listening to people about their experience of healthcare, the Trust can learn new ways to improve the quality and safety of services and prevent problems happening in the future. Such learning from comments, concerns, complaints and compliments can only take place when they are managed in a positive and open manner. The Trust will therefore promote an open, honest, just and fair culture, where all staff can learn from complaints.

Patients/service users/relatives/carers/visitors can bring comments, concerns and compliments to the attention of any member of staff. Wherever possible, staff at a local level will actively seek to resolve dissatisfaction in a sensitive manner at the earliest opportunity. In circumstances where such frontline resolution is not possible, this policy outlines the process to ensure complaints are handled in an efficient and effective manner.

Where complaints raise concerns regarding the conduct or performance of staff, these will be escalated to the relevant Director / Professional Lead (ie Divisional Nurse, Divisional Social Worker etc), with Clinical Record Reviews or Independent Case Reviews being conducted as appropriate and escalated to Chairs of Division as required.

Copies of completed Clinical Record Reviews will be sent to the relevant Executive Lead for tracking.

Effective communication is essential in good complaint handling. Complainants must be involved in deciding how the issues they have raised are handled and, where appropriate, advised of what will be done as a result of their feedback. A meeting with the Service Area should be offered to complainants upon conclusion of any investigation to allow an opportunity for discussion of the findings.

All complaints will be treated in confidence, with openness, honesty and respect being paramount at all times.

Complaints form a vital part of the Trust's performance management systems. Positive action will be taken as a result of complaints, and learning from complaints will be embedded in the Trust's governance and risk management arrangements. Where something has gone wrong or fallen below standard the Trust will take every opportunity to improve and avoid a recurrence.

4.3 Compliments

Details of compliments received by Service Areas must be provided to the Complaints Department (via compliments@belfasttrust.hscni.net) to ensure accurate onward reporting.

Figures must be submitted on an ongoing basis in relation to the following areas for collation and inclusion in the Trust's formal reports to the Department of Health each quarter :

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Telephone
Quality of Treatment and Care						
Staff Attitude and Behaviour						

Information and Communication						
Environment						
Other						

**Social Media refers to compliments received by official Facebook and Twitter accounts only*

All compliments received by the Chief Executive or Complaints Department will be acknowledged and shared with the staff/department named, and details recorded on Datix.

4.4 How can complaints be made?

Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service that may enhance the communication of the complaint to the organisation. Patients must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint.

Complaints may be made verbally or in writing and should also be accepted via any method, for example, telephone or e-mail. The Trust should be mindful of technological advances and ensure local arrangements are in place to ensure there is no breach of patient/client/staff confidentiality.

All complaints will be treated in confidence, with due care and respect being paramount at all times.

Complaints may be made to any member of staff - for example receptionists, medical or care staff. In many cases complaints are made orally and front-line staff may resolve the complaint "on the spot". As such, all front-line staff must be trained and supported to respond sensitively to comments; concerns and complaints raised and be able to distinguish those issues that would be better referred elsewhere.

Front line staff should familiarise themselves with the the DoH Guidance in relation to the Health and Social Care Complaints Procedure, and the Parliamentary Health Service Ombudsman's principles for dealing with and managing complaints.

It is essential that all staff are aware of their roles and responsibilities when dealing with complaints. This will enable them to respond positively, and where possible, resolve the complaint at local level.

4.5 Complaint Management processes

Where a concern or complaint is made within a Service Area, every attempt should be made to achieve resolution at that time.[1] Where frontline resolution has been unsuccessful, the complainant should then be offered the option of contacting the Complaints Department.

All formal complaints must be formally acknowledged within 2 working days. Where possible the complainant's issues and expected outcomes from the complaint will be clarified and a timescale for response agreed. The format of the response will also be agreed with the complainant, this may be verbal (by phone or at a meeting), by email or written letter.

[1] All complaints raised with front line staff should be recorded on "Frontline Resolution" forms (these can be found on the Trust intranet, see Appendix 7) including details of any actions taken and the outcome of such. Completed forms should be forwarded to the Complaints Department for entry onto the Datix system.

All complaints will be investigated according to the category of grading in which they fall, as referred to in the Regional matrix (see Appendix 2). Where a complaint involves the death of a patient/service user complainants should be offered a meeting with the Service Area to discuss their concerns at both the start and the end of the complaints process.

The Trust will investigate the complaint in a manner appropriate to the nature of the issues raised, aim to complete the investigation as efficiently and effectively as possible and ensure that the complaint response is provided within the agreed timescales.

Where it is unavoidable that the response will not be provided within the agreed timescales the Service Area will notify the Complaints Department immediately with a clear explanation as to the reason(s) for delay, and will appoint a key contact within the service area for the duration of the complaint investigation and response process. The Service Area will continue to update the Complaints Department to enable the complainant to be kept regularly informed as to the progress of the investigation and response. Whilst a holding letter may be issued, it is preferred practice to maintain (as far as reasonably practicable) verbal contact with the complainant.

At all stages within the complaints process the Complaints Manager will provide support and assistance to the complainant and staff involved. Independent advice and support for complainants is also available from the Patient Client Council and from Independent and specialist advocacy services, (see Appendix 11*).*

Regular reports will be provided to Directorates by the Complaints Department highlighting key issues such as trends in complaint subjects, length of response times, Ombudsman cases, and identifying any multiple complaints about individual employees / departments.

Joint Complaints

Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify the other organisation(s) involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations.

In cases of this nature there is a need for co-operation and partnership to agree how best to approach the investigation and resolution of the complaint. It is possible that various aspects of complaints can be divided easily, with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for coordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.6 Complaint Investigation

The designated Investigating Manager within each Service Directorate will be forwarded a copy of the complaint correspondence by the Complaints Team on receipt of the complaint. Copies of key guidance documents will also be enclosed as appropriate to support thorough and timely investigation of, and response to the complaint issues.

The Complaints Team will provide a reminder to the Investigating Manager via email 10 working days before the final response is due to prompt them to return the internal response, and will subsequently escalate delayed responses to Co-Director or Director level as required (see Appendix 7 below).

Upon completion of the complaint investigation, the Investigating Manager must forward a draft response to the relevant Complaints Manager who will ensure that all aspects of the complaint have been addressed. Where the quality check of the draft identifies significant changes or omissions, the response will be sent to the relevant Co-Director for checking and approval prior to forwarding to the relevant Director for final approval and signature.

A complaint should be made as soon as possible after the action giving rise to it, normally within 6 months of the event. There may be occasions when a complainant was not aware that there was cause for complaint at the time. In such circumstances a complaint should normally be made within 6 months of the complainant becoming aware of the cause for complaint.

Full and proper investigation is hindered where timescales extend beyond a 6 month period. Complainants should be advised that the time delay may impact on the investigation and any response would be based largely on a review of records.

Advice should be sought from the relevant Complaints Manager in conjunction with the relevant Co-Director when deciding whether to investigate a complaint older than 6 months. Any serious allegations should be investigated if at all possible, regardless of timescale.

Any decision not to proceed with an “out of time” investigation rests with the relevant Director and a letter explaining this decision (signed off by the Director) should be sent to the complainant.

4.7 Children Order Representations and Complaints Procedure

Under the Children (NI) Order 1995 HSC Trusts are statutorily required to follow established procedures for considering any representations (including any complaint) made to the Trust about the discharge of its functions under part IV or, and paragraph 4 of Schedule 5 to, the Order; and matters in relation to children accommodated by voluntary organisations and privately run children’s homes; and personal social services to children provided under the Adoption Order (NI) 1987. Further details regarding complaints in relation to Children Order Representations can be found at *Appendix 6.*

4.8 Independent Sector Providers (ISPs)

Complaints relating to Independent Sector Providers may be received directly by ISPs, or the complainant may contact the Trust directly. Generally, in the first instance, the ISP investigates and responds directly to the complainant. If the complainant contacts the Trust directly, the Trust will consider how best to proceed and if the matters raise serious concerns, the Trust may decide to investigate the complaint.

In all cases the complainant must be kept informed and advised of which organisation will investigate their complaint. Where a complaint relates to the actions of more than one Directorate the Complaints Manager in conjunction with the Co-Directors will identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy has relevance for all Belfast Trust staff, and applies equally to those in permanent, temporary, voluntary or contractor roles.

The policy will be available for download from the Trust central policy intranet page and the Trust website, and will be circulated by e-mail to all Directors for cascading to their relevant areas of responsibility.

5.2 Resources

A programme of complaints awareness and management training will be ongoing throughout the Trust to ensure that this procedure is followed and that staff encourage service users to provide feedback about their treatment and care experiences.

Complaints Awareness Training is part of the mandatory induction programme for all new Belfast Health and Social Care Trust employees.

Further information and resources can be found in the Complaints section on the Hub, and in the Appendices below.

5.3 Exceptions

In certain circumstances, concerns and complaints may be excluded from the scope of this policy.

Such exclusions are as follows:

- private care and treatment or services (including private dental care or privately supplied spectacles); except for those patients having private care in one of the Trust's facilities and the complaint is about care and treatment.
- services not provided or funded by the HSC, e.g., provision of private medical reports;
- the independent regulated sector (except for services commissioned by the Trust)
- staff grievances (the Trust has separate procedures for handling staff grievances. Staff may, however, complain about the way they have been dealt with under the HSC Complaints Procedure and, provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman)
- staff complaints
- an investigation under the disciplinary procedure
- an investigation under SAI investigation
- an investigation by one of the professional regulatory bodies
- services directly commissioned by Health and Social Care Board (HSCB)
- a request for information under Freedom of Information
- access to records under the Data Protection Act
- an independent inquiry
- a criminal investigation
- protection of vulnerable adults
- child protection procedures
- Coroners cases
- legal action

In such circumstances the Chief Executive (or relevant delegated Director) should inform the person outlining why the exclusion applies.

6.0 MONITORING

Implementation / Resource requirements:

The effectiveness of this policy is monitored and reported through:

Governance Structure
At a service level, governance meetings are held on a regular basis and complaints are included as a standard agenda item for these meetings. The learning from complaints is incorporated on the agenda and discussed at these meetings.

Complaints data is provided as part of a wider governance information system underpinning the Trust's Professional Assurance mechanisms

There are designated groups with operational responsibility for the oversight and monitoring of complaints process within the Trust Assurance Framework, including the Learning from Experience Group, Assurance Group and Assurance Committee, a standing committee of Trust Board.

The Service User Experience Feedback Group meet regularly to review the number of on-going complaints, spot trends, discuss Key Performance Indicators in relation to complaints, consider cases of specific concern and agree shared learning.

An annual Complaints Report is generated and reported through the Trust Assurance Framework structures and published on the Trust website. Complaints information is also included in the Trust's Annual Quality Report.

Compliance with this policy at Service Level will be overseen by Governance Leads who will continuously monitor the number of complaints received, any trends, and the results of complainant satisfaction surveys, the number and outcome of Ombudsman cases, and a range of Key Performance Indicators relating to complaints.

Any identified areas of non-compliance or gaps in assurance arising from the monitoring of this policy will result in recommendations and proposal for change to address areas of non-compliance and/or embed learning.

7.0 EVIDENCE BASE/REFERENCES

DoH Guidance in relation to the Health and Social Care Complaints Procedure
Revised April 2019
HPSS Complaints Procedure Regulations: April 2009
The Children (NI) Order 1995:
Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration

8.0 CONSULTATION PROCESS

Senior Managers within Risk and Governance
Governance Leads within the Service Directorates
Staff side

Human Resources and Equality Department
Independent Service User Group.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 Responding to a comment, concern or complaint
Appendix 2 Grading of a Complaint
Appendix 3 Complaint Investigation and Resolution
Appendix 4 Complaint Process Flowcharts
Appendix 5 Vulnerable Adults
Appendix 6 Children Order Representations And Complaints Procedure
Appendix 7 Formal Complaints Escalation Process
Appendix 8 Northern Ireland Public Service Ombudsman Cases
Appendix 9 Record Keeping
Appendix 10 Consent, confidentiality, and third party confidence
Appendix 11 Internal/ External Support/ Contacts
Appendix 12 Unreasonable, vexatious or abusive complaints
Appendix 13 Unacceptable Actions Policy

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

8 April 2020

Date: _____

Chris Hagan
Interim Medical Director

8 April 2020

Date: _____

Cathy Jack
Chief Executive

Appendix 1 -Responding to a comment, concern or complaint

Comments, concerns, complaints and compliments from patients/ relatives/carers and the public are encouraged and welcomed.

Should patients/relatives/carers or the public be dissatisfied with the care provided by the Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously.

Under no circumstances should patients/relatives/carers be treated any differently as a result of making a complaint. At the outset of any comment, concern or complaint, it is imperative that the complainant is actively listened to and asked to establish the outcome he/she is seeking.

1. Frontline Resolution

When something has gone wrong, patients/relatives/carers are encouraged to raise concerns or make a complaint as soon as possible and directly to the staff involved. This is often to front line staff in wards, clinic, and reception. All Trust staff, as a means of improving service provision, should deal with concerns or complaints in a positive manner.

In the majority of circumstances the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise as soon as possible. Usually this is best undertaken as close to the point of care/service delivery as possible.

If the concern or complaint requires further investigation or if the complainant wishes to address their concerns to somebody not involved, the complainant will be referred to the Complaints Department.

On receipt of a concern or complaint, the first responsibility is to ensure that the patient's immediate health needs are being met.

Records should be kept of all discussions, local actions taken etc and forwarded to the Complaints Department upon resolution of the issues.

A Frontline Resolution form should be completed with details of the complaint, the corrective / remedial actions taken to resolve the complaint, confirmation that the complainant is content that their issues and concerns have been satisfactorily resolved, and identifying any potential professional assurance concerns indicated by the complaint (see below).

Frontline Complaint Record Form

Date:	
Time:	
Details Taken By:	
Location and Service Directorate:	

Details of Patient/Client/Service User:

Name			
Address			
Date of Birth		Hospital Number	
Contact number (if patient is complainant)			
Contact e-mail address (if patient is complainant)			

Complainant Details (if different from Patient/Client/Service User above):

Name	
Address	
Contact number	
Contact e-mail address	

NB: Advise complainant, if they are not the patient, that written consent will be required before the complaint investigation can begin

Note of Complaint/Enquiry

Action Taken

Is the complainant happy that their complaint has been satisfactorily resolved? **Yes** ☐ **No** ☐

Please identify any staff where the issues identified by this complainant have highlighted potential concerns. This information is critical to the Trust's Professional Assurance governance mechanisms:

Staff member Surname	Staff member Forename(s)	Job Title	Specialty	Nature of Concern	Comments
e.g. Smith	*John, Robert*	*Consultant*	*Orthopaedics*	*Quality of Treatment and Care* *Staff attitude / behaviour*	*Concern regarding failure to diagnose patient's cancer and dismissive attitude towards family member*

Please return to: Complaints Department, 7th Floor, McKinney House, Musgrave Park Hospital, Belfast, BT9 7JB, or email to: complaints@belfasttrust.hscni.net

2. Formal Complaints

In cases where frontline resolution has not been possible, the Complaints Department will be notified and will offer assistance to the complainant. Concerns and complaints received into the Trust by other means (eg sent directly to CEO office) will be promptly forwarded to the Complaints Department.

At the outset, the Complaints Department will identify a named Complaints Manager as single point of contact for the complainant, with whom they can liaise throughout the process. The Complaints Manager should establish with the complainant the outcome he/she is seeking. *NB Where the complainant is not the service user affected by the issues of complaint, written consent must be secured from the service user before investigation of the complaint can only proceed.*

The nature and grade of the complaint will influence the level of investigation and the level of notification/cascade throughout the organisation. A framework to support this decision-making can be found in the Trust Risk Matrix, *(see Appendix 2).* Higher graded complaints require prompt action, more robust investigations and may require the involvement of external investigators. Complaints relating to Quality of Treatment and care should be investigated in conjunction with the Clinical Record Review process (*see Appendix 3*)

It is the responsibility of the relevant Investigating Officer to prepare the draft complaint response from the information obtained during the investigation. The response should be clear, accurate, balanced, simple, and easy to understand. It should aim to answer all the issues raised by the complainant, in an open and honest way, explaining the situation, why it occurred and the action taken or proposed action. Where possible this should be provided to the relevant Complaints Manager within 10 working days from receipt of the complaint.

3. Meeting a Complainant

If a meeting is arranged with a complainant at any point in the complaint management process the Investigating Officer in collaboration with the Complaints manager will ensure that:-

- an appropriate time and venue for the meeting is arranged (taking cognisance of the sensitivities of the complaint)
- the complainant receives details of the meeting a minimum of 5 working days prior to the meeting
- an agreed agenda is sent to the complainant and attendees a minimum of 5 working days prior to the meeting
- arrangements are made to meet the complainant prior to the meeting
- the relevant Trust staff are present at the meeting
- where appropriate a Complaint's Manager is present at the meeting
- a record is kept of the meeting. The Service Area should provide a minute-taker at family meetings. A copy of the meeting notes should be sent to the Complaints Department for issue to the complainant (if requested) no later than 10 working days from the date of the meeting.

4. Complaint Response

All complaints will receive an open, fair and honest response. The complainant may prefer to receive their response via letter, email, at a meeting or by a telephone call (telephone conversations will usually be followed up in writing or via an email). A response does not need to be long or to provide a detailed account of dates/times of events, however it should:

- include an apology for the poor experience
- explain who has investigated the complaint
- address all the issues raised in a proportionate and fair manner
- acknowledge the importance of receiving feedback
- avoid abbreviations, and if possible use of technical jargon. Explain any technical words, phrases or procedures
- provide a full explanation of all issues raised
- acknowledge if the service/treatment provided fell below the expected standards of the Trust.
- detail any learning, actions taken or proposed to put the matter right and prevent recurrence
- offer to meet the complainant if appropriate
- indicate that a named person is available to clarify any aspect of the letter
- indicate the right to escalate their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

A series of checklists have been produced to support the provision of high quality responses to complainants:

Belfast Health and Social Care Trust
caring supporting improving together

Quality Assurance Criteria - Complaint Responses

Service Area QA

	QA Criteria	☑	☒	N/A	Comments
1	All points of complaint are fully addressed including clear explanation of investigation findings into each issue raised				
2	Independent Peer Review (Clinical Record Review process) has been conducted (*if complaint relates to quality of treatment and care*)				
3	If Professional issues have been identified in the complaint, the response has been reviewed and signed off by the relevant Professional Lead				
4	Plain English is used, medical / technical terminology kept to a minimum and explained fully if necessary				
5	Appropriate language is used – personalised, sincere, non-defensive tone, empathetic, courteous and sensitive Tone of letter matches nature of complaint.				
6	Acknowledgement of failures, apology and acceptance of responsibility made to complainant where appropriate				
7	Response includes description of changes made / actions put in place to minimise risk of reoccurrence as a result of the complaint included (eg changes in policy or clinical practice, re-training of staff)				
8	Offer of remedy made where appropriate (eg offer of further clinical appointment; reimbursement of car parking fees)				
9	Response thanks complainant for raising the complaint				
10	Response includes expression of condolence if the complainant has been bereaved				
11	Response offers complainant an opportunity to meet and discuss outcome of the complaint investigation				
12	Response includes an apology and explanation if not within 20 working days				
13	Response reflects Trust Values				
14	I would be happy for my loved one to receive this response				

OTHER COMMENTS:

Completed by: _____ **(Name)** _____ **(Role)** _____ **(Date)**

Complaints Administrative QA

	QA Criteria	☑	☒	N/A	Comments
1	Font – Arial Size 12, paragraphs fully justified, 1.15 line spacing				
2	Name & address details correct				
3	Date correct				
4	Correct Title(s) used				
5	Consistent naming conventions throughout letter: - Complainant / family members - Staff members				

Completed by: _____ **(Name)** _____ **(Role)** _____ **(Date)**

Complaints Managers QA

QA Criteria		☑	☒	N/A	Comments
1	All points of complaint are fully addressed including clear explanation of investigation findings into each issue raised				
2	Independent Peer Review (Clinical Record Review process) has been conducted (*if complaint relates to quality of treatment and care*)				
3	If Professional issues have been identified in the complaint, the response has been reviewed and signed off by the relevant Professional Lead				
4	Appropriate language is used – personalised, sincere, non-defensive tone, empathetic, courteous and sensitive. Tone of letter matches nature of complaint.				
	Consistent style and use of terminology throughout letter - particularly for cross-Directorate responses				
5	Consistent naming conventions and correct titles used throughout letter: - Complainant / family members Staff members				
6	Acknowledgement of failures, apology and acceptance of responsibility made to complainant where appropriate				
7	Response offers complainant an opportunity to meet and discuss outcome of the complaint investigation				
8	Includes details of complainant's option to revisit the complaint within 1 month				
9	Includes signposting to NIPSO				
10	Reflects Trust Values				
11	I would be happy for my loved one to receive this response				
Completed by: _____ (Name) _____(Role) _____(Date)					

Complaint Closure QA - Complaints Administration

QA Criteria		☑	☒	N/A	Comments
1	Named Professional Template Issued and Returned				
2	Details of Named Professionals added to Datix				
3	Relevant Professional Assurance Lead notified				
4	Key complaint documents (inc signed Trust response) saved to Datix				
General Comments:					
Completed by: _____ (Name) _____(Role) _____(Date)					

Quality Assurance Criteria - Complaint Ref:

Chief Executive / Director QA

	QA Criteria	☑	☒	N/A	Comments
1	All points of complaint are fully addressed including clear explanation of investigation findings into each issue raised				
2	Plain English used, medical / technical terminology kept to a minimum and explained fully if necessary				
3	Appropriate language is used – personalised, sincere, non-defensive tone, empathetic, courteous and sensitive. Tone of letter matches nature of complaint.				
4	Acknowledgement of failures, apology and acceptance of responsibility made to complainant where appropriate				
5	Description of changes made as a result of the complaint included				
6	Offer of remedy made where appropriate (eg offer of further clinical appointment; reimbursement of car parking fees)				
7	Thank you to complainant for raising their complaint				
8	Expression of condolence included if the complainant has been bereaved				
9	Reflects Trust Values				
10	I would be happy for my loved one to receive this response				
General Comments:					

In line with DoH guidance, complaints must be investigated and the complainant issued with a written response (signed by the relevant Director, on behalf of the Chief Executive) within 20 working days where possible.

If for any reason this is not possible the complainant must be advised of the delay as soon as possible, including an explanation of the reason(s) for the delay and a time frame within which they are likely to receive a full reply.

When the Service Directorate Manager and Co-Director / Divisional Professional Lead is satisfied that the complaint has been fully addressed and has agreed the draft response, this should be promptly forwarded to the Complaints Manager together with all relevant documentation and copies of all investigative reports.

Upon receipt of the Service Area's ratified response letter, the Complaints Manager will quality check the response to ensure accuracy of details and that the letter adequately addresses all issues raised by the complainant before promptly forwarding the final draft response for signature by the relevant Director.

When the final response is signed off by the Director, the Director's secretary will promptly send the letter to the complainant and return a copy of the signed letter to the Complaints Manager for the complaint file. The complaint is then closed.

If upon receiving the response letter the complainant remains dissatisfied they can contact the Complaints Department to request that their complaint be re-opened. This must be done within 1 month from the date of the Trust's response. Consideration will then be given to revisit the issues of complaint for further local resolution. This may include advocacy, conciliation or the use of lay persons. The Complainant or the Trust can also contact the Northern Ireland Public Services Ombudsman (the Ombudsman) at this stage.

5. Closure of Complaints

When a final letter has been sent by the relevant Director, or any alternative complaint resolution process that has been agreed with the complainant has been completed, the complaint is recorded as being closed on Datix.

On those occasions where a complainant subsequently highlights issues that have not been addressed, this is known as a 're-visited' complaint. Such complaints should be investigated as soon as possible and follow the same process as for the original complaint. If the complainant raises new issues, the designated Complaints Manager will formally determine whether the complaint should be deemed as a new complaint and update Datix accordingly.

While every effort must be made to ensure that a response has covered all the issues raised by the complainant in an open, honest and fair manner, it may not be possible to resolve a complaint where the complainant's expectations of the outcome are unrealistic. In these circumstances the relevant Director should consider referring the complaint to the Ombudsman as an independent arbitrator.

Once a complaint has been closed, the Complaints Department will issue the form below for completion by the relevant Service Area to identify any staff members for whom the investigation of the complaint has identified potential concerns (eg regarding their attitude / conduct / behaviour, or in relation to the quality of treatment and care they provided). This information is critical to the Trust's Professional Assurance governance mechanisms and should be returned to the Complaints Department no later than 2 weeks after the closure of the complaint.

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Complaint Closure Form – Identification of Named Staff

Complaint Ref	C/	Division		Specialty		Date Closed		
Staff member Surname		**Staff member Forename(s)**		**Job Title**	**Specialty**	**Nature of Concern**		**Comments**
e.g. Smith		*John, Robert*		*Consultant*	*Orthopaedics*	*Quality of Treatment and Care* *Staff attitude / behaviour*		*Concern regarding failure to diagnose patient's cancer and dismissive attitude towards family member*

Please identify any staff for whom the complaint investigation may have highlighted a need for provision of professional support and / or guidance, and return the completed template to [Complaints Administrator] within 2 weeks.

6. Learning from complaints

The Trust is strongly committed to the concept of continuous learning, and to listening to the views of patients/relatives/carers and the public about the care and services we provide. We welcome all form of feedback and recognise that comments, concerns, complaints and compliments provide opportunities for organisational learning and improvement to occur.

All trends and themes that are identified through concerns, complaints and compliments are reported through the Service User Experience Feedback Group, Learning from Experience Group, Assurance Group and to the Trust Board.

For Directorate complaints with a more local focus, the Investigating Officer for the complaint will produce an action plan for the service area in order to bring about improvements and avoid repetitions of the incident(s) giving rise to the complaint.

Complaints often provide learning that will be relevant to a number of wards / departments beyond that in which the complaint originated. Examples of such Trust-wide learning are presented by Directorates for discussion at quarterly Service User Experience Feedback Group meetings and thereafter for consideration by the Learning from Experience Group (see Shared Learning Template below).

Shared Learning dissemination should be actively considered by Service Area in relation to all Northern Ireland Public Services Ombudsman investigation findings where the issues of complaint have been upheld.

Feedback should always be given to the individual involved in the circumstances giving rise to the complaint. The Co-Director will identify the most appropriate means of providing such feedback including consideration of necessary measures in response to the complaint investigation findings (such as further training, disciplinary procedures) or advising that no further action will be required.

Shared Learning 	Ref. No.	Date issued:

Safety Message:

Summary of Event

Learning Points

Learning applicable to:

Specific Directorate(s) (specify):		Trustwide	
Other (specify):		Regional	

Action Required (*for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group*)

Approved by:	Designation:	Date approved:

Appendix 2 – Grading of a Complaint

It is the responsibility of the Complaints Manager (in conjunction with the Service Area) to ensure that all complaints are graded using the risk grading process as outlined in the Adverse Incident Reporting Policy and Procedure including Adverse Incident Investigation Procedure. The grading will also be agreed with the Service Directorate Manager. This will determine the level of investigation required and whether any additional actions need to be taken, such as a Serious Adverse Incident Review by Root Cause Analysis, or liaison through the Coroner or involvement of the Trust Safeguarding Team.

All complaints graded as high or extreme risk will be highlighted on the Weekly Governance Teleconference with associated onward notification to the Executive Team and Trust Board.

Where a complaint is received and graded as high or extreme risk, consideration should also be given to ascertain if this will meet the SAI reporting criteria. This should be highlighted by the Complaints Manager to the Senior Manager – Corporate Governance and to the Co-Director and Director of the relevant Service Area, cc'd to the Co-Director for Risk and Governance, the Medical Director, and the relevant Divisional Professional Lead. In cases where the complaint is graded as high risk (red) the Co-Director / Director will agree the level of investigation to be carried out e.g. Root Cause Analysis (RCA). If the complaint is high risk but does not meet SAI criteria, consideration should be given by the Director to undertaking an independent investigation.

Where a complaint falls into the SAI criteria, the complaint investigation can continue if the complaint does not involve the serious adverse incident investigation. It is the responsibility of the appointed Chair of the Serious Adverse Incident Panel to agree a communication plan and ensure the complainant is contacted at the earliest opportunity and provided with information contained in the serious adverse incident leaflet. The final outcome of the investigation will be shared with the complainant.

Complaints can be escalated to Serious Adverse Incident (SAI) status. Where this occurs, the Chief Executive (or designated Director), must advise the complainant in writing that an SAI investigation is under way and that although the complaints process will be suspended for any SAI-related element(s) of the complaint pending completion of appropriate investigation, any aspect of the complaint not covered by the SAI process will continue to be investigated under the HSC Complaints Procedure.

The overall consideration must be to ensure that when the investigation has moved into the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

All other complaints will be investigated accordingly to the degree of the grading, with Clinical Record Reviews undertaken for complaints relating to Quality of Treatment and Care.

Where a complaint is received and the issues are already subject to another investigation (e.g. Professional Body, Ombudsman, Police Inquiry) the complaint cannot be processed until this investigation is completed. The complainant will be advised of this by the Complaints Department. If the complainant wishes they can then re-engage with the HSC Procedure should they remain dissatisfied.

APPENDIX 2 continued- BHSCT Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY and PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION and ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

BHSCT RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table				
Likelihood **Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

	Consequence Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

- Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.
- Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.
- Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.
- Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Appendix 3 – Complaint Investigation and Resolution

1. The purpose of the complaint investigation process is to establish the facts, to identify areas for improvement, and gain 'resolution' for the complainant. On occasion this process may identify areas of individual concern that will then be investigated separately.

2. The nature and grade of complaints will influence the level of investigation and notification/cascade throughout the Trust. All complaints will be thoroughly investigated in a manner appropriate to resolving the issues in an efficient and effective manner within the agreed timeframes.

3. Higher graded complaints require prompt action and a robust investigation. They may require the involvement of investigating contributors external to the Directorate or even external to the organisation. In complex cases consideration should be given to the use of Independent Persons to help resolve the complaint. Any requests for factual amendments to independent expert reports (including SAIs) must be fully reasoned, explained and recorded. Only an independent expert or SAI panel (as appropriate) can agree and sign off on amendments to their report.

4. On receipt of the complaint from the Complaints Department, the Service Manager will ensure the appropriate person(s) are promptly identified to carry out the investigation. The level of investigation must be proportionate to the grading of the complaint. Complaints made in relation to Inequalities Human Rights or Disabilities should also be forwarded to the Health and Inequalities Manager for information.

5. All investigations should be undertaken by a suitably trained person with appropriate expertise, and conducted in a manner that is supportive to all those involved. The Investigating Officer will oversee the quality and timeliness of the investigation to ensure it has been thorough and addresses all the issues raised by the complainant. The Complaints Manager's role is to continuously monitor progress and escalate any delays or difficulties to the Co-Director if necessary.

6. Where the complaint raises issues in relation to Quality of Treatment and Care, a Clinical Record Review should be conducted by the Service Area in accordance with the process outlined below.

7. The Investigating Manager will assess the complaint, and plan the scope and approach to the investigation. They should contact the complainant to introduce themselves and where appropriate, clarify any issues in the complaint. They should also provide a point of contact should the complainant wish to raise any questions during the course of the investigation.

8. A scoping meeting (organised by the Investigating Manager) should be held **within 48 hours** of receipt of each complaint to identify any immediate actions and support the investigation planning. This includes identifying the key staff who will be required to contribute to the investigation. The Investigating Manager should establish the facts relating to the complaint and assess the quality of the evidence and call upon the services of others if required.

9. Where staff are directly involved in the complaint, statements will be taken at the time of the investigation as an accurate account of events. Individuals should be interviewed by one of the following: -
    - Line manager / Senior Manager with the appropriate level of seniority
    - An independent person with appropriate level of seniority
    - A relevant Medical, Clinical, Nursing or Professional person with the appropriate level of understanding and Seniority.
    - Senior Manager Complaints and Legal Services / Complaints Manager where appropriate.
    - Governance Manager where appropriate

10. In certain circumstances it may be preferable for two persons to interview the individual. Consideration must be taken to ensure that the interviews are carried out in a fair and just manner and that the interview is independent and proportionate to the complaint.

11. The interviewing person should always review any relevant documentation that may have bearing on the complaint. This will include medical, nursing, social work or any other patient /client notes that may be relevant. The interviewer(s) will then formulate their report / response based on the information received and forward to the Investigating Manager. Where it is not possible for an interview to take place the individual named in the complaint will be asked to respond in writing and this response will be considered by their Professional line manager.

12. Issues of complaint relating to named professionals must always be peer reviewed by an appropriate person with appropriate level of skills and understanding of the speciality. Peer reviews must be clearly documented and sent to the Investigating Manager for inclusion in the overall investigation and response process.

13. Where professional issues are identified in a complaint the appropriate Executive Director will be notified and sent a copy of the complaint for information.

    - If the staff member is a Doctor or a Dentist, the Medical Director, Chair of Division and relevant Clinical Directors for the Division will be informed.
    - If the staff member is a Nurse, the Director of Nursing and User Experience and relevant Divisional Nurse will be informed.
    - Information will be provided by the Complaints Department annually regarding all medical and nursing staff named in complaints for inclusion in the appraisal process.
    - If the member of staff is a Social Worker, the Director of Children's Community Services and Adult Social and Primary Care and Divisional Social Worker will be informed.
    - If the member of staff is an Allied Health Professional the Director of Unscheduled and Acute Care and Professional AHP Lead will be informed.

14. Should an individual person be named more than twice within a period of 1 year the Complaints Team will inform the Director/Co-Director and relevant Professional Lead for the Directorate.

15. It is recognised that involvement in both the complaints and investigation processes can be distressing for staff. It is therefore important that staff named in a complaint are appropriately supported throughout, and if necessary following, the investigation process. The Trust's "Buddy" system is available to staff requiring advice and support for example in relation to complaints being investigated by the Norther Ireland Public Services Ombudsman.

16. The Investigating Manager will collate the information and formulate into a response. This response is then ratified or signed off by the Co-director /senior manager and then forwarded to complaints department. Staff must also be kept informed of the investigation and have the opportunity to review the draft response prior to the Director signing off. All investigation correspondence should be uploaded onto DATIX web.

17. It may be appropriate, depending on the complexity or the particular issues raised in the complaint, that a meeting is offered to the family to discuss the outcome of the investigation. This decision will be agreed by the Complaints Manger and Service Directorate Manager. A meeting should be offered as routine in every complaint relating to the death of a patient / service user.

18. On completion of the investigation, the Investigating Manager should prepare a draft response. The response should include and explain how the investigation was carried out and how the conclusions were reached. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement. It should then be ratified by the Co Director / nominated person before being forwarded to the Complaints Department for quality checking and then forwarded to the Director for final signature.

19. Some complaints will take longer than others to resolve because of the complexity, seriousness and the scale of the investigative work required. It is important that the Complaints Manager is informed of any delays to ensure that the Complainant is kept updated.

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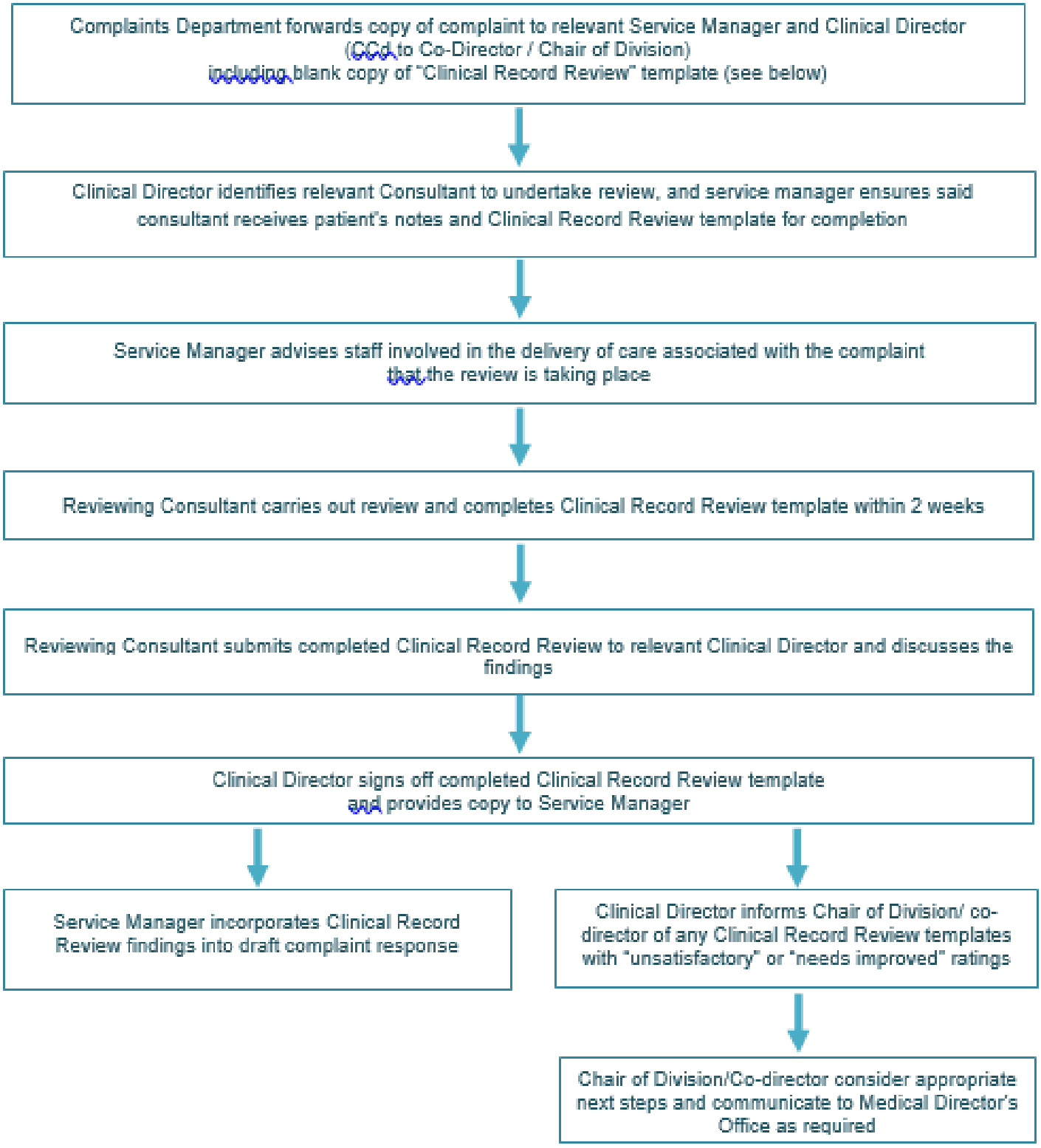
Clinical Record Review – Process

This process should be followed for all complaints relating to Quality of Treatment and Care



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Clinical Record Review

Complaint number/patient ID:

	Analysis of Care provided	Rating
(1)	Case Description – summary of clinical case	
(2)	Assessment (includes history taking, examination and diagnoses)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(3)	Investigation	Not Applicable Satisfactory Needs Improved Unsatisfactory
(4)	Treatment (decision making, case selection, procedures or operation)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(5)	Communication (patients, family, GP and consent)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(6)	Teamworking (communication within hospital including MDT/and handover)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(7)	Documentation (record keeping, appropriate follow up etc)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(8)	Overall/Assessment	

Name individual undertaking review:

Doctor GMC number: **Date:**

Name Clinical Director:

Signature: **Date:**

Definitions

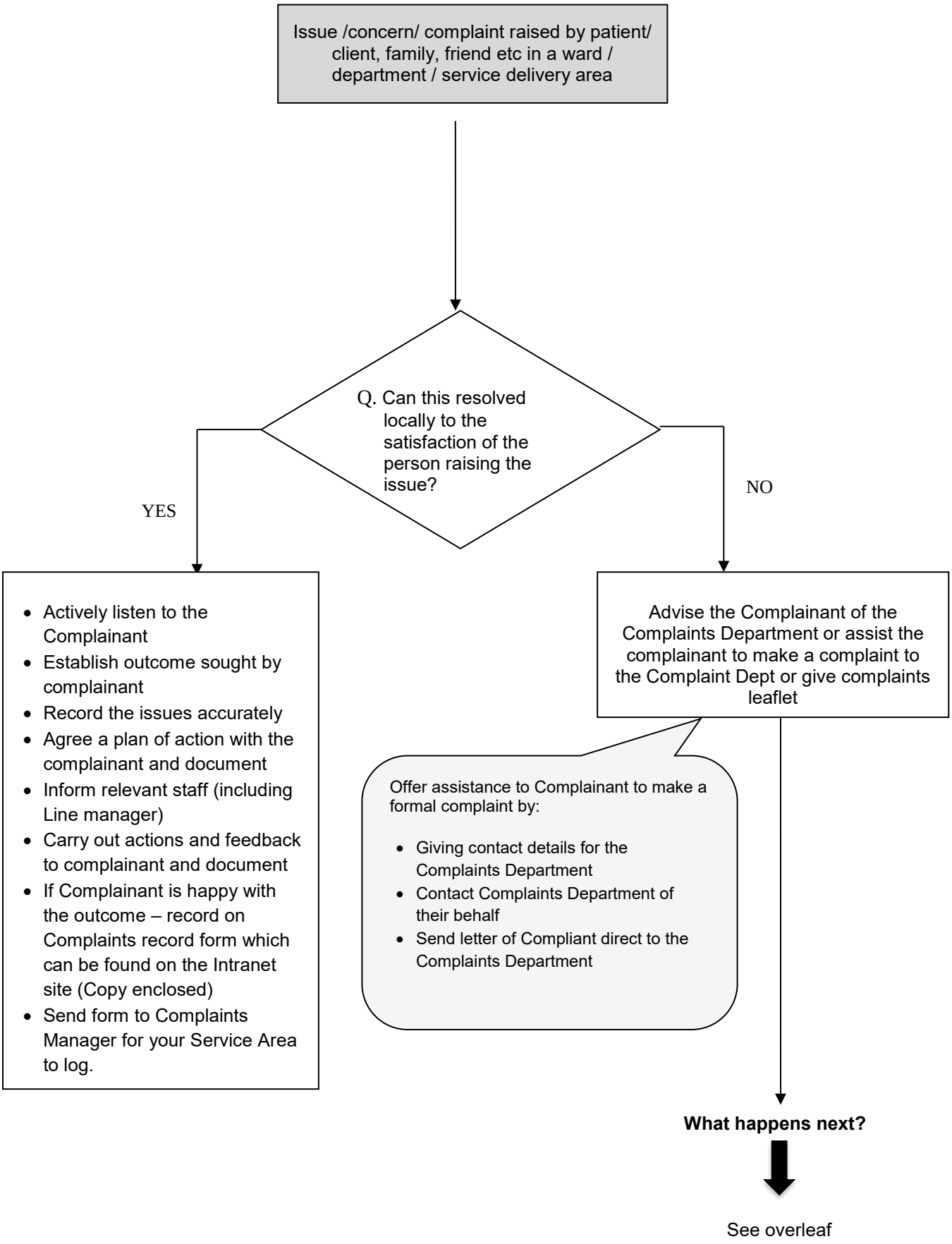
***Satisfactory care**:- Care which complies in all aspects with the standard expected taking into consideration the wider systemic issues.*

***Care which could be improved but not unsatisfactory**:- Care which did not fall significantly below the standard expected but there were areas identified which could be improved.*

***Unsatisfactory care**:- Care which falls significantly below the standard expected, having considered wider systemic issues.*

Appendix 4

Complaint Process Flowcharts



Complaint Department will:

- Log complaint onto Complaints Information System (Datix)
- Issue a letter of acknowledgement to complainant within 2 working days
- Identify all points of complaint which require investigation and response
- Issue all relevant correspondence to the relevant Service Manager (copied to Service Area Co Director/ Director and any other Director, Professional Lead or Clinical Director as relevant) for investigation and provision of draft response by Service Area.

↓

Investigating Manager will undertake appropriate investigation (including Clinical Record Review / Independent Review where relevant) and provide draft response letter – reviewed and approved by Co-Director – to relevant Complaints Manager **within 10 working days**

↓

Complaints Manager will Quality Assure (QA) the approved draft response including ensuring that all points of the complaint are adequately addressed

↓

Complaints Manager forwards QAd draft response and associated files to the relevant Director's office for signature

↓

Director reviews final draft response. If required, Director sends to Service Area (copied to Complaints Manager) for any amendments. Service Area returns amended response to Director (copied to Complaints Manager) for final approval.

↓

Director carries out final QA review and signs off.
Response issued to complainant by Trust HQ (copied to Complaints Admin).

↓

Complaint Manager will ensure signed copy of the response is issued to all relevant staff, and records all aspects of complaints process on Datix

↓

Learning from complaint to be identified by the Service Area. Co-Director ensures progression of any required actions arising from learning, including appropriate sharing of learning
(NB: In all such cases the Governance Manager will be advised)

↓

Service Area will forward completed form identifying all staff where the complaint investigation has identified potential areas of concern to the Complaints Department within **2 weeks** of the complaint being closed.

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Professional Assurance Process - Complaints

Process to be followed for any complaint received where a professional is named

Complaints Department forwards copy of complaint to relevant Service Area (cc to Relevant Professional Director and Divisional Lead where professional is named in initial complaint details)

↓

Service Area investigates complaint issues

↓

Service Area provides draft response to Complaints Team (inc details of findings from Clinical Record Review as appropriate)

↓

Complaints Team finalise draft and forward to Service Area Director for approval and issue

↓

Upon closure of complaint, Complaints Team requests confirmation from Service Area re any professionals identified regarding the issues of complaint

↓

Complaints Department shares final complaint response letter with relevant Director if professional named, and also shares with relevant named professionals themselves.

↓

Complaints Team enter named professional details into Datix

↓

Complaints Team extract report identifying named professionals on annual basis

Service Area initiates Clinical Record Review process if appropriate

↓

Service Area identifies appropriate next steps and communicates to relevant Professional Assurance Lead as required

↓

Professional Assurance Lead and Service Area progress any required actions, keeping Director / Chair of Division / Divisional Lead informed as necessary

Complaints Department forwards copy of complaint to relevant Professional Assurance Lead

↓

Professional Assurance Lead liaises with Service Area and identifies appropriate next steps

↓

Professional Assurance Lead and Service Area progress any required actions, keeping Director / Chair of Division / Divisional Lead informed as necessary

NB If the issues of complaint become the subject of an SAI investigation or litigation process, the formal complaints process **relating to those issues** will cease (NB the complaints process can continue for other issues not falling within the remit of the SAI / or litigation processes)

However the Clinical Record Review process and associated Professional Assurance mechanisms can continue even if the complaint investigation process stops.

The formal complaint process can subsequently be re-commenced upon confirmation that the SAI / Litigation process has been completed / terminated.

Appendix 5– Vulnerable Adults

Definition of vulnerable adult

For the purposes of 'Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance' the term 'vulnerable adult' is defined as: *a person aged 18 years or over who is, or may be, in need of community care services* ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation.*

Adults who 'may be eligible for community care services' are those who's independence and well being would be at risk if they did not receive appropriate health and social care support.

They include adults with physical, sensory and mental impairments and
learning disabilities, however those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail. The Trust should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

Reportable offences and allegations of abuse

Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect then the regional *Safeguarding Vulnerable Adults Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults (Dec 2003)* should be activated.

Appendix 6 – Children Order Representations And Complaints Procedure

Children Order Representations and Complaints Procedure

1. **Complaint: Does it fit the definition of a Children Order complaint as below?**

"Any representation (including any complaint) made to the Trust…about the discharge of any of its functions under part IV of the Order or in relation to the child."
(Children (NI) Order 1995, Article 45 (3))

OR

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order."
(Guidance and Regulations – Vol.4, Para 12.5 – DHSS)

If **YES** to **EITHER** of the above

If **NO** to **EITHER** of the above → Progress via Trust Complaints Procedure

2. **Does it meet the criteria of what may be complained about under Children Order?**

"..about Trust support for families and their children under Part IV of the Order."

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

If **YES** to **ANY** of the above

If **NO** to **ALL** of the above → Progress via Trust Complaints Procedure

3. **Complainant: Does he/she fit the definition of a Children Order complainant?**

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need

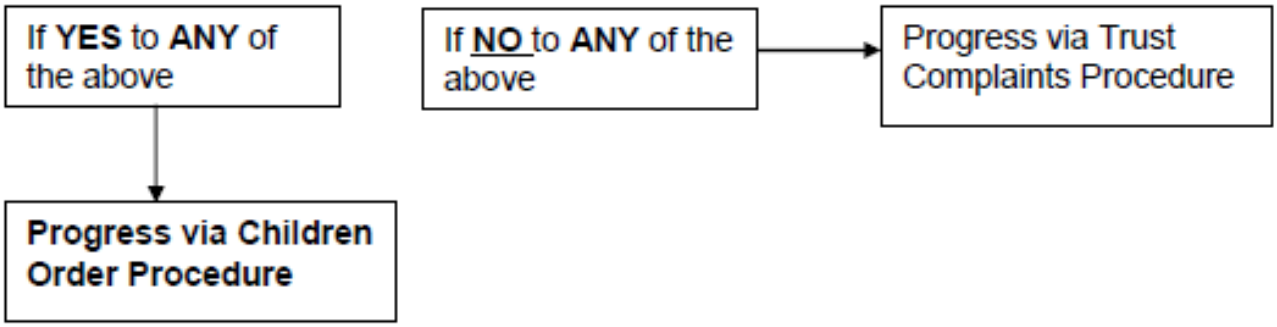
c. A parent **of his/her**

d. Any person who is not a parent of theirs but who has **parental responsibility for them**

e. Any Trust foster parent

f. Such other person as the Trust considers has sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- The person who had the day to day care of the child within the past two years;
- The child's Guardian Litem;
- The person is a relative of the child (as defined by the Children Order, Article 2 (2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- A friend;
- A teacher;
- A general practitioner
(Children (NI) Order 1995 Article 45 (3))



NB:** For a complaint **to be eligible to be considered under the Children Order Procedure, the answer** to 1 **and** 2 **and** 3 **MUST ALL BE YES.

The Trust should always check with the child (subject to their understanding) that a complaint submitted reflects their views and that they wish the person submitting the complaint to act on their behalf (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under part IV of, and paragraph 4 of Schedule 5 to, the Order and

- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and

- those personal social services to children provided under the Adoption Order (NI) 1987.

1. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.

2. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4

3. All staff should familiarise themselves with these requirements

Appendix 7 - Formal Complaints Escalation Process

Every effort should be made to ensure complaints are responded to within 20 working days. Efficient processes for the prioritisation and management of complaints must be established in all Directorates, with every effort being made by staff to promptly identify potential obstacles to provision of responses within 20 days and to take action (escalating to more senior staff as necessary) to ensure the prompt handling of complaint investigation and response writing.

It is recognised however that there may be instances when, for example the complaint is complex and/or involves several Directorates, that it becomes apparent 20 working days will not afford adequate time to fully investigate the concerns raised. It is vitally important to identify likely delays at the earliest opportunity and to immediately notify the relevant Complaints Manager to allow prompt communication with the complainant.

1. Reminders should be sent by the Complaints Department to the relevant **Service Manager/ Investigating Manager 10 working days** following receipt of the complaint.

2. If a response is not received and no information provided when the response is likely to be completed within **12 working days** from receipt of the complaint, the relevant **Co-Director** will be informed.

3. If no response or contact has been made with the complaints team by the **15th working day,** the relevant **Director** will be informed.

4. Complaints which have not been responded to within the 20 working day time frame will be escalated as follows:

   - Complaints outstanding **after 20 working days** (without reasonable explanation provided by Service Area)
     A reminder will be sent to the **Service Manager, Co-Director and Director*** highlighting that the complaint is now outside the 20 working day timeframe.

   - Complaints outstanding **after 30 working days** (without reasonable explanation provided by Service Area)
     A further notice will be sent to the **Co-Director and Director*** advising that the complaint is now well outside of the time frame and urgently requires action. The Medical Director and Co-Director Risk and Governance will be made aware of the delay.

   - Complaints outstanding **after 40 working days** (without reasonable explanation provided by Service Area)
     An escalation notice will be sent to the Chief Executive

* When a complaint covers a number of Service Areas / Directorates all appropriate Directors will be advised.

Appendix 8 - Northern Ireland Public Service Ombudsman Cases

Receiving Correspondence

1. The Chief Executive's Office will scan correspondence from the Northern Ireland Public Services Ombudsman on the day of receipt and email to complaints@belfasttrust.hscni.net with a copy sent to the relevant Complaints Manager.
2. A hard copy of correspondence will be sent to the Complaints Department via post.
3. Complaints Manager will acknowledge receipt of Ombudsman correspondence from the Chief Executive's Office via email, and initiate appropriate action on the day of receipt.
4. Complaints Admin will acknowledge receipt of correspondence to Ombudsman's Office within 1 working day and confirm the name of the designated Complaints Manager. *Correspondence with the Ombudsman's Office is to be password protected at all times.*

Consideration Stage

The Ombudsman reviews details of the case to decide whether to instigate an investigation.

1. Complaints Admin will open a File to hold all documentation in relation to the Ombudsman's correspondence.
2. Senior Complaints Manager and Complaints Manager will discuss and agree an action plan and confirm which Co-Director will take responsibility for overseeing a response.
3. Complaints Admin will forward to the Service Group for action. A copy will also be sent to the relevant Director/Co-Director.
4. Complaints Manager will remove all duplications from the Complaints File and arrange for a copy to be sent to the Ombudsman's Office within 2 working days.
5. Complaints Manager will provide copies of any relevant complaints information required to the Ombudsman throughout the process. *If original notes are requested, ensure that these are requested and tracked in line with Trust procedures.*
6. Complaints Manager will identify actions with the Co-Director and lead Service Group Manager, and confirm a timeframe for responses to be received by the Complaints Department.
7. Service Group Manager will liaise with Health Records staff, within 2 working days, to arrange for copy of medical records to be sent to Complaints Manager.
8. Service Group Manager will prepare a draft response which addresses all of the issues raised within the agreed timeframe.
9. Complaints Manager will quality assure draft response. They will then send the draft response to the relevant Co-Director for approval, before being signed off by the Director.
10. Chief Executive Office will email the signed response to the Ombudsman's Office and send the hard copy, and any other documents requested, to the Ombudsman's Office via secure transport.

11. Complaints Admin staff will keep information on DATIX up-to-date. *An Ombudsman case should not be closed on DATIX until the final decision is made by the Ombudsman.*
12. The Co-Director will ensure any areas of good practice or issues for concern are highlighted with the relevant managers.
13. All staff will adhere to the Ombudsman's timescales. If there is any reason to anticipate delays that cannot be resolved through escalation measures, approval must be sought from the relevant Director to seek an extension from the Ombudsman's office (see process overview and associated templates below).

Investigation Stage

At this second stage, the Ombudsman has made a decision to accept the complaint for Investigation by the NIPSO Investigation Officers.

BHSCT staff will follow the same steps required during the Consideration Stage above plus:

1. Complaints Managers will review all documentation previously sent to the Ombudsman.
2. Complaints Managers will collate and quality assure any additional information requested.
3. Complaints Admin will arrange a meeting with the relevant staff, including Complaints Manager, to approve draft Trust response and associated enclosures.
4. Complaints Managers will highlight any areas of concern and work with Directorates to draft an Action Plan using the agreed Trust template.

Ombudsman's Draft Report

The Ombudsman provides the Trust with a confidential copy of the draft findings, and allows a short review period for the Trust to respond.

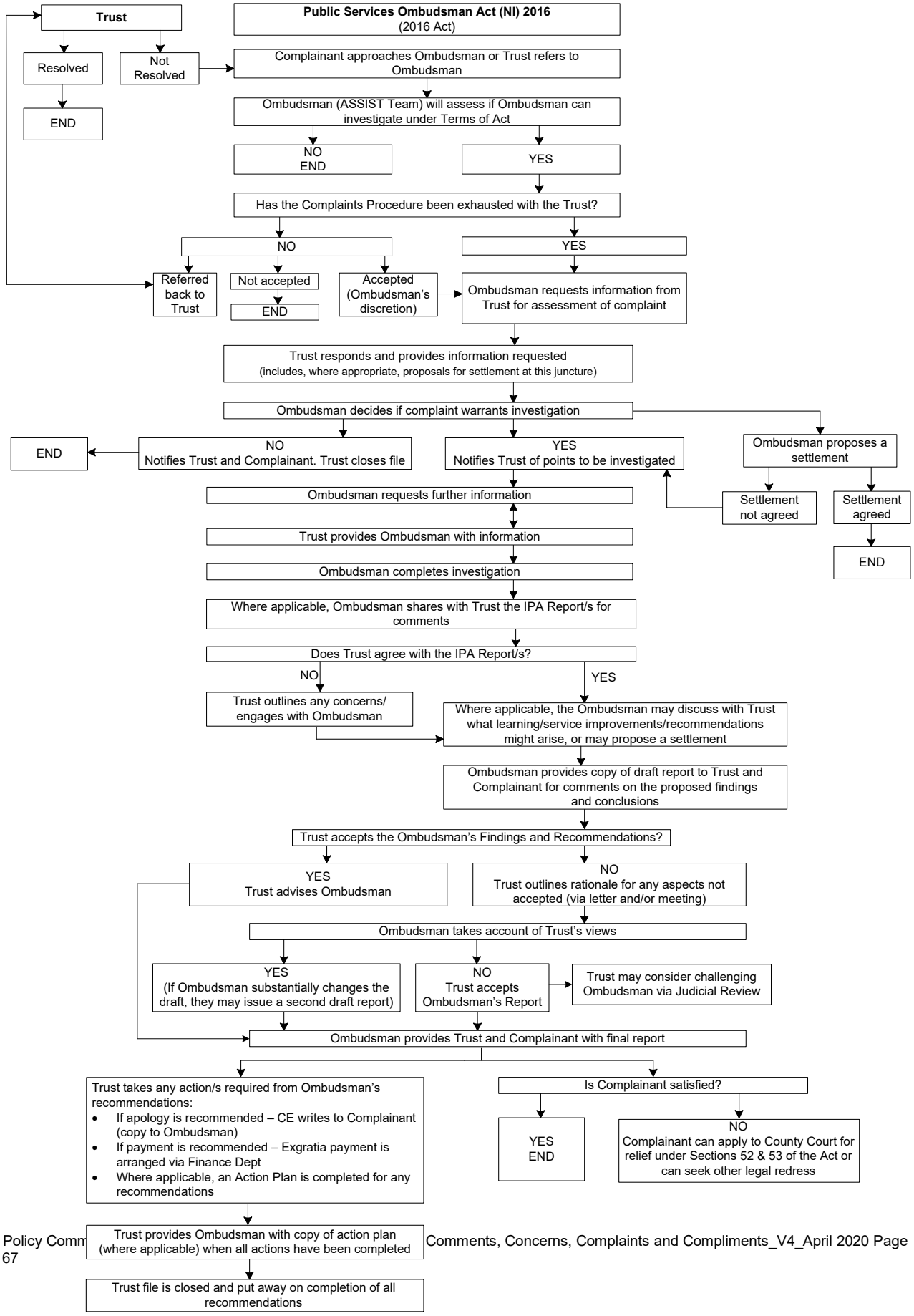
1. On receipt of the Ombudsman's Draft Report, the Complaints Manager will email a copy of the Draft report to all key stakeholders and advise of timescale for response.
2. Complaints Manager may arrange a meeting of all relevant staff to:
    a) Consider and agree the issues raised in the draft findings report
    b) Consider any factual inaccuracies
    c) If appropriate, review all documentation relating to the case
3. Complaints Manager will draft an Action Plan to address any areas of concern highlighted.
4. Service Group Manager will prepare a draft response for the Director's approval.
5. Following the Co-Director's approval of draft response, the relevant Director's Personal Assistant will forward it to the Director/Chief Executive for signature.
6. If appropriate, Complaints staff will prepare for informal meeting with Ombudsman's Office including pre meeting if deemed necessary.

Ombudsman's Final Report

1. The Complaints Manager will acknowledge the final report within 2 working days of receipt.
2. Complaints Manager will draft a letter of apology, to be approved and signed by Director/Chief Executive.
3. Chief Executive Office will issue the letter of apology to the complainant on the Ombudsman's instructions and send a copy to the Ombudsman's office.
4. Complaints Manager will ensure requests for financial redress are processed and appropriately approved and will ensure that the Action Plan is approved and sent to the Ombudsman along with any other documents, if requested.
5. Complaints Manager will record the outcome of the Ombudsman's investigation on the DATIX database investigation screen and close the complaint.
6. Complaints Manager will document Ombudsman cases in the Trust Quarterly and Annual Complaints Reports and other reports as required.
7. Senior Complaints Manager will discuss all Ombudsman cases at Complaints Manager meetings and Complaints Review Group, and will ensure recommendations and learning are shared as required.
8. Action Plans arising from Ombudsman recommendations will be presented by Directorates at Service User Experience Feedback Groupto ensure shared learning and to provide assurance regarding progression of necessary corrective / preventative actions.

Pathway for Complaints being considered by the NI Public Services Ombudsman

(Given the level of discretion available to the Ombudsman, this process may, on occasion, not be strictly followed)



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NIPSO Correspondence Protocol - Requests for information, 3 week timeframe

DAY 1	**NIPSO correspondence received via e-mail**	*1 copy to Trust HQ, 1 copy to Complaints Team*
DAY 1	**Complaints Team extract all points of requested information / documentation into template (see Appendix A below) and e-mail to relevant Service Area(s) along with copy of original NIPSO letter.**	*e-mail will be sent to relevant Co-Director(s) and CCd to relevant Director(s)*
DAY 3	**Service Area(s) return completed template to Complaints Team confirming details of staff responsible for each element of the response (including identifying lead person to co-ordinate overall response), and identifying any anticipated delays**	*Completed template to be CCd to relevant Co-Director(s) and Director(s). Agreement to be reached between relevant Directors to assign lead responsibility for complaints involving multiple Directorates*
DAY 3 - 11	**Service Area(s) gather required information and produce draft response to address all points identified by NIPSO.** **Service Area(s) liaise with Complaints Team to provide updates confirming ability to submit response by required deadline.**	**Complaints Team issue reminders / update requests to named contact points in Service Area(s) at 7 and 9 working days after receipt of NIPSO request** **Complaints Team escalate non-response to update requests, or indication of delays from Service Area***	*Non-responses will be escalated to Co-Director after 2 working days; identified delays immediately escalated to Co-Director and Director*
DAY 11	**Service Area(s) submits draft response to Complaints Team – <u>all draft responses to be ratified by relevant Co-Director prior to submission to Complaints Team.</u>**	
DAY 12	**Complaints Team QA draft response for completeness, accuracy of personal details and tone and forward to relevant Director.**	*Completed QA Checklist (Appendix C) to be sent to Director with draft response*
DAY 13 – 15	**Director reviews final draft and liaises with Complaints Team regarding any required amendments.** **Director signs off final response**	
DAY 15	**Complaints Team issue response via secure e-mail to NIPSO**	

**If extension to NIPSO deadline is required, request template (see Appendix B below) must be completed by Service Area and submitted to Director for sign off. Complaints Team will then submit to NIPSO.*

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Northern Ireland Public Services Ombudsman – Response Tracker APPENDIX A

Complaint C/xxxx/xx NIPSO Ref xxxxx RESPONSE DUE – BHSCT HQ Deadline __/__/____ – NIPSO Deadline __/__/____							
Lead Contact for final Complaint Response: Directorate _____ Named point of contact_____							
NIPSO information / documentation requested			**Organisation / Directorate / Service Area**	**Lead Contact for each query**		**Any anticipated delays / difficulties in providing the required information by [Insert BHSCT HQ Deadline]?**	**Any required escalation to ensure provision of required information by [Insert BHSCT HQ Deadline]?**
				Name	**Contact details**		
1	Populated by Complaints Team – to be reviewed by Service Area						
2							
3							
4							
Any additional issues identified by Service Area requiring provision of information as part of NIPSO response:							
5							
6							

Please complete this template and return via e-mail to the relevant Complaints Manager within **2 working days of receipt**

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Northern Ireland Public Services Ombudsman – Extension Request Template APPENDIX B

Complaint C/xxxx/xx NIPSO Ref xxxxx **DATE REQUESTED BY NIPSO : ____/____/_____ DATE RESPONSE DUE – NIPSO Deadline ____/____/_____**					
	Outstanding information / documentation*	**Reason(s) for delay**	**Details of escalation / measures taken to address delays**	**Current Status / Comments**	**Expected date response available**
1					
2					
3					
4					
5					
Completed by: (Signature) _____ (Printed Name) _____ Role: _____ Date:_____					
I confirm that the information / documentation detailed above is unable to be provided to the Ombudsman within the required timeframe and as such request an extension to the indicated deadline. Signed (Director):_____ Name :_____ Date:_____					
Received Complaints Department: Date _____ Complaints Manager: _____ Date submitted to NIPSO: _____					

**NB Extension requests should only be made in exceptional circumstances where the requested information remains unavailable despite every reasonable effort having been made by the Service Area to provide a response. Full reasons for delays must be detailed, and the extension request signed off by the relevant Director. Extension requests should be made as promptly as possible once an unavoidable delay has been identified. Where multiple pieces of information / documents have been requested by the Ombudsman, a partial response incorporating all available elements should be submitted by the required deadline, with the extension request only applying to outstanding areas.*

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Northern Ireland Public Services Ombudsman – Response QA Checklist Template APPENDIX C

Complaint C/xxxx/xx NIPSO Ref xxxxx NIPSO Request Date __/__/____ **Response Due: BHSCT HQ Deadline __/__/____ NIPSO Deadline __/__/____**					
	Response element	*Y*	*N*	*N/A*	*Comments / Action Taken*
1	Is font Arial, size 12 used and are all paragraphs fully justified?	☐	☐	☐	
2	Are reference number, date, address, salutation line and complainant details accurate throughout?	☐	☐	☐	
3	Does the response fully address all the points raised by the Ombudsman's Office?				
	i	☐	☐	☐	
	ii	☐	☐	☐	
	iii	☐	☐	☐	
	iv	☐	☐	☐	
	v	☐	☐	☐	
	vi	☐	☐	☐	
	vii	☐	☐	☐	
	viii	☐	☐	☐	
4	Are there any spelling mistakes	☐	☐	☐	
5	Are there any disparities / conflicting statements	☐	☐	☐	
6	Is the tone of the response appropriate and are apologies included where appropriate?	☐	☐	☐	
8	Does the response include information detailing corrective action taken, or where learning and improvement have been identified if relevant?	☐	☐	☐	
9	Is plain English used, and medical terminology and jargon kept to a minimum and explained fully if necessary?	☐	☐	☐	
10	If policies, procedures or good practice guides are being specifically relied upon, are they clearly identified and enclosed where required?	☐	☐	☐	

Complaints Department

Completed by: _____ *Role:* _____ *Date:*_____

Trust HQ

Comments: (about any required amendments or other concerns)

Signed…… (Director) Date……

Appendix 9 - Record Keeping

1. Complaint records and correspondence about complaints will be kept separately from clinical records, subject to the need to record information which is strictly relevant to patient's health in clinical records.

2. A record of a complaint should include:

   - the name of the complainant,
   - DOB
   - address
   - contact details
   - where appropriate Health and Care number, Dept/ Ward/ Facility and GP details
   - clear details of all issues identified in the complaint
     - who or what is being complained about, including the names of staff if known
     - where and when the events of the complaint happened
     - where possible, what remedy is being sought- e.g. an apology or an explanation or changes to services
   - confirmation of advice given on consent when appropriate

3. When the Frontline Resolution Form (see page 17) is completed this should be forwarded to the Complaints Department immediately for acknowledgement and action.

4. A complaint file has the same status as any other record created by a healthcare organisation and is therefore a confidential record.

5. The Trust will ensure that the management and storage of complaint files is consistent with relevant guidance including GDPR, Data Protection, and Good Management Good Records

6. All correspondence regarding the complaint will be marked 'confidential'.

7. The minimum recommended period for retaining a complaint file is *ten years* from the date on which action was completed. For complaint about children and young people the file must be kept until the patient's 25th birthday.

8. Files must be disposed of under confidential conditions (Records Management)

9. Confidential information sent outside the Trust must have the appropriate level of security applied (e.g. encryption, password protection etc).

Appendix 10 – Consent, confidentiality, and third party confidence

Staff should be aware of their legal and ethical duty to protect the confidentiality of service users' information as set out in General Data Protection Regulations, Data Protection Act and the Human Rights Act.

Where a service user is the complainant, it is good practice to explain that information from health and social care records may need to be disclosed to those involved in investigation of the complaint. If the service user objects to this, it should be explained that this could compromise the investigation and potentially result in an unsatisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is a significant public interest in continuing with the matter.

Where the complainant is not the patient it is necessary to obtain the patient's written consent to use personal information prior to investigating a complaint. Third party complaints may be made by a service user's relative, friend, carer, or other representatives (such as their solicitor) provided the service user has given his/her written consent. In such circumstances the Complaints Team will forward a consent form to the relevant person(s) requesting authorisation. The Complaints Manager, in discussion with the Service Director, Data Protection Officer, or other senior person, will determine whether the complainant has sufficient interest to act as a representative.

The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative the Trust will provide information in writing to the person outlining the reasons the decision has been taken. Where Consent has not been received, the complaints response will not be released. A second request letter to the complainant will be sent advising that consent is required. If consent has not been received, a third and final letter will be sent advising that the complaint will be closed within a stated timeframe.

There may, however, be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (e.g. rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the individual is deceased.

Third Party Confidence

The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social service professional. Only that information which is relevant to the complaint should be considered for disclosure, and then only to those within the HSC who have a demonstrable need to know in connection with the complaint investigation.

Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure. Disclosure of information provided by a third party outside the HWSC also requires the express consent of the third party. If the third party objects, then it can only be disclosed where there is an overriding public interest to do so.

Information on consent can be found in the Department of Health Good Practice in Consent guidance. Staff are also directed to the DoH Code of Practice on Protecting the Confidentiality of Service Users.

Use of Anonymised Information

Where anonymised information about a patient/client and/or third parties would suffice, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use information, then it can only be used where there is an overriding public interest in doing so.

Appendix 11 – Internal/ External Support/ Contacts

ADVOCACY AND CONCILIATION

Some people who might wish to complain do not do so because they do not know how to, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their wishes and views known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

Within the Health and Social Care sector, advocacy has been available mainly for vulnerable groups, such as people with learning problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and can be intimidated by professional attitudes that may seem paternalistic and authoritarian.

The Trust should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to gain a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations such as:

- where staff or practitioners feel the relationship with the complainant is difficult
- when trust has broken down between the Trust and both parties feel it would assist in the resolution of the complaint
- where it is important, e.g. because of on-going care issues, to maintain the relationship between the complainant and the Trust
- when there are misunderstandings with the relatives during the treatment of the patient

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

Complaints raised by unreasonable, vexatious or abusive complainants are NOT suitable for conciliation.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, e.g. if there is a breakdown in the relationship between a doctor or practitioner and their patient.

Conciliation may be requested by the complainant or the Trust.

COMPLAINTS DEPARTMENT

The BHSCT Complaints Department is located at:

Musgrave Park Hospital
McKinney House
Stockman's Lane
Belfast
BT9 7JB

Tel: 028(95) 048000

LAY PERSONS

A Lay Persons is an independent person that does not act as an advocate, conciliator or investigator. Neither do they act on behalf of the complainant or complained about. Their involvement is to help bring about resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

NORTHERN IRELAND PUBLIC SERVICES OMBUDSMAN

The Northern Ireland Public Services Ombudsman (the Ombudsman) can carry out independent investigations into complaints about poor treatment or services or the administrative actions of the Trust. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly- and the Trust or practitioner has not put things right where they could have- the Ombudsman may be able to help.

The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman

Freepost NIPSO
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Tel: 028 90 233821
Freephone: 0800 34 34 24
Text phone: 028 90 897789

email: nipso@nipso.org.uk

PATIENT AND CLIENT COUNCIL

The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public
- promoting involvement of the public
- providing assistance to individuals making or intending to make a complaint
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services

If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the Complaints Procedure and advice on how to take a complaint forward
- discussing the complaint and drafting letters
- making telephone calls
- helping prepare for a meeting and accompanying the complainant
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services;
- help on accessing medical / social services records.

All advice, information and assistance with complaints are provided free of charge and are confidential. Further information can be obtained from; **www.patientclientcouncil@hscni.net** or Freephone 0800 917 0222

REGULATION AND QUALITY IMPROVEMENT AUTHORITY - (RQIA)

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. The Regulation and Quality Improvement Authority will monitor how complaints about the regulated services are handled.

Contact Details:

The Regulation and Quality Improvement Authority Headquarters
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Email: info@rqia.org.uk

Telephone number: 028 9051 7500
Fax: 028 9051 7501

Appendix 12 – Unreasonable, vexatious or abusive complaints

All Trust staff should respond to complainants in an appropriate and professional manner. However, there may be times when nothing can reasonably be done to assist a complainant and where further contact with a complainant places inappropriate demands on resources.

In such cases and in consultation with Senior Manager/ Co-Director will establish if the "Unacceptable Actions Policy". Or Guidance for the handling of Habitual or Vexatious complains should be considered.

1. Introduction

The difficulties in handling unreasonable, vexatious or abusive complainants place an unreasonable strain on time and resources and can cause undue stress for staff that may need support in these difficult situations. Staff should respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can be reasonably done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling such complainants, the Trust is presented with two key considerations:

a) To ensure that the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint is overlooked or inadequately addressed, and to appreciate that even habitual or vexatious complaints may have aspects to their complaints which contain some genuine substance. The need to ensure an equitable approach is crucial.

b) To be able to identify the stage at which the complainant has become habitual or vexatious.

2. Purpose of the Guidance

The aim of the guidance is to identify situations where a complainant might be properly considered to be habitual or vexatious and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints following the Trust's complaints procedure, i.e., through local resolution.
Judgement and discretion must be used in applying the criteria to identify potential or vexatious complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration of the actions and behaviour of a complainant by a Director of the Trust, in conjunction with the relevant Patient/Client Liaison Manager.

3. Definition of an unreasonable, vexatious or abusive complainants

Complainants (and/or anyone acting on their behalf) may be deemed to be unreasonable, vexatious or abusive where previous or current contact with them shows that they meet any one of the following criteria:

Where complainants:

a) persist in pursuing a complaint after the Complaints Procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as 'Out of time')

b) change the substance of a complaint or continually raise additional issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response (Not all complainants who raise further concerns or questions on receipt of a response are vexatious. They may be doing so to seek clarification as part of the local resolution process. Care must be taken not to discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints)

c) are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, medical or computer records, or deny receipt of an adequate response in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

d) do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate

e) focus on a relatively minor matter to an extent, which is out of all proportion to its significance and continue to focus on this point (It is recognised that determining what a '*relatively minor*' matter can be is subjective, therefore careful judgement must be used in applying this criteria)

4. Dealing with unreasonable, vexatious or abusive complainants

A Director of the Trust and/or nominated deputies may decide to deal with complainants in one or more of the following ways:

a) Once it is clear a complainant meets any one of the criteria above, they should be informed in writing that they may be classified as habitual or vexatious complainants. This procedure should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust.

b) Decline any contact with the complainants either in person, by telephone, by fax, by email, by letter or any other combination of these, or restrict contact to liaison through a third party (If staff are to withdraw from a telephone conversation with a complainant, it may be helpful to have an agreed statement to be used at such times).

c) Notify the complainants in writing that a Director of the Trust has responded fully to the points raised, and have tried to resolve the complaint, that there is nothing more to

add and continuing contact will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

d) Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors or to the Police if violence or threats are made against staff.

e) Temporarily suspend all contact with the complainants regarding their complaint whilst seeking legal advice and advise the complainant accordingly. It may still be necessary however to continue providing a healthcare service.

5. Withdrawing 'unreasonable, vexatious or abusive' Status

Once a complainant has been identified as 'habitual or vexatious' there needs to be a mechanism in place for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should use discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, a discussion between key staff and the Chief Executive and/or nominated deputies will take place. Subject to his/her approval, normal contact with the complainants and application of the Trust's complaints procedure will then be resumed.

Even correspondence from complainants who have been classified as habitual or vexatious should be screened to ensure that no new complaint has been raised and to determine if the Trust's discretion should be applied.

Appendix 13 –Unacceptable Actions Policy

1. Introduction

HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complainants, staff need to:

- Ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- Appreciate that even habitual complainants may have grievances which contain some substance;
- Ensure a fair approach;
- Be able to identify the stage at which a complainant has become habitual.

The following Unacceptable Actions Policy should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

This policy sets out the approach to those complainants whose actions or behaviour HSC organisations consider unacceptable. The aims of the policy are to:

- Make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met;
- Deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights.
- Provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;
- Ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

2. Defining Unacceptable Actions

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint.

The actions of complainants who are angry, demanding or persistent may however result in unreasonable demands on the HSC organisation or unacceptable behaviour towards HSC staff. It is such actions that HSC organisations consider unacceptable and aim to manage under this policy.

These unacceptable actions are grouped under the following headings:

a) Aggressive or abusive behaviour

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

b) Unreasonable demands

Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

HSC organisations consider these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

c) Unreasonable persistence

It is recognised that some complainants will not or cannot accept that the HSC organisation is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the HSC organisation can or cannot do and continuing to pursue a complaint without presenting any new information.

The way in which these complainants approach the HSC organisation may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not. HSC organisations consider the actions of persistent complainants to be unacceptable when they take up what the HSC organisation regards as being a disproportionate amount of time and resources.

3. Managing Unacceptable Actions

There are relatively few complainants whose actions a HSC organisation consider unacceptable. How the organisation manages these depends on their nature and extent. If it adversely affects the organisation's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The HSC organisation will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The organisation may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The organisation will try to maintain at least one form of contact. In extreme situations, the organisation will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

HSC organisations do not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The HSC organisation will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The HSC organisation may require future contact to be through a third party.

HSC staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the HSC organisation may decide to:

- Only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- Require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- Return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- Take other action that the HSC organisation considers appropriate. The HSC organisation will, however, tell the complainant what action it is taking and why.

Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation's decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read

and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

4. Deciding to restrict contact

HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy.

With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff.

Wherever possible, the HSC organisation will give the complainant the opportunity to modify their behaviour or action before a decision is taken.

Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

5. Appealing a decision to restrict contact

A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

6. Recording and reviewing a decision to restrict contact

The HSC organisation will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

LD Inpatient OU Induction

Presentation	Presenter	Time
Introduction **Hopes and expectations**	Billie Hughes	09.30-09.45
HSC Values	Helen Crawford	09.45- 10.00
Expectations of placement **Role of Student Nurse**	Helen Crawford	10.00-10.30
Tea Break		10.30-10.45
Positive Behaviour Support overview	Collette Caldwell	10.45-11.45
Safeguarding and Raising Concerns	Safeguarding Team	11.45-1215
Questions and Answers	Kelly Anderson Helen Crawford	12.25-12.30

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 71/11

Title:	**Core Statutory and Mandatory Training Policy**		
Policy Author(s)	Yvonne Connolly, Senior People and Organisational Development Manager [redacted] Elaine Kehelly, Senior People and Organisational Development Manager [redacted] Bernie Owens, Director of Neurosciences, Radiology, MAH [redacted] Charlene Stoops: Director, Performance Planning and Informatics [redacted]		
Responsible Director:	Jacqui Kennedy, Director of Human Resources and Organisational Development		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☐	Non Clinical Trust Wide ☒
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			
Date:			

Approval process:	Trust Policy Committee Executive Team Meeting	**Approval date:**	08/10/2020 13/10/2020
Operational Date:	October 2020	**Review Date:**	October 2025
Version No.	3	**Supercedes**	V2 – April 2015 – April 2018
Key Words:	The Belfast Health and Social Care Trust (BHSCT) recognises that statutory and mandatory training is of vital importance in the provision of high quality services to our patients and clients and is essential for effective risk management and the maintenance of required standards.		
Links to other policies			

Date	Version	Policy Author	Comments
10/12/2010	0.1	E Kehelly	Initial draft
03/02/2011	0.2	E Kehelly	Minor changes
11/04/2011	0.3	E Kehelly	Update further to consultation
06/06/2011	0.4	E Kehelly	Final amendment
21/10/2011	0.5	E Kehelly	Minor updates further to Policy Committee
01/12/2012	0.6	E Kehelly	Review of Policy for consultation
22/05/2014	1.1	E Kehelly	Review of Policy for consultation
06/01/2015	1.2	E Kehelly	Final minor amendments to policy following audit
22/05/2015	2	E Kehelly	Sent for Hub
22/05/2019	3.1	Y Connolly	Revision and update of Policy
13/11/2019	3.2	Y Connolly	Update further to consultation

19/02/2020	3.3	Y Connolly	Update further to changes requested by Exec Team
14/07/2020	3.4	Y Connolly	Update further due to Welcome Event being stood down
06/08/2020	3.5	E Kehelly	Update further to Equality Manager and Trust Committee Feedback

1.0 INTRODUCTION / SUMMARY OF POLICY

This policy addresses only Core Statutory and Mandatory training requirements, that is, Statutory and Mandatory training which all Trust staff are required to attend/complete regardless of role and/or profession. **The policy does not cover individual/role specific training which is applicable across broad groups of staff and/or training regarded as being a requirement of individual professions for their members to maintain core occupational competences.**

1.1 Background

Belfast Health and Social Care Trust (BHSCT) is committed to providing safe and high quality care to all patients, clients and service users.

Statutory and mandatory training is of vital importance in the provision of high quality services and is essential for effective risk management and maintenance of required standards.

We recognise our duty to deliver appropriate training and ensure employees have reasonable access to complete such training. This policy identifies the minimum core mandatory training requirements across all Trust staff and clarifies the monitoring and reporting arrangements in place for this training.

For the purposes of this policy, core statutory and mandatory training will be referred to under the collective title of mandatory training.

1.2 Purpose

This policy identifies core statutory and mandatory training for all Trust staff and arrangements in place to meet our obligations as an employer.

The purpose of this policy is to ensure all staff complete their core statutory and mandatory training within the required timescale and frequencies in order to contribute to the delivery of high quality services and care. This will support the Trust in ensuring compliance with the law as well as promoting quality standards and minimising risk to staff, service users, visitors and the public.

This policy will outline governance and assurance mechanisms for the management, provision and recording of core statutory and mandatory training. This will be by ensuring there is a process whereby all such training is consistently delivered, attendance recorded, compliance monitored and action taken where non-attendance occurs.

1.3 Objectives

- To reduce risks to our service users, staff, visitors and the public;
- To comply with the law;
- To support staff in carrying out their duties safely and efficiently;

- To provide a systematic approach to the provision, recording and monitoring of core statutory and mandatory training for all staff;
- To ensure robust governance arrangements and assurance mechanisms are in place and maintained regarding the provision, attendance/completion and recording of core statutory and mandatory training;
- To outline responsibilities for managers and all staff members to comply with the requirements of this policy;

2.0 SCOPE OF THE POLICY

This policy applies to all staff (including bank staff) and volunteers at the Belfast Trust regardless of role, contract type, staff group or professional status.

Temporary staff, employed through agencies and/or by contractors, are required to have had their core mandatory training needs met by their employer before starting work in the Trust.

The policy applies to all Core Statutory and Mandatory training set out in the Core Mandatory Training Matrix (Appendix 1). All staff are required to attend/complete, within the specified timeframes, all training identified within this matrix. Please note the training identified is applicable to all staff, some groups of staff will be also be required to attend additional training known as Role Specific/Individual.

Individual / Role Specific Mandatory Training, which is applicable across broad groups of staff, and training regarded as being a requirement of individual professions for their members to maintain core occupational competences, is not covered by this policy or included in the Core Mandatory Training Matrix. Clarification on such training requirements will be provided to staff members by their line managers and/or professional heads.

Reference should be made to other Trust policies which set out additional mandatory training requirements for broad groups of staff and/or individual professions.

3.0 ROLES AND RESPONSIBILITIES

Directors: It is the responsibility of Directors to:

- Provide assurance of compliance with this Policy.
- Implement the policy on Core Mandatory Training within their Directorate, ensuring Managers are aware of their responsibilities for staff to attend/complete the relevant training.
- Ensure that, where necessary, insurmountable issues with compliance are identified and appropriately recorded and assessed with monitoring of progress on the appropriate risk register.
- Directors who carry responsibility for provision of core statutory and mandatory training should ensure arrangements are in place to meet objectives of this policy.

Managers: It is the responsibility of Managers to:

- Ensure all new to Trust staff complete the Welcome Event Programme on their first working day or if this is not possible within their first week of employment *(the majority of staff including Medical staff are required to complete this programme*. *Separate arrangements are in place for Trainee Doctors).*

- Communicate to their staff the core mandatory training required and facilitate their attendance/completion.

- Inform training providers if a staff member cannot attend a booked training session to reducing Do Not Attend rates and minimise waste.

- Cascade information relating to attendance/completion of training to Line Managers, agreeing an action plan were the Department/area is not achieving the targeted uptake of relevant mandatory training.

- Implement and monitor this policy ensuring that all employees within their areas of responsibility have addressed issues of non-compliance for training attendance /completion.

- Contact Trust Mandatory training providers, if required, to request the provision of targeted training sessions in their Directorate.

- Ensure that all staff within their remit have a current Personal Development Plan (PDP). During the process to agree this, a review of the training completed during the previous year will be undertaken and the mandatory training requirements for the forthcoming year will be identified and included in the employee's personal development plan. The line manager and the employee must agree an appropriate timetable and to ensure attendance at mandatory training events.

- Encourage staff planning to go on an extended period of leave to update their training requirements before the leave commences.

- To ensure that any training that requires an update is completed promptly on their return.

- Follow up and investigate non-attendance/completion of training and rearrange for training as soon as possible.

- Notify Co-Directors should significant issues arise in securing compliance with this policy.

- Pay due care and attention to the training records of their staff.

Employees: It is the responsibility of Employees to:

- Be aware of their personal core mandatory training requirements and required refresher frequencies as outlined in the core mandatory training matrix and in their own personal development plans.

- Complete the Welcome Event Programme on their first working day or if this is not possible within their first week of employment.

- Use the Employee Self Service function on HRPTS to check their own training records and to raise with their Manager if there are inaccuracies or to flag up if training needs to be arranged.

- Exercise personal accountability to ensure that core mandatory training requirements are kept up to date and report to their line manager any difficulties preventing them from undertaking the required training.

- Attend / complete core mandatory training as agreed with their line manager. Ensure that when attending/completing training the attendance/completion register is signed to ensure their training record is updated. Failure to do this will result in the individual appearing to be non-compliant with this policy.

- Complete and return as necessary, training evaluation forms and report to their manager any areas of concern they may have following the training.

- Exercise personal accountability to ensure they inform the training provider of any reasonable adjustment and or accessible alternative formats they may require

In-House Core Mandatory Training Providers: It is the responsibility of in- house training providers to:

- Plan for and provide sufficient training to meet the identified staff need in line with specified timeframes and to identify to the Senior Responsible Officer (SRO) for the training any issues that may prevent this.

- Arrange for the provision of training, in an appropriate format and mode, being flexible in approach if necessary, to meet organisational need and also accommodating any reasonable adjustments/alternative format* requests. This includes, if required, being available to deliver their core mandatory training as part of the Trust's Welcome Event Programme.

    * *Accessible/ Alternative formats should be made available upon requests eg. larger font print. For advice on making information accessible and inclusive for staff with a disability, click Making Communication Accessible guidance.*

- Monitor DNA rates on training programmes and take appropriate actions as necessary in order to reduce waste and maximise availability of training places.

- Clearly communicate details for the provision of training (other than training provided as part of the Corporate Induction programme) to managers and staff in a timely way.
- Regularly review training to ensure its currency and relevance with both content and modern workplace learning technologies.
- Ensure any electronic systems for training or associated processes are capable of identifying the individual member of staff who has completed the training.
- Ensure that all training has specific learning objectives stated as well as an appropriate programme of content.
- Carry out administration and maintain an accurate attendance / completion record on the HRPTS for all training delivered.
- Provide reports of attendance/completion to service managers on request.
- Provide information and reports as requested by the Statutory and Mandatory Training Policy Working Group.
- Provide to the Statutory and Mandatory Training Policy Working Group, any proposals for revisions to the core training matrix using the agreed process.
- Ensure cancellations of training only happen in extreme circumstances, participants notified and arrangements made to reschedule as early as possible.
- Carry out and record appropriate evaluation of training.

HR, People and Organisational Development Team: It is the responsibility of the HR, People and Organisational Development Team to:-

- Manage and oversee the Trust Welcome Event Programme.
- Ensure an invite to complete the Trust Welcome Event Programme is issued to all new to Trust staff within the agreed timeframe.
- Record attendance and update staff training records on HRPTS for all Core Mandatory Training completed as part of the Trust's Welcome Event Programme.
- Advise managers of non-completion in respect of new to Trust staff and completion of the Trust's Welcome Event Programme.
- Produce and send monthly Core Mandatory Training matrix dashboard reports to Directors, Divisional Leads etc. for their information and action.
- Regularly review and make updates/changes to the Trust's Welcome Event Programme.
- Obtain feedback and evaluate the Trust's Welcome Event Programme.

- Should a member of the HR, People and Organisational Development team become aware that there is a requirement for a reasonable adjustment and/or alternative accessible format this should be communicated to the In-House Core Mandatory Training Provider

4.0 CONSULTATION

This policy has been subject to consultation with Directors, Co-Directors, Senior Managers, Members of Statutory and Mandatory Training Policy Working Group and Statutory and Mandatory Training Providers. Trade Unions have been consulted through the Learning and Development Sub Committee.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Policy Principles

Mandatory training is compulsory for all staff regardless of staff group or professional status. However the mandatory training requirements differ depending on staff group, profession and individual role. **This policy pertains to and sets out only the core mandatory training common to all staff in the Belfast Trust.** Please note Core Mandatory Training is suitable for all staff. Some groups of staff will also require additional training in some of these subject areas. For example many staff will require additional training in Manual Handling, Safeguarding Children and Safeguarding Adults to ensure they have the necessary knowledge and competence for their job role.

There are currently four imperatives that govern whether or not training is considered as core mandatory training and therefore falls under this policy:

1. The training is applicable to all Trust staff regardless of their role and/or profession;

and;

2. Is a statutory obligation: where the law defines that training must be undertaken;

or

3. A Health and Social Care mandate: where a formal, official directive has been handed down within the Health and Social Care sector;

or

4. A corporate mandate – where the Trust has identified training as being essential to organisational priorities;

Training which is regarded to be a requirement by service managers and or by individual professions so their members maintain core occupational competences, is <u>not</u> covered in this policy or identified within the corresponding core mandatory training matrix. Service managers, along with professions will determine and record separately what training is mandatory to cover specific role skills.

In making a distinction between core mandatory training and Continuing Professional Development (CPD), it is acknowledged that some staff are required to undertake specific training and updates in order to fulfil professional registration requirements. It is the responsibility of the individual, with their line manager, to identify and agree

any CPD required through their personal development plan. It is emphasised that these requirements must be undertaken in addition to the Trust's core mandatory training programme.

All staff are expected to comply with the training set out within the core mandatory training matrix within the stated time frame. Completion of such training will take priority over non-mandatory training.

All Trust staff must ensure they undertake core mandatory training at the required frequencies to ensure they remain compliant (eg. Manual Handling Theory every two years).

New to Trust staff (with the exception of Doctors in Training for whom separate arrangements are in place) should have completed Core Mandatory training on their first working day or within their first week of employment if this is not possible. Core mandatory training is currently provided for new to Trust staff (with the exception of Doctors in Training for whom separate arrangements are in place) via the Trust's Welcome Event Programme. Prior to commencing employment with the Trust, new to Trust staff are invited to complete this programme. In circumstances where staff are unable to complete this training prior to or on their first day of employment, they should do so within their first week of employment. The manager, at all times, must ensure that any delay in completion of core mandatory training does not create a risk for the employee or service user.

Where there is agreement from managers and training is undertaken or completed before an individual commences employment or outside of normal working hours, the individual can be paid for these hours or avail of time off in lieu (TOIL) to be taken at a mutually convenient time.

In line with the Assistance to Study policy, mandatory training will be fully funded for any associated course fees with paid time off to attend. Please refer to the Assistance to Study policy for detail regarding completion of training outside of normal working hours. Separate payment arrangements are set out for bank staff within the Bank Staff policy.

Core mandatory training requirements specific to the Trust for Agency staff must be met by their employer as well as the Trust, as appropriate. Such staff must be able to demonstrate evidence of competency in such requirements. Reference should be made to the specific conditions of the contract for agency staff. For health and safety training, the cost of any training which the Trust is required to provide will be met by the employer of the agency staff.

It will be a requirement that Agencies providing staff to the Trust will have ensured that all staff have up to date training to undertake the duties of their post. This is reflected in the contract arrangements with Agencies. Where staff are recruited from off-contract Agencies, it is the responsibility of the approaching Trust Officer to ensure such training is in place and to follow the appropriate Trust checklist.

Individuals undertaking a placement in the Trust must have their core mandatory training needs considered by their placement supervisor in the Trust and arrangements made for training attendance/completion if deemed necessary. A

record of the training should be kept by the Placement Supervisor. Reference should be made to the Trust's Placement Policy.

Attendance / completion of core mandatory training will be monitored by the Training Provider on a regular basis and reported to various Trust committees which have responsibility for such matters. Such committees will determine what action may be required to address non-compliance and communicate this to managers. Core Mandatory training provided to new to Trust staff as part of the Trust's Welcome Event Programme will be recorded and reported to Directors by the HR, People and Organisational Development Team.All managers and staff are expected to comply with core mandatory training requirements. It is acknowledged however that service priorities, sickness and leave may occasionally impact on the achievement of compliance from time to time. However it is expected that the highest levels of compliance are achieved. Directorates will be required to report on this as part of performance management and accountability arrangements.

Non-compliance with the required core mandatory training may result in an investigation from which possible disciplinary action may be taken in accordance with the Trust's Disciplinary policy.

Core mandatory training is currently delivered for new to Trust staff (with the exception of Doctors in Training for whom separate arrangements are in place) via the Trust's Welcome Event Programme. The Trust will explore and develop methods of learning to assist with flexibility of access, as appropriate, to the subject matter.

The Trust strives to ensure that our welcome programme is accessible and inclusive and will provide reasonable adjustment upon request.

Core Mandatory Training **must** be advertised, administered and recorded using HRPTS. Training Providers who wish to seek an exemption from this must secure the agreement of the Statutory and Mandatory Training Policy Working Group. Local training databases may also be held, if required, but these should supplement rather than be an alternative to the recording of SM training on HRPTS.

All proposed new areas of core mandatory training will be considered by the Statutory and Mandatory Training Policy Working Group. in line with the agreed Protocol and endorsement by the Executive Team. (Appendix 2)

For Agenda for Change staff, the non-achievement of core mandatory training may result in the employee's failure to comply with the Knowledge and Skills Framework core dimension Health, Safety and Security and may adversely affect progression through gateways. Line Managers are required to ensure that they have facilitated the completion / attendance at training to avoid this situation occurring.

5.2 Dissemination

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

If support or alternative formats and reasonable adjustments are required in terms of communication / delivery in relation to the Policy, this will be provided.

5.3 Resources

A range of training provision is widely available through both in-house and external Training Providers. Further details of training can be accessed by contacting the named contact person on the Training Matrix (Appendix 1).

5.4 Exceptions

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

6.0 MONITORING AND REVIEW

The Statutory and Mandatory Training Policy Working Group will be responsible for monitoring the overall compliance with the Policy. Regular reports will be provided to Directors to enable them to monitor compliance within their own service areas and take appropriate action.

7.0 EVIDENCE BASE/REFERENCES

Belfast HSC Trust Policies:

- Assistance to Study Policy
- Induction Policy
- Medical Appraisal
- Staff Development Review Guidance Notes
- Knowledge & Skills Framework Guidelines
- General Health and Safety Policy
- Manual Handling
- Risk Management Strategy
- Data Protection and Protection of Personal Information
- Fire Safety Policy
- Equal Opportunities Policy
- Bank Policy
- Zero Tolerance Policy
- Our responsibilities for safeguarding children – an information and training framework
- RQIA Guidance on mandatory training for providers of care in regulated services
- Data Protection Policy
- Placement Policy
- Volunteers Policy

8.0 APPENDICES

Appendix 1: Training Matrix
Appendix 2: Process for Amendment to Training Matrix

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the

opportunity to have experience of and become proficient in **(insert name of policy related practice/skill)**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy haspotential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

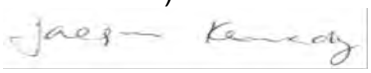
Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



13/10/2020

Date: _____

Policy Author

13/10/2020

Date: _____

Director

Appendix 1

Core Training Programmes	Frequency	Lead Contact *	Senior Responsible Officer **	Directorate	Operational Contact *** (if different from Lead Contact)
Trust Welcome Programme ***1***	Once	Kevin Kennedy	Jacqui Kennedy	HR & Organisational Development	Kevin Kennedy
Fire Safety Awareness Training ***2***	Annually ***3***	Joanna Dougherty	Maureen Edwards	Finance & Estates	Mairead McCartan
Health & Safety Awareness Training	Once	Anne Mageean	Claire Cairns	Medical Directorate	
Adverse Incident Reporting (incorporates Being Open)	Once	Gillian Moore	Claire Cairns	Medical Directorate	Heather Whiteman
Data Protection	3 yearly	Gillian Acheson	Charlene Stoops	Planning, Performance & Informatics Directorate	Cathy Cole & Deborah Crozier
Equality for Staff/Managers	5yrly	Samantha Whann	Jacqui Kennedy	HR & Organisational Development	Martin McGrath
Manual Handling Theory	2 yearly	Caroline Parkes / Elaine McConnell	Jacqui Kennedy / Bernie Owens	HR & Organisational Development / Unscheduled & Acute Care	Maria Rush (Mater & RVH) Angela Clarke (MPH & BCH) Claire Campbell (Community)
Quality 2020: Level 1 Awareness	Once	Kevin Kennedy	Jacqui Kennedy	HR & Organisational Development	Eamon Doherty
Safeguarding Adults and Children Awareness ***4***	Once	Caroline Brogan (Social Work, Social Care) Jennifer Donnelly (only for induction awareness training)	Carol Diffin	Children's Community Services	
Infection Prevention Control Awareness ***5***	Once	Lead Nurse IPC	Brenda Creaney	Nursing and User Experience	

[1] The majority of staff including Medical staff are required to complete the Welcome Event Programme. Separate arrangements are in place for Trainee Doctors.
[2] The E-learning training module is designed solely for staff who **DO NOT** have any involvement/responsibility for patient/client evacuation in the event of a fire
[3] Residential care staff are required to attend Fire Safety Training every six months.
[4] This is awareness raising only. More detailed training will need to be completed by identified groups of staff e.g. Allied Health Professionals, Dentists, Medical Practitioners, Nursing, Psychology, Social Work and Social Care Staff. If in doubt, please check with your line manager.
[5] This is awareness raising only. More detailed training will need to be completed by identified groups of staff e.g. Clinicians. If in doubt please check with your line manager

Please Note:

* Lead Contact is responsible for managing the provision of the specific training indicated and not necessarily other levels beyond awareness.

** Senior Responsible Officer has responsibility or delegated responsibility from the Director for the provision of training in line with the Policy.

*** Operational Contact supports the delivery of training on a day to day basis.

Appendix 2

Request for Amendment to Trust's Core Statutory / Mandatory Training Matrix within the Trust's Core Statutory / Mandatory Training Policy

This form must be fully completed for training to be added or amended on Core Statutory Mandatory Training Matrix

1.	**With reference to the Core Statutory / Mandatory Training Policy, which of the following is the reason for the training to be included on the Matrix?**	☐ *A statutory obligation: where the law defines that training must be undertaken* ☐ *A Health and Social Care mandate: where a formal, official directive has been handed down within the Health and Social care sector* ☐ *A Corporate mandate: where the Trust has identified training as being essential to organisational priorities*
2.	**Please provide details of the reason selected in 2:**	
3.	**Title of training course:**	
4.	**Please detail who is the lead responsible officer for the provision of this training in the Trust:**	
5.	**Please confirm that the training is applicable to all Trust staff:**	
6.	**What is the method(s) of delivery**: *(please tick one or both boxes as appropriate)*	☐ Face to Face ☐ e-learning

7. **Frequency of training**: *eg. to be completed once, annually, three yearly. If there is a refresher / update version of this course the frequency of the course above will be "Once"*

8. **Is there a separate update / refresher version of this course?**: *(please tick appropriate box)* ☐ YES ☐ NO

NOTE: Only complete questions 9, 10, 11 if you have ticked "YES" in question 8 above

9. **What is the title of the update / refresher course?**

10 **What is the method(s) of delivery?**: *(please tick one or both boxes as appropriate)* ☐ Face to Face ☐ e-learning

11 **Frequency of update / refresher**: *eg. to be completed annually, three yearly*

12 **The Trust's Core Statutory Mandatory Training Policy identifies the roles and responsibilities of Trust training providers in relation to such training. Please provide assurance that there are arrangements in place to meet the following requirements of the Policy for this training**:

Please tick the appropriate box for each question	***Yes***	***No***
a) Will sufficient training be provided to meet the identified need within required timeframes?		
b) Will the details regarding the provision of this training be clearly communicated to Managers and Staff in a timely way?		
c) Has the training content and delivery method been prepared to ensure its currency?		
d) Does this training programme have stated objectives and programme of content?		

e) Will there be a procedure in place to notify Line Managers when staff do not attend/complete this training?		
f) Will this training programme be evaluated?		
g) Will an attendance record be maintained for this training?		

h) Will HRPTS be used to record attendances for this training? *(Please note all providers are required to use HRPTS for the recording of their training activity):*

If you have indicated NO on any of the above questions, please provide further details:

Sign Off:

Requested by:	*Name & Grade:*	*Signed*:	*Date:*
Approved by Responsible Lead Officer for	*Name & Grade:*	*Signed*:	*Date:*

Provision of this Training:

Please forward completed form to:

[redacted]**People and Organisational Development Team, 3rd Floor McKinney House Musgrave Park Hospital Stockman's Lane Belfast**

Final Sign Off:

Approved by Statutory and Mandatory Training Policy Working Group:	*Nae & Grade:*	*Signed:*	*Date:*
Added to Matrix:	*Name & Grade:*	*Signed:*	*Date:*

Process for Training to be included on Trust's Core Statutory/Mandatory Training Matrix

A need for new (or a change to) statutory/mandatory training arises as a result of a statutory obligation, a Health & Social Care mandate or a corporate mandate.

A training programme is designed or identified to meet the requirements identified above. The programme will include clear objectives and a programme of content. This will be the responsibility of the Lead Responsible Officer.

The training requirements and provision should be endorsed by the relevant professional committees and appropriate sponsorship secured with Executive Team.

The Lead Responsible Officer for the provision of the training in the Trust will formulate a plan to communicate, deliver and evaluate the training within the necessary timescales.

The Lead Responsible Officer will complete the request form for amendment to the Trust's Core Statutory/Mandatory Matrix and submit it to Eimear Moore, People and Organisational Development Team, email: [redacted]

The Request Form will be tabled for endorsement at the next available Statutory and Mandatory Training Policy Working Group meeting.

The Training will be added to the Trust's Core Statutory Mandatory Training Matrix by the People & Organisational Development Team in Human Resources. The updated Matrix will be issued to Directors & Co-Directors for implementation in their Directorate. A copy will be uploaded to the intranet. The training will also be added to the course catalogue in HRPTS by the relevant training provider.

Human Resources will assign relevant training to positions in HRPTS to indicate any training gaps in training requirements for staff.