

May 2011

CQC registration toolkit: Appendix C - Policies and protocols

Guidance for GPs

CQC registration for NHS GPs toolkit: Appendix C - Policies and Protocols

Contents

Appendix C1:	Confidentiality protocol
Appendix C2:	Content of a practice's leaflet
Appendix C3:	Provision of lifestyle protocol
Appendix C4:	Reviewing and acting on correspondence, reports and Results protocol
Appendix C5:	Sharing and acting on clinical guidance, formularies, medical device alerts and safety alerts protocol
Appendix C6:	Infection and prevention control policy
Appendix C7:	Decontamination policy
Appendix C8:	Repeat prescribing policy
Appendix C9:	Recruitment policy
Appendix C10:	Staffing policy
Appendix C11:	Significant event review template
Appendix C12:	Complaints procedure protocol

Please note: You must be satisfied that these example policies and protocols are suitable for your practice or modify them accordingly before implementing them.

The BMA excludes all liability and has no responsibility for any action taken by CQC, including remedial action, enforcement action and penalties, or action taken by any other body against individuals and/or providers that have used these policies and protocols.

Appendix C1

Confidentiality Protocol

Person responsible for review of this protocol: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the protocol is to set out the obligations for all working at *[insert name of practice]* concerning the confidentiality of information held about patients and *[insert name of practice]*.

This protocol is relevant to all employers and any one who works at *the practice*, including non-clinical staff. Individuals on training placements and visitors/observers on the premises must also adhere to this.

This protocol will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Importance of confidentiality

Confidentiality is a fundamental part of health care and crucial to the trust between doctors and patients. Patients entrust their practice with sensitive information relating to their health and other matters in order to receive the treatment and services they require. They should be able to expect that this information will remain confidential unless there is a compelling reason why it should not. All staff in the NHS have legal, ethical and contractual obligations of confidentiality and must ensure they act appropriately to protect patient information against improper disclosure.

Some patients may lack the capacity to give or withhold their consent to disclosure of confidential information but this does not diminish the duty of confidence. The duty of confidentiality applies to all patients regardless of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

Information that can identify individual patients must not be used or disclosed for purposes other than healthcare unless the patient (or appointed representative) has given explicit consent, except where the law requires disclosure or there is an overriding public interest to disclose. All patient identifiable health information must be treated as confidential information, regardless of the format in which it is held. Information which is effectively anonymised can be used with fewer constraints.

The confidentiality of other sensitive information held about the practice and staff must also be respected.

Obligations for all staff

All staff must:

- 1) always endeavour to maintain patient confidentiality;
- 2) not discuss confidential information with colleagues without patient consent (unless it is part of the provision of care);
- 3) not discuss confidential information in a location or manner that allows it to be overheard;
- 4) handle patient information received from another provider sensitively and confidentially;
- 5) not allow confidential information to be visible in public places;
- 6) store and dispose of confidential information in accordance with the Data Protection Act 1998 and the Department of Health's Records Management Code of Practice (Part 2);
- 7) not access confidential information about a patient unless it is necessary as part of their work;
- 8) not remove confidential information from the premises unless it is necessary to do so to provide treatment to a patient, the appropriate technical safeguards are in place and there is agreement from the information governance lead or Caldicott Guardian;
- 9) contact the information governance lead or Caldicott Guardian if there are barriers to maintaining confidentiality;
- 10) report any loss, inappropriate storage or incorrect disclosure of confidential information to the information governance lead or Caldicott Guardian;
- 11) if applicable, document, copy, store and transfer information in the ways agreed with other providers (see Annex 1);

It is expected that members of staff will comply with the law and guidance/codes of conduct laid down by their respective regulatory and professional bodies.

Information disclosures:

When a decision is taken to disclose information about a patient to a third party due to safeguarding concerns/public interest, the patient should always be told and asked for consent *before the* disclosure unless it would be unsafe or not practical to do so.

In the circumstances that consent can not be sought, then there must be clear reasons and necessity for sharing the information.

Disclosures of confidential information about patients to a third party must be made to the appropriate person or organisation and in accordance with the principles of the Data Protection Act 1998 (Annex 1), the NHS Confidentiality Code of Practice (see below) and the GMC's Good Medical Practice.

Obligations for employers

The employers at the practice must:

- 1) ensure that confidential information can be stored securely on the premises and that there are processes in place to guarantee confidentiality;
- 2) make sure that all individuals to whom this protocol is relevant have read, understood and signed this protocol;
- 3) review and update this protocol on a regular basis.

This protocol is subject to the provisions set out in the legislation and guidance listed below:

Data Protection Act 1998; The Information Commissioners' Office guide to data protection can be viewed at:

http://www.ico.gov.uk/for_organisations/data_protection/the_guide.aspx

The Department's Code of Practice for Records Management (Part 2)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093024.pdf

Human Rights Act 1998

The Common Law Duty of Confidence

Access to Health Records Act 1990

Confidentiality: NHS Code of Practice 2003

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253

NHS Care Record Guarantee 2009 www.nigb.nhs.uk/guarantee/2009-nhs-crg.pdf

Annex 1 Agreed ways to document, copy, store and transfer information in the ways agreed with other providers (see Annex 1)

[Insert locally agreed methods]

Appendix C2

Contents of a practice's leaflet

We advise that your leaflet include the following as a minimum:

- 1) The name of the contractor/partners;
- 2) In the case of a limited partnership, the status of the partners;
- 3) In the case of a company, the names of the directors, the company secretary and the shareholders, and the address of the company's registered office;
- 4) The full name of each person performing services and their professional qualifications;
- 5) Whether the practice undertakes the teaching or training of health care professionals or persons intending to become health care professionals;
- 6) The practice's boundary area, by reference to a sketch diagram, plan or postcode;
- 7) The address of each of the practice's premises;
- 8) The practice's telephone and fax numbers and website address (if any);
- 9) Whether the practice premises has suitable access for disabled patients and, if not, the alternative arrangements for providing services to such patients;
- 10) How to register as a patient;
- 11) The right of patients to express a preference of practitioner and the means of expressing such a preference;
- 12) The services available;
- 13) The opening hours of the practice's premises and the method of obtaining access to services during core hours;
- 14) The criteria for home visits and the method of obtaining such a visit;
- 15) The arrangements for services in the out of hours period and how the patient may contact such services;
- 16) If out of hours services are not provided by the contractor, the fact that the Primary Care Trust is responsible for commissioning the services;
- 17) The name and address of any local walk-in centre;
- 18) The telephone number of NHS Direct (or equivalent) and details of NHS Direct (or equivalent) online;
- 19) The method by which patients are able to obtain repeat prescriptions;

- 20) If the practice offers repeatable prescribing services, the arrangements for providing such services;
- 21) If the practice is a dispensing practice, the arrangements for dispensing prescriptions;
- 22) How patients may make a complaint or comment on the provision of service;
- 23) The rights and responsibilities of the patient, including keeping appointments;
- 24) The action that may be taken where a patient is violent or abusive;
- 25) Details of who has access to patient information (including information from which the identity of the individual can be ascertained) and the patient's rights in relation to disclosure of such information;
- 26) The name, address and telephone number of the Primary Care Trust from whom details of primary medical services in the area may be obtained.

Appendix C3

Provision of lifestyle information protocol

Person responsible for review of this protocol: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the protocol is to set out the types of information that should be provided to patients when it is necessary to encourage them to change certain behaviour for the benefit of their health.

This protocol is relevant to all employers and healthcare professionals who work at *[insert name of practice]*.

This protocol will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Importance of the provision of lifestyle information

Healthcare professionals can play an important role in their patients' health by providing lifestyle information to patients who need to change lifestyle behaviours that are placing their health at risk.

Obligations for all healthcare professionals

All healthcare professionals must:

- 1) ensure that ways to improve lifestyle behaviour are discussed in consultations with patients when appropriate and/or necessary;
- 2) make sure that they can either give advice or know where to find leaflets on the premises on topics such as:
 - a) how to improve their diet and reduce weight;
 - b) how to reduce blood pressure;
 - c) reducing stress;
 - d) ways to quit smoking;
 - e) the benefits of exercise;
 - f) the benefits of reducing alcohol consumption;
 - g) how to improve sexual health;
 - h) how to check for symptoms of common cancers such as testicular and breast cancer;
 - i) available support programmes in the local area and how to refer patients to them.

An extensive range of patient information leaflets can be accessed at:

- 1) The [BMJ Evidence Centre webpage](#);

2) The [Patient UK website](#).

Obligations for employers

The employers at *[insert name of practice]* must:

- 1) ensure that all individuals to whom this protocol is relevant have read, understood and signed this protocol;
- 2) make sure that there is lifestyle advice i.e. leaflets and posters, in the reception/waiting room;
- 3) review and update this protocol on a regular basis.

Appendix C4

Reviewing and acting on correspondence, reports and results protocol

Person responsible for review of this protocol: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the protocol is to set out the procedure for reviewing and acting on correspondence, reports and investigation results that are received at *[insert name of practice]*. This protocol is relevant to anyone who works at the practice.

This protocol will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Importance of having a clear procedure for reviewing and acting on correspondence, reports and results

For the welfare and safety of our patients it is crucial to process and act on correspondence, reports and results from outside of the practice in a timely but safe manner. The information that the practice receives can be from a variety of locations including hospitals, out of hours care providers and community health teams.

Procedure

Correspondence, reports and investigation results from outside of the practice may be received by fax, post, or electronically.

Paper correspondence/reports/results

- 1) Any paper correspondence/reports/results received by fax or post must be given to a member of the practice reception staff who will stamp the document with the date of receipt and scanned onto the computer system;
- 2) The member of the practice reception staff must then pass the correspondence/report/results to the healthcare professional that referred the patient or, if that is not indicated on the correspondence/report/results, the patient's registered GP;
- 3) The healthcare professional that receives the correspondence/report/results will decide what action to take;
- 4) The correspondence/report/results will be added to the patient's paper or electronic record;
- 5) If the correspondence/report/results are scanned into the patient's electronic record then the paper copy will be kept on file for three months before being destroyed.

Electronic reports/results

- 1) Electronic reports/results must go to the email inbox of the member of staff responsible for taking action on those results;
- 2) The practice reception staff will redirect the electronic reports/results to the healthcare professional that referred the patient or, if that is not indicated on the report/results, the patient's registered GP or the duty doctor;
- 3) The healthcare professional that receives the report/results will decide what action to take in accordance with practice procedures.

Absence

There will always be a member of staff within the practice to handle the incoming correspondence/reports/results.

When the referring GP and the patient's registered GP are on leave the duty doctor will review the correspondence/report/results and decide what action to take.

Appendix C5

Sharing and acting on clinical guidance, formularies, medical device alerts and safety alerts protocol

Person responsible for review of this protocol: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the protocol is to set out the procedure for sharing national/local clinical guidance, national/local formularies and acting on drug and safety alerts at *[insert name of practice]*. This protocol is relevant to anyone who works at the practice.

The individual responsible for the dissemination of guidance/alerts at *[insert name of practice]* is *[insert name]*. This protocol will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Procedure

- 1) The responsible individual will ensure that they are on local and national information cascades.

The cascade includes:

[Insert list of guidance on the cascade that is relevant to the practice e.g.

1) NICE and other national clinical guidance

2) Local clinical guidance

3) National and local formularies

4) Alerts that would be found on the Central Alerting System:

- o *The Medicines and Healthcare products Regulatory Agency alerts;*
- o *The National Patient Safety Agency alerts;*
- o *The Chief Medical Officer (for England)]*

- 2) The responsible individual will determine who to send the guidance/alerts to and send it to them.

- Appropriate clinical alerts/guidance will be shared with healthcare professionals at the practice;

- Alerts about medical devices will be shared with the practice manager for investigation;

- 3) The individuals that receive the guidance/alerts will decide the action needed (including whether it needs to be discussed at the next practice meeting) and the timescale for action;

Appendix C6

Infection Prevention and Control Policy

Person responsible for review of this policy: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the policy is to set out the infection prevention and control procedures at *[insert name of practice]*.

This policy is relevant to all employers and any one who works at *[insert name of practice]*, including non-clinical staff. Individuals on training placements and visitors/observers on the premises must also adhere to this.

This policy will be monitored and reviewed *[Insert timescale]* by the Infection Prevention and Control Lead.

Commitment of the practice

The employers and all staff at *[insert name of practice]* are committed to minimising the risk of infection and to ensure the safety of patients.

Infection Prevention and Control Lead

The IPC lead for the practice is: *[insert name]*

The contact details for the IPC Lead are:

The PCT/local commissioning body's Infection Prevention and Control Lead is: *[insert name]*

The contact details for the PCT/local Lead are:

Standard Precautions

Hand washing procedures

Washbasins with suitable taps, liquid soap dispensers, alcohol rubs, paper towels and clinical waste bins are provided in all clinical care areas

Protective Clothing

Gloves (non-sterile and sterile), aprons and goggles are available and should be worn for procedures with associated risk. Gloves and aprons are single use.

General Dress Code

Staff should wear clothes that are clean and fit for purpose.

Handling and disposal of healthcare waste including sharps and single use-devices

See waste management protocol

Other procedures

Venepuncture procedure

- 1) Staff should be adequately trained to perform this procedure
- 2) Wounds or abrasions should be covered and gloves should be worn
- 3) Equipment should be easily accessible
- 4) The patient should be comfortable and relaxed
- 5) Special sterile phlebotomy (Vacutainer system) syringes and needles must be used only once. Healthcare professionals should ensure that no blood contacts their skin by:
 - i) Covering the site of the needle puncture with a cotton wool ball when removing the needle (any drop of blood should be allowed to drip onto the wool ball)
 - ii) Do not sheath the needle
 - iii) Place the needle and vacutainer immediately into a sharps box
 - iv) Specimens should be sealed in pathology sample bags for transportation

Vaccinations

- 1) Vaccines are administered in association with recommended best practice
- 2) Vaccines are stored as manufacturers' guidance in well maintained, monitored refrigerators to ensure maximum efficacy of products to combat infection
- 3) Care should be taken in using hypodermic equipment during administration to patient and subsequent equipment disposal as with venepuncture

Obtaining specimens

Urine

- 1) Avoid contamination of personnel or clothing
- 2) Gloves need not be worn when handling urine containers (or performing pregnancy or dipstick tests) unless the container is contaminated with blood or faeces, when gloves are to be worn
- 3) Hands should always be washed after handling urine and testing urine
- 4) Samples of urine in open containers are to be handled carefully to avoid spillage and transported a minimum distance after production to analysis, and after analysis to disposal
- 5) If required the sample should be poured into a laboratory container by the patient to the indicated level avoiding contamination to the outside of the bottle
- 6) A patient should be warned that failure to comply with this would lead to the disposal of the bottle without analysis. The patient and the staff member are to wash their hands after handling urine containers that have been used

Microbiological Swabs

- 1) An infected area must not be touched by a healthcare professional's clothes or hands
- 2) The swab must have enough material for testing but not too much, so as to avoid any spillage during the transfer of the swab to the specimen container
- 3) The specimen container must be sealed adequately and the specimen form placed in the correct compartment of the specimen bag

Cervical Smears

Cervical smears should be taken in accordance with current liquid-based cytology protocols

Speculums

- 1) Re-usable specula will be cleaned and sterilised then stored for clean use
- 2) Disposable specula are to be inserted into an appropriate plastic hazard bag after use.
- 3) Used gloves are to be placed into a hazard bag

Handling specimens

- 1) Samples in sealed containers should pose low risk as long as the outside has not been contaminated or damaged. However, all samples should be handled as little as possible
- 2) All samples in appropriate containers are to be inserted into the approved plastic bag that is sealed
- 3) All blood or potentially infected matter such as urine or faeces for microbiological examination should be treated as high risk and precautions used

Processing of medical instruments

This practice out-sources the sterilising of re-usable instruments needed for all clinical examination, smear and minor operations. Some disposable single-use versions may be used as supplements

Minor operations and dressing instruments

These are cleaned sterilised and stored clean for use or re-sterilised immediately prior to use for sterile needs

Accidents

Needle stick Injuries

- 1) If the mouth or eyes are involved, they should be washed thoroughly with water
- 2) If skin is punctured, free bleeding should be gently encouraged and the wound should be washed with soap or chlorhexidine and water, but not scrubbed or sucked
- 3) If there is any possibility of HIV exposure, immediate advice should be sought about the relative indications for anti-retroviral post-exposure prophylaxis
- 4) The practice IPC lead and an appropriate GP e.g. duty doctor, senior partner should be informed
- 5) If the source of injury was from a patient, their details should be recorded
- 6) The staff member should immediately attend the Occupational Health Services provided by the PCT or Accident and Emergency according to local arrangements
- 7) The incident should be recorded in the practice accident log

Immunisation

Patient immunisation

- 1) A record will be kept of all immunisations given to patients
- 2) The immunisation status and eligibility for immunisation patients will be regularly reviewed
- 3) After a review of the immunisation record patients will be offered further immunisation as needed

Staff immunisation protection

- 1) All medical personnel or staff who obtain or handle blood or pathological specimens are to be protected against Hepatitis B
- 2) A record of employees' Hepatitis B status is to be kept and maintained
- 3) All staff are offered annual influenza immunisation

Training

Infection control training will take place for all staff as part of the practice induction and on an annual basis. All clinical staff will receive aseptic technique training

Audit and risk assessment

There will be one infection control audit and one infection prevention and control risk assessment per year

However, if the purpose of a room changes to that of treatment then a risk assessment will be conducted of that room

Annual statement

An annual statement will be written by the IPC Lead and include a summary of the following:

- 1) any infection transmission incidents and any action taken (If necessary these incidents should be reported in accordance with the incident reporting procedure)
- 2) the infection control audit(s)
- 3) the infection prevention and control risk assessment
- 4) relevant staff training

Related documentation/links

NICE's Infection control: Prevention of healthcare-associated infection in primary and community care (2003)

http://www.nice.org.uk/nicemedia/pdf/Infection_control_fullguideline.pdf

Vaccine Administration Task force's Guidance on Best Practice in Vaccine Administration (2001)

http://www.rcn.org.uk/_data/assets/pdf_file/0010/78562/001981.pdf

HMSO (1996) Immunisation against Infectious Diseases - The Green Book

<http://www.dh.gov.uk/en/PublicHealth/Immunisation/Greenbook/index.htm>

Appendix C7

Decontamination Policy

Person responsible for review of this policy: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the policy is to set out the decontamination procedures at *[insert name of practice]*. The policy should be read in conjunction with the Cleanliness Plan, Infection Prevention and Control policy and the Waste Management Policy.

This policy is relevant to all employers and any one who works at *[insert name of practice]*, including non-clinical staff. Individuals on training placements and visitors/observers on the premises must also adhere to this.

This policy will be monitored and reviewed *[Insert timescale]* by the Cleaning and Decontamination Lead.

Commitment of the practice

The *[insert name of practice]* is committed to minimising the risk of infection, injury or contamination to staff, patients and others.

Cleaning and Decontamination (CD) Lead

The CD lead for the practice is: XXXXXXXX

The contact details for the CD Lead are: XXXXXXXX

This individual is responsible for the implementation of this policy.

DEFINITIONS

Cleaning

“Cleaning is the physical removal of infectious agents and the dirt and organic matter on which they thrive”. MHRA (2003). Cleaning removes up to 80% of micro-organisms and is an essential part of an infection control programme. Given that organic matter will inactivate disinfectants, all items must be cleaned before disinfection or sterilisation can be achieved.

Contamination

The soiling or pollution of inanimate objects or living material with harmful, potentially infectious or other unwanted material

Decontamination

The process of making a person, object, or environment free of micro-organisms, radioactivity, or other contaminant

Disinfection

Disinfection is the removal or destruction of adequate numbers of potentially harmful micro-organisms to allow the item to be handled or used safely

Sterilisation

Sterilisation is the total destruction and removal of all micro-organisms including spores. Prions are not destroyed in this process

Medical Device

Any equipment used in the treatment, diagnosis and/or care of patients.

Single Use Items

These are items designated by the manufacturer as being suitable for one use on an individual patient only and then discarded. They must **not** be reprocessed (cleaned, disinfected or sterilised) for further use as this may damage the item and invalidate product liability. The reuse of single use items contravenes the Consumer Protection Act and will render the user liable to prosecution.

Single Patient Use

These items can be used for more than one episode on one patient only. The device will need to undergo some form of decontamination between each use. The manufacturer must state the number of times that the item can be reused prior to disposal.

POLICY

- 1) All medical devices and equipment used in healthcare environments may become contaminated with biological, chemical or radioactive material and thus can present a risk to patients, as well as to those subsequently handling or using them
- 2) Inadequate decontamination has frequently been responsible for outbreaks of infection in health care establishments and can result in the transmission of a broad range of micro-organisms
- 3) Safe and effective decontamination and handling of medical devices / equipment is essential in reducing the risk of cross infection
- 4) Staff handling used medical devices and equipment should assume they are contaminated and take precautions to reduce the risk to themselves and others
- 5) The whole process of decontamination should begin at purchasing and acquisition of health care equipment. It is essential to establish methods of decontamination at the earliest stage of acquisition. Suppliers have a responsibility to provide information on safe decontamination methods and chemical compatibility
- 6) Any instrument which is required to be sterile should be single use only. Where this is not possible, it must be reprocessed by a licensed contractor. They must be transported in a suitable container and must not be rinsed prior to return
- 7) Accumulation of dust, dirt and liquid residues in the environment will increase infection risks and should be reduced to a minimum. This can be achieved by regular and thorough cleaning

Relevant legislation and guidance

- 1) Health and Social Care Act (2008)
- 2) The Health and Safety at Work etc. Act (1974)
- 3) The Management of Health and Safety at Work Regulations
- 4) Control of Substances Hazardous to Health (COSHH) Regulations
- 5) The National Specifications for Cleanliness in the NHS (2010)

Training

All staff will receive infection prevention and control training as part of the practice induction and on an annual basis.

PROCEDURES

Risk assessment for decontamination of medical devices

- 1) All equipment must be adequately decontaminated in between use and between patient use
- 2) Decontamination methods must be chosen according to the risk of infection associated with the use of a particular piece of equipment
- 3) Decontamination must always be carried out in accordance with this policy and with the manufacturers' instructions
- 4) Devices, which are not used on a regular basis, will still need to be cleaned
- 5) Equipment that cannot be adequately and safely decontaminated should not be purchased
- 6) Appropriate Personal Protective Equipment must be worn.
- 7) Thorough cleaning must always be the first step in the decontamination process.

Infection risk to patients from contact with an item of equipment

RISK	USE OF ITEM	MINIMUM DECONTAMINATION REQUIRED
High	<ul style="list-style-type: none"> • In close contact with a break in the skin or mucous membrane • For introduction into sterile body areas 	Single use item or sterilisation. To be carried out by registered contractors only
Medium	<ul style="list-style-type: none"> • In contact with intact mucous membrane • Contaminated with particularly virulent or readily transmissible organisms • Prior to use on immunocompromised patients 	Thorough cleaning followed by disinfection
Low	<ul style="list-style-type: none"> • Items in contact with healthy skin, or • Not in direct contact with patient 	Thorough cleaning is usually adequate (disinfection if infection risk is present)

Stages of decontamination

1) Cleaning

- i) Thorough cleaning of the item with a general purpose neutral detergent and hot water
- ii) The item must be cleaned thoroughly using neutral detergent and hot water, rinsed and dried. Alternatively detergent wipes may be used. Where wipes are used the cleaning process must be as thorough as with neutral detergent and water.
- iii) Wipes must be disposed of in accordance with the practice's policy on waste management.

2) Disinfection

The most common method of disinfection is with liquid chemicals e.g. alcohol, chlorine-releasing agents.

Safe use of disinfectants

- i) When handling disinfectants wear appropriate protective clothing i.e. plastic aprons, gloves and goggles
- ii) Work in a well ventilated area with easy access to running water and eye wash solution
- iii) Staff handling disinfectants must be trained in their use
- iv) Disinfectants should be used and stored in compliance with the COSHH Regulations

Some bacteria can grow in disinfectants. To prevent this from happening the following should always be observed:

- i) Replace container caps securely after use
- ii) A sterile solution, once opened, should be regarded as non-sterile
- iii) The expiry date on each solution should be checked before use
- iv) Water must never be left standing in clean buckets, even if it contains a disinfectant
- v) All mop heads should be colour coded disposable or launderable, stored clean, with head upright
- vi) Partially full bottles of disinfectant should never be 'topped up'
- vii) Expiry dates should always be checked
- viii) Staff should report to their line manager immediately any suspected reactions to products used for decontamination. The manager will refer the staff member to Occupational Health.

If it is necessary to dilute a disinfectant, remember:

- i) They work best at the right dilution. Always follow the manufacturer's instructions
- ii) Diluted disinfectants rapidly become inactive, use the same day and dispose of any left over via the correct disposal route.
- iii) Always mix them in a clean separate vessel with fresh tap water
- iv) Always use personal protective equipment as appropriate
- v) Products should never be decanted into an unlabelled bottle

Chlorine-releasing agents

Chlorine-releasing agents are relatively cheap and effective disinfectants which act by releasing available chlorine. They are rapidly effective against viruses, fungi, bacteria and most spores. They are particularly recommended for use where there is a hazard of viral infection, such as hepatitis B virus or HIV. However, chlorine-releasing agents are inactivated by organic matter. They should not be mixed with other chemicals, unless directed by the manufacturer.

- i) Care is necessary with metals as chlorine is corrosive
- ii) Hypochlorites such as Milton will lose their efficacy once opened and any remainder must be discarded.
- iii) The concentration of hypochlorite solutions is expressed as parts per million of available chlorine.

Alcohol

- i) Alcohol is available as a gel for hand decontamination.
- ii) Alcohol has a variable efficacy against viruses and is ineffective against spores. (See hand hygiene policy)
- iii) Ethyl alcohol 70% (ethanol) and 60% isopropyl alcohol (isopropanol) are both effective and rapidly acting disinfectants, with the advantage of evaporation, leaving the treated surface dry. However, they have poor penetrative powers, therefore must only be used on clean, dry surfaces.

Decontamination of items sent for repair, replacement or return

Those who inspect, service and repair or transport medical equipment have a right to expect that equipment has been appropriately decontaminated in order to remove or minimise the risk of infection. In order to comply with MHRA DB 2006(05) all such items must be accompanied by a declaration of contamination statement or decontamination form.

Environmental cleaning products

A neutral detergent and hot water, (made up to the dilution stated by the manufacturer) is recommended for general environmental cleaning. Where disinfection is required, then a chlorine releasing agent in the dilution of 1000 parts per million of available chlorine should be used. A COSHH assessment should be completed prior to use.

Maintaining good standards of environmental hygiene

- 1) Ensure clinical areas are visibly clean and free from clutter
- 2) A cleaning plan and schedule should be in place based on NPSA's "The National Specifications for Cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises (April 2010)
- 3) The cleaning schedule should be available in all areas and visible to staff and public.
- 4) The cleaning plan schedule must be monitored and evaluated regularly.
- 5) Staff should be trained in correct cleaning procedures and the use of cleaning products

Spillages

Sample leakages

If the leak is contained within a plastic hazard/specimen bag the bag should not be opened but should be inserted within another plastic bag, which should then be sealed and the whole disposed of in an approved sharps box.

If the leak is not contained within the bag and contaminates either the outside of the bag or external objects the following action is to be taken:

- 1) Using protective gloves, avoid any further contamination by containing the sample within another plastic bag.
- 2) Dispose of the entire protected sample within an approved sharps box.
- 3) Ensure hand washing

Body Fluid Spillages

Vomit can contain infective organisms and is thus a risk to personnel. Always assume that it is infected. Patients will usually have time to obtain a bowl or find their way to the toilet. Bowls should be emptied into a toilet and washed out immediately after being emptied. They should then be sterilised using an antiseptic solution.

Occasionally patients will vomit or deposit other bodily fluids on the floor or furnishings. In this event, scrape or blot up all excess soiling and dispose. The area will then need to be prepared for cleaning by applying the appropriate solution directly to the affected area with sprayer and blot with disposable towels or tissue. Repeat until there is no further improvement. Do not rub.

Clean the affected area with the supplied carpet cleaning equipment using the appropriate solution in the correct dilution.

Dispose of all towels or tissue as clinical waste.

Decontamination and disposal of Materials contaminated with biological substances

Clothes

Protective clothing (e.g. aprons) should be worn to avoid contamination whenever appropriate. When contamination of clothes with biological material occurs:

- 1) Use gloves and a wipe to remove surplus material
- 2) If there is a risk to staff or patients then the individual should change into clean clothing
- 3) Take all soiled clothing home and wash or dry-clean immediately.
- 4) On rare occasions, items may need to be disposed of as clinical waste.

Linen

The disposal of soiled linen used by the practice in the course of caring for patients will depend on the extent of soiling and the cause of the illness. In certain circumstances it may be decided to destroy linen if the risk to laundry personnel is too great. In this circumstance's destruction of the linen would be by incineration by double bagging in 'yellow bags' and sending with all other clinical waste.

A – Z of decontamination of equipment

This is not intended to be an exhaustive list of all items of medical equipment used within the practice.

Please note the following points carefully

- 1) The manufacturer's instructions must always be followed in regards to decontamination of a product. Where manufacturer's decontamination instructions are unclear, or alternative disinfection agents to those described above are recommended, the Infection Prevention and Control Team should be contacted.
- 2) Items should always be cleaned before disinfection.
- 3) In the event of recommended one -stage disinfectants being unavailable, and where an item is used by an identified or suspected infected patient, decontaminate by thorough cleaning with a neutral detergent and hot water, or detergent wipe, followed by wiping with a solution of 1000 parts per million of available chlorine, unless contraindicated by manufacturers instructions.
- 4) Ensure items are decontaminated and dried before storage.
- 5) No local thermal reprocessing should take place. e.g. Autoclaving

Baby Changing Mat	Cover with paper roll Clean and disinfect	Change between each baby. Use wipes at the end of each clinic session, when visibly soiled and /or contaminated with bodily fluids
Baby Scales	As for changing mat	As above
Blood Glucose Monitoring Pen and Machine	Single patient use only – only use for one patient or alternatively, use single use retracting needles. Clean /disinfect	Wipes Between each patient
Blood pressure sphygmomanometer and cuff	Wipeable Clean and disinfect	Wipes After each patient
Carpets	Carpets should be avoided wherever possible in clinical areas (not including admin areas, waiting rooms or corridors). Vacuum Shampoo Spillages of bodily fluid	Daily When soiled
Crockery and Cutlery	Machine wash with rinse temperature above 80oC and air dry. Or hand wash in hot soapy water, using neutral detergent. Rinse and dry with a disposable paper towel.	After use

Curtain rails	Clean using a high damp dusting mop	Chlorine-releasing agent Daily, between patients Care must be taken not to scatter dust.
Chairs/Cushions	Frame and wipeable cushions Fabric chairs are not recommended due to the fact that they cannot be adequately decontaminated.	Chlorine-releasing agent or wipes. Cushions should be inspected regularly and discarded if damaged or evidence of strike through.
Cervical Diaphragms and Caps	Follow manufacturer's guidance. Single use only	
Doppler Ultrasound Probe	Remove gel from the probe after use with disposable paper towel. Then clean/ disinfect.	Wipes After each use
Dressing scissors	Use sterile disposable scissors for sterile procedures. Single use only.	
ECG Equipment leads Machine	Electrodes -Single use only Clean/ disinfect	Wipes or follow manufacturers instructions
Examination Couches	Cover with disposable paper roll. (Paper roll ideally should be attached to either a holder on couch or a wall-mounted dispenser). Avoid linen. Clean/disinfect	Change paper between each patient Wipes or Chlorine-releasing agent. At the end of each session, if visibly soiled or contaminated with bodily fluids, or after a patient with a known or suspected infection. (For blood or blood stained fluids see 9 above)
Mops and cloths for cleaning	Mops – should be colour coded and mop heads changed daily. Cloths- disposable	
Peak flow mouthpiece	Disposable - single patient use	Discard after use
Pillows	Always ensure that pillows are completely enclosed in an impermeable plastic cover with welded seams. On examination couches, the pillow clean/ disinfect	Wipes or Chlorine-releasing agent. At the end of each session and if visibly soiled. Wipes or Chlorine-releasing agent. When visibly dirty
Pulse Oximeter	Clean/ disinfect	Wipes Between patients and at least weekly.
Specula (Vaginal)	Single use - discard into appropriate waste stream.	

Suction Equipment	<p>All new suction machines purchased must be of a type that uses disposable collection bottle liners. Change liner. Discard into appropriate waste bag.</p> <p>Accessories e.g. suction catheters – single use. Use once and discard into appropriate waste stream.</p> <p>Filters – disposable</p> <p>Tubing - single patient use</p>	<p>Wipes</p> <p>Daily when in use, or weekly.</p> <p>Change every three months or when wet or visibly soiled or as per manufacturers instructions.</p>
Tympanic thermometers	<p>Disposable tips Thermometer - clean/disinfect</p>	<p>Change after each patient. Wipes daily and when visibly soiled</p>
Toilet seats (raised)	<p>Clean/ disinfect</p>	<p>Chlorine-releasing agent. Daily and more frequently if D&V/outbreaks.</p>
Toys	<p>Soft toys and those made of wood are not recommended. Only plastic toys that are in good condition and easy to clean are suitable for the clinical environment.</p> <p>Clean/disinfect</p>	<p>Wipes</p> <p>At the end of each clinic or when visibly dirty. Those in waiting areas must be cleaned at least weekly and when soiled.</p>
“Vacutainer” Needle Holders	<p>Single-Use – discard after each procedure.</p>	
Vomit Bowls / Kidney Dishes	<p>Single use only. Discard into macerator or dispose of contents into toilet and then dispose of receptacle in appropriate waste bag.</p>	
Weighing scales (<p>Clean/ disinfect</p>	
Work surfaces	<p>Clean/ disinfect</p>	<p>Chlorine-releasing agent or wipes Daily and when visibly dirty.</p>

Appendix C8

Repeat prescribing policy

Person responsible for review of this policy: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of this policy is to set out a prescribing procedure that ensures that the prescriber can monitor usage and the effects of repeat medication and that the patient is offered regular medication reviews. A robust prescribing procedure ensures that the prescriber can monitor usage and the effects of repeat medication and that the patient is offered regular medication reviews.

This policy is relevant to all employers and any one who works at *[insert name of practice]*.

The policy will be reviewed *[Insert timescale]* to ensure that it remains effective and relevant.

1) The repeat prescribing process

Production

Requests for repeat prescriptions may be received from the patient, their carer, district nurse, pharmacist or care home staff. The practice should be confident that the person making the request has the patients' permission to do so.

Requests can be made by a variety of methods:

- 1) In writing
- 2) Via the internet

It is preferable that requests are made in writing as they are more likely to be accurate and there is a reduced opportunity for errors and misunderstandings.

Repeat prescriptions must normally be ready for the patient to collect within 2 working days of the request being made (excluding weekends and bank holidays)

Requests for "all repeats" or just involving a description of medication should not be accepted and the patient should be contacted to clarify what exactly they are requesting.

Issuing a repeat prescription

- 1) Make sure that the items requested are on the patient's current repeat list. If not check the patients notes to see if there is an entry to say that the medication has been stopped, if not complete the request slip and pass it to the relevant GP
- 2) If the item is on the list, verify that the name, form, strength and dosage instructions match the request. If there are any discrepancies, refer to the relevant doctor
- 3) If the authorised number of issues has been met, follow the instructions below

- 4) Investigate whether the request is being made earlier (or later) than expected as this may indicate over or under usage. If in doubt refer to the relevant GP
- 5) Cancel any repeat medication that has not been accessed for more than 12 months (except seasonal medications such as for hay fever)
- 6) Always print a counterfoil with all repeats showing
- 7) Patients receiving their medications in Monitored Dosage Systems should receive a prescription for 28 days and not 4 x 7 days, unless clinically appropriate

Process to follow when the number of authorised repeats has been met

- 1) Establish whether a medication review has been done recently. If so you may re-authorise the repeat items to end 12 months from the date of the review
- 2) If the patient has not had a medication review check to see if they are due a chronic disease review, you may re-authorise the items, up to the date the review is due
- 3) Re-authorise all items, not just those in italics, to keep the repeats in line
- 4) If the medication is a controlled drug "Morphine based drug", Amiodarone, Methotrexate, Lithium or Benzodiazepine issue 1 month only and given a medication request slip to the prescribing doctor

Process after printing

Once printed, if the patient is tagged to a chemist, the prescription should be entered onto that chemist's collection sheet and tagged to the back of the sheet, in the order that they appear on the sheet. They should then be placed into the appropriate basket for signing

Patients who are not tagged to a chemist – place the prescriptions into the appropriate basket for signing

After signing:

- 1) Check that all prescriptions have been signed
- 2) Check that all prescriptions listed on the chemist collection sheet are still attached
- 3) Prescriptions for collection by the patient should be filed in the collection box in surname then first name order

When a prescription is collected always check the patients name, date of birth and address.

Prescriptions should not be given to children

The prescription collection box should be checked on a monthly basis. Any prescription more than one month old should be destroyed and the code [Insert code] – prescription not collected should be added to the patient's notes, along with the date of the prescription and a note that it has been destroyed

2) Management control

Medications must only be added to a patients' repeat list by appropriately qualified staff

When a repeat medication is added to the list a read coded reason must be added as to why the medication has been started

Practice staff who are involved in the preparation of repeat prescriptions must be appropriately trained

Blank FP10's must be stored securely in the filing cabinet in *[insert location]*

Periodic audit of repeat prescribing will be carried out

Lost prescriptions

If a prescription is reported as lost check the date of issue and any places where it could possibly be – i.e. mis-filed, sent to the chemist or to the wrong chemist

If the prescription cannot be found **reprint** the prescription – **do not re-issue**

Make an entry in the patient's notes using code [Insert code] – lost prescription noting the date of the prescription and that it has been re-printed

Patients who report that their medication or prescription has been stolen should report the matter to the police and obtain a crime number

Patients who regularly "lose" their prescriptions should be seen by a doctor who will decide if it is appropriate to re-issue the prescription

Under no circumstances must a receptionist re-print or re-issue a prescription for controlled drugs

Hospital discharge medication/Outpatient letters

Patients who are seen in an outpatient clinic or admitted often have their medication changed. It is important that these changes are made on the patients repeat medication list

Hospital discharge letters are distributed to the relevant doctor to amend the repeat screen as necessary

Medication changes indicated on an outpatient letter may be amended by the Prescribing Clerk once the GP has reviewed the letter and authorised the amendments

Home visits

Alterations to a patients medication made on a home visit must be amended on the patient's notes as soon as is practicably possible. Handwritten prescriptions must also be entered onto the patient's records

3) Clinical Control

Medication review

The following protocol must be adhered to when reviewing patients' medication:

- 1) Ask if experiencing any possible side effects or questions regarding the medication?
- 2) Is the patient still wishing to continue the medication, and what is their compliance like?
- 3) Does the patient know what the drug is for and how to take it?

- 4) Check if any blood or other tests are required for monitoring, if so arrange these.
- 5) The fall back mechanism of regular searches by *[insert name]* should pick up any of these defaulting.
- 6) Weekly a search will be run to identify those patients on four or more medications who have had a medication review. Those patients will be checked and their medications re-authorised.
- 7) Is the drug being used for a recognised, and still valid, indication; and according to current guidelines?
- 8) Are there any serious interactions or contraindications or particular advice. I.e. Missed COCP or how to take biphosphonates.
- 9) Can any simplifications, switches or changes to generic medications be made?
- 10) Is the patient on the Heart Failure or CKD register; if so are they also on an NSAID or COX2?
- 11) If so make sure this medication is not interfering with their illness and discuss stopping if necessary.
- 12) The doctor or nurse then re-authorises all medications.

Doctor or pharmacist then enters the READ code '**Medication Review**' in the patients notes.

This should be performed yearly for all patients on repeat medication.

Shared care protocol:

Patients, whose consultant sends a shared care pro-forma to the practice, will be reviewed by *[Insert name]*. The pro-forma will be scanned and a morbidity of "Shared care specialist /GP" will be entered on the same date, this will also be put onto the summary screen. If *[Insert name]* is not sure about the particular drug, then this will be checked with *[Insert name]*.

Appendix C9

Recruitment policy

Person responsible for review of this policy: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the policy is to set out the recruitment process for *[insert name of practice]*. This policy applies to all staff involved in recruitment.

This policy will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Importance of an effective recruitment process

To provide the best possible care and treatment to patients the best persons need to be recruited for all positions. At the same time a fair and transparent recruitment process is needed to ensure that all candidates have an equal opportunity to apply for vacancies. To achieve these two goals there needs to be an effective recruitment process.

Responsible individual(s)

The responsible individual(s) for the recruitment of new staff is/are:

[Insert name of individual(s)]

Obligations for all staff involved in recruitment

- 1) The staff of *[insert name of practice]* will ensure that the recruitment process offers equal opportunities to all persons, will be free from discrimination and comply with the principles of the following legislation:

Equality Act 2010

Employment Rights Act 1996;

Human Rights Act 1998;

General Medical Services Contracts Regulations 2004

Personal Medical Services Agreements Regulations 2004

- 2) Approval for the advertisement of any position must be approved by the responsible partner/manager *[according to local arrangements]*.
- 3) The process in this policy must be followed by all staff.

Recruitment process

- 1) Approval for advertisement of a position

The advertisement of a position must be approved by the responsible individual(s). The responsible individual(s) must seek agreement according to the partnership agreement/company arrangements.

2) Job description and person specification

An existing job description and person specification should be reviewed and amendments made to ensure that it accurately reflects the position that is being recruited. When there is no job description then it should be written to accurately reflect the position.

3) Advertising the position

An advertisement for the position can be put in the following relevant publications:

XXXXX
XXXXX
XXXXX

4) Candidate applications

A CV and covering letter would be expected but appropriate alternatives will be accepted from candidates if this allows participation in the process that would not otherwise occur.

Receipt of applications should be made by an appropriate member of staff and filed.

The applications should cover employment history and reasons for their last position ending (if not provided then this will be discussed during the interview)

5) Short-listing of candidates

Applications from candidates should be scored against the elements of the person specification. The candidates with the highest scores should be invited for an interview.

The short-listing and interview panel should consist of existing partners with or without the practice manager. Short-listed candidates for a partnership will be allowed to access, in confidence, to the practice accounts and be given a draft contract or the existing partnership agreement on request.

6) Pre-interviews

Before interviews for partnerships short-listed applicants will be offered the opportunity to spend a day in their practice, to attend surgery and meet members of the practice team. It must be made clear to applicants whether the visit constitutes part of the selection process.

The structure and content of interviews (including a question agenda) will be planned in advance.

All interviewers will be reminded of relevant legislation before the interview. The information relevant to the position and the candidate will be supplied to the panel before the interview and a list of the applicants attending will be held at reception.

7) Interviews

During the interview notes will be made about each candidate by the panel in relation to the person specification. A question will be asked about the reasons for their last position ending/why they wish to change roles.

Once all interviews are complete the panel will discuss the notes taken about the candidates and make a decision.

All records, including personal notes made by individual panel members, will be retained for at least one year in case they are required if a complaint is made about the selection process.

8) Offering the advertised position and rejection of other candidates

The chosen candidate should be verbally offered the post as soon as possible but it will be made clear that the offer is subject to references and the relevant checks. If the offer is accepted then a provisional start date will be agreed with the candidate

Rejection letters can be sent to all interviewed candidates. The letters will extend the opportunity to unsuccessful candidates to contact a designated person for feedback.

9) Checks and references for the successful candidate

The following will be required for all staff:

- a) evidence of legal entitlement to work in the UK;
- b) proof of a CRB check;
- c) proof of identity;
- d) two references from previous recent employment (see more specific requirements for health care professionals below);
- e) certificates of relevant qualifications and training;
- f) any relevant information about physical or mental conditions that relate to their ability to perform regulated activities.

In addition the following will be required for healthcare professionals:

- a) a check that they are registered and in good standing with their professional regulator (GMC/Nursing Midwifery Council)
- b) a check that they are not subject to any form of suspension;
- c) two clinical references relating to two recent posts as a healthcare professional which lasted for three months without a significant break (or where this is not possible, a full explanation and alternative referees);
- d) a check that they are not on an Independent Safeguarding Authority barred list.

The responsible individual will check that any GP is on a Performers List and whether they are on the List subject to conditions.

Once the above has been completed/received, any relevant documentation should be stored on file.

10) Contract of employment

Once the checks and references have been completed the relevant standard contract of employment (e.g. for salaried GPs, the BMA's [model contract](#)). Two copies of the

contract should be sent to the candidate; one to be kept for their records and one to be returned to the practice for the practice records.

A job description should be given to the new staff member.

A job plan should be agreed with a new salaried GP. The BMA has [guidance on job plans for salaried GPs](#).

11) Induction

An induction pack should be prepared for the candidate, including the outline of the practice induction scheme.

Guidance

BMA's *Recruitment and selection of doctors* guidance

http://www.bma.org.uk/careers/becoming_doctor/Recruitmentandselectionofdoctors.jsp?page=1

BMA's guidance on the relevant legislation except for the Equality Act 2010 can be viewed at:

http://www.bma.org.uk/careers/becoming_doctor/Recruitmentandselectionofdoctors.jsp?page=21

BMA's guidance on the Equality Act 2010 can be viewed at:

http://www.bma.org.uk/equality_diversity/equalitybillsummary.jsp

Appendix C10

Staffing policy

Person responsible for review of this policy: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The purpose of the policy is to set out the necessary staffing for *[insert name of practice]*. This policy applies to all staff working at the practice.

This policy will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Importance of having adequate staffing levels at all times

To maintain the quality of care and safety for patients there must be an appropriate skill mix of staff available to the practice at all times.

Responsible individual(s)

[Insert name], is responsible for assessing and maintaining adequate staffing in the practice.

The responsible individual(s) should be contacted when advice is needed or there are inadequate staffing levels and can be contacted in the following ways:

[Insert contact details]

Minimum required staffing in normal circumstances

There should be as a minimum the following number of each type of staff available to the practice when it is providing its services to patients.

[Insert minimum staffing requirement, if appropriate with reference to the day and time]

This minimum staffing is based on a risk assessment and an assessment of the needs of patients that has been conducted by the responsible individual.

Procedure for ensuring the maintenance of adequate staffing levels in normal circumstances

- 1) All staff will attend work punctually and inform the responsible individual if they will be unexpectedly absent from work;
- 2) All staff will inform the responsible individual if they wish to take leave for training, holiday, compassionate reasons etc.
- 3) The responsible individual will respond promptly to requests for planned leave from staff;
- 4) The responsible individual will manage the staff rota to ensure that there are adequate staffing levels at all times.

Procedure in long term unpredictable events e.g. pandemics

- 1) An assessment will be made on the staffing requirements of the practice by the responsible individual;
- 2) The responsible individual will either:
 - a) adjust the rota for the practice to ensure that the minimum staffing is in place;
 - b) arrange for temporary staff;
 - c) activate the arrangements for escalation.

The escalation arrangements are:

[Insert arrangements e.g. buddying-up system]

Procedure in the case of short term unexpected absence (e.g. sickness)

- 1) The staff member who is absent will contact the responsible individual. The responsible individual will assess whether the practice is below the minimum required staffing level;
- 2) If the staffing levels are below the minimum requirements the responsible individual will either:
 - a) adjust the rota for the practice to ensure that the minimum staffing is in place;
 - b) arrange for temporary staff.

Procedure in the case of long term absence (e.g. maternity leave)

- 1) The responsible individual will assess whether the practice is below the minimum required staffing level;
- 2) If the staffing is below the minimum requirements the responsible individual will either:
 - a) adjust the rota for the practice to ensure that the minimum staffing is in place;
 - b) arrange for temporary staff.

Procedure in the case of vacancies

- 1) The responsible individual will assess whether the practice is below the minimum required staffing;
- 2) If the staffing is below the minimum requirements the responsible individual will either:
 - a) adjust the rota for the practice to ensure that the minimum staffing is in place;
 - b) arrange for temporary staff
- 3) The responsible individual will start the recruitment process in accordance with the recruitment policy for the practice.

Changes in service provision

When there is a significant expansion or reduction in the services provided to patients then the responsible individual will review the minimum staffing levels of the practice by conducting a new risk assessment.

Arranging for temporary staff

The responsible individual will arrange for locum health care professionals by contacting:
[Insert contact details]

The responsible individual will arrange for locum non-clinical staff by contacting:

Appendix C12

Complaints Procedure Protocol

Person responsible for review of this protocol: XXXXXXXX

Date of last review: XXXXXXXX

Date of next review: XXXXXXXX

Purpose

The protocol sets out the approach of *[insert name of practice]* to the handling of complaints.

This protocol is relevant to all employers and any one who works at *[insert name of practice]*, including non-clinical staff. Individuals training and visitors/observers on the premises must also adhere to this.

This protocol will be reviewed *[insert time scale]* to ensure that it remains effective and relevant.

Importance of having a complaints procedure

In spite of the efforts of all staff it is likely that a complaint will be made by a patient at some point. To reduce the anxiety and apprehension for both patients and staff it is crucial to have a procedure for handling complaints.

How complaints can be made

Complaints may be received in writing or orally. Where a patient is unable to communicate a complaint by either means on their own then arrangements will be made to facilitate the giving of the complaint.

Persons who can complain

Complaints can be made by patients, former patients, someone who is affected, or likely to be affected, by the action, omission or decision of individuals working at the practice, or by a representative of a patient who is incapable of making the complaint themselves.

When a complaint is made on behalf of a child, there must be reasonable grounds for the complaint being made by the representative rather than the child and the complaint must be being made in the best interests of the child. If this is not the case, then written notification of the decision not to investigate the complaint must be sent to the representative.

Time limit for making a complaint

Complaints can be made up to 12 months after the incident that gave rise to the complaint, or from when the complainant was made aware of it. Beyond this timescale it is at the discretion of the practice as to whether to investigate the matter.

Persons responsible for handling complaints

Responsible Person: The Responsible Person is a partner responsible for the supervision of the complaints procedure and for making sure that action is taken in light of the outcome of any investigation.

Complaints Manager: The Complaints Manager is responsible for the handling and investigation of complaints.

Initial handling of complaints

- 1) When a patient wishes to make an oral complaint then the Complaints Manager is to arrange to meet the complainant in private to make an assessment of the complaint. The complainant is to be asked whether they would like to be accompanied at this meeting.
- 2) The complaint should be resolved at this meeting if possible. If the complaint is resolved then it should be recorded in the complaints register and the implicated staff member is to be told about the details of the complaint.
- 3) When the complaint can not be resolved the patient is to be asked to make a written complaint. If necessary the Complaints Manager is to write down the complaint on their behalf verbatim. The written complaint is to be recorded in the complaints register.
- 4) The Complaints Manager is to acknowledge a written complaint in writing within 3 working days, stating the anticipated date by which the complainant can expect a full response.

Investigation of complaint

- 1) The Complaints Manager is to discuss the complaint with the implicated member of staff to establish their recollection of events.
- 2) If the complaint is against the Complaints Manager, then the complaint is to be referred to the Responsible Person for investigation.
- 3) The complainant is to be invited to a meeting to discuss the complaint with the Complaints Manager and asked if they would like to be accompanied at this meeting. If appropriate and with prior consent from the complainant the staff member complained about can be present at that meeting. Minutes should be taken.
- 4) The timescale to respond (maximum of 6 months) is to be agreed with the complainant at that meeting and documented in the complaints register.
- 5) The full response to the complainant is to be signed by the responsible person, and include:
 - a) an explanation of how the complaint was considered;
 - b) the conclusions reached in relation to the complaint and any remedial action that will be needed;
 - c) confirmation as to whether the practice is satisfied that any action has been taken or will be taken.

- 6) If it is not possible to send the complainant a response in the agreed period it is necessary to write to the complainant explaining why. Then a response is to be sent to the complainant as soon as is reasonably practicable.
- 7) If the complainant is dissatisfied with the handling of the complaint then they are to be advised to contact the Health Service Ombudsman and how to do so.

Recording complaints and investigations

A record must be kept of:

- a) each complaint received;
- b) the subject matter of the complaint;
- c) the steps and decisions taken during an investigation;
- d) the outcome of each investigation;
- e) when the practice informed the complainant of the response period and any amendment to that period;
- f) whether a report of the outcome of the investigation was sent to the complainant within the response period or any amended period.

Review of complaints

Complaints received by the practice are to be reviewed at staff meetings to ensure that learning points are shared.

A review of all complaints will be conducted annually by the Complaints Manager to identify any patterns that are to be reported to the Responsible Person.

The Complaints Manager will notify the Responsible Person of any concerns about a complaint leading to non-compliance. The Responsible Person will identify ways for the practice to return to compliance.

A report on complaints is to be submitted to the Primary Care Trust (or replacement body) annually (year ending 31st March). This report is to:

- a) specify the number of complaints received;
- b) specify the number of complaints which it was decided were well-founded;
- c) specify the number of complaints which the practice has been informed have been referred to the Health Service Ombudsman;
- d) summarise the subject matter of complaints received;
- e) summarise any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
- f) summarise any matters where action has been or is to be taken to improve services as a consequence of those complaints.

This report is to be available to any person on request.

Publicity

The practice's arrangements for dealing with complaints and how further information about these arrangements may be obtained by patients is to be publicised by the Complaints Manager. How to contact independent advocacy services and the right of patients to approach Primary Care Trusts with complaints is also to be publicised.

Unreasonable complainants

When faced by an unreasonable complainant staff will take action in accordance with page 34 of the DH's [*Listening, responding, improving: a guide to better customer care*](#) guidance.