United Medicare Doctors Handbook

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1.Introduction

Thank you for registering with United Medicare. We provide a quality service to our patients and clients by ensuring the Doctors who are registered through the Agency meet our specific criteria and are of the highest calibre.

The success of any organisation and that of its workers depends largely on the workers themselves, and so we look to you to play your part as we shall continue to play ours.

To make your experience of working with United Medicare a happy one, the following information is designed to inform you of our way of working. We hope it will assist you as fully as possible with any questions that you may have relating to the Agencies' processes, policies and procedures.

History

Established in 2001, United Medicare, was formed to provide a specialist medical recruitment service for doctors looking to find work within the UK healthcare sector. United Medicare focuses on the provision of agency cover to the General Practice/Primary Care sector, and also doctors of all grades and specialties to secondary care NHS trusts and private organizations, across the United Kingdom.

How we operate

The United Medicare teams apply a strict set of criteria to all applicants, so that we can ensure that all doctors are properly qualified, experienced and adaptable to client needs. Following a successful agency registration, the completion of checks and the receipt of satisfactory references, doctors become eligible to work through the Agency.

United Medicare make extensive use of the latest technology, with our innovative database software and use of the Internet. Paper based copies of this document will only be accurate at the time of publication and keep copies online up-to-date.

2.Enrolling with the Agency

Enrolling with the Agency
Potential doctors wishing to register or re-register with United Medicare should initially contact the appropriate recruitment team.

By necessity, the recruitment process is very thorough and will include checks into your professional registration, qualifications, experience and competencies, a review of current immunisation records and Criminal Records Bureau disclosure checks etc.

United Medicare aim to provide a quality service to our clients through the provision of the very best Agency workers. It is for this reason that our processes strive to exceed the minimum guidelines, standards and statutory requirements required of Locum Doctors Agencies. United Medicare support and endorse the 'Code of Practise in the Appointment and Employment of HCHS Locum Doctors' as published by the NHS Executive, and also the 'Code of Practise for the Supply of Temporary Staffing' from the Department of Health.

The key requirements of the recruitment and selection process are noted below:

- Completed Application/Health Questionnaire
- Curriculum Vitae (with explanations for any gaps of employment)
- Two current referees (from current/last employer)
- GMC/GDC Certificate
- Letter of entry on to the Specialist Register (if applicable)
- Passport
- Proof of eligibility to work in UK (Visa etc)
- Proof of ability to speak English (IELTS) if applicable
- Completed CRB Application Form (if entered UK in previous 6 months please also include police check from country of origin dated within last 3 months)
- Hepatitis B Lab report showing titre levels (preferably from UK Occupational health department)
- Hepatitis C Lab report (preferably from UK Occupational health department)
- Rubella Lab report (preferably from UK Occupational health department)
- Completed TB questionnaire
- Varicella declaration (on application form)
- Copies of all registerable and additional registerable (higher) qualifications certificates.
- Copy of driving licence (if you have one)
- Copy of Ionising Radiation certificate (Radiologists only)
- Proof of Section 12 Approval if applicable (Psychiatrists only)
- 2 Passport size photographs
- Any doctor looking to work as a General Practitioner (GP) in the UK must also provide
- Proof of eligibility to work in the UK as a General Practitioner (e.g. JCPTGP or (T) GP stated on GMC annual certificate - EU GMC fast-track process)
- Proof of professional indemnity insurance with sufficient cover for the duties/hours/remuneration you wish to work
- Proof of inclusion on Performers (Supplementary) list with a Primary Care Trust for the relevant region (England and/ or Wales and/or Scotland)

Documentary evidence requirements for all assignments
In addition to the requirements of the initial enrollment process with the Agency all Doctors will be required to provide documentary evidence, at the client's request, on all assignments. Such documentary evidence may include:-

- I.D. Badge
- Photographic identification (e.g. Passport, Photo driving licence etc)
- Proof of eligibility to practise as a GP - if appropriate
- Original valid GMC certificate
- Original valid indemnity insurance certificate
- Proof of inclusion on a Performers List with a Primary Care Trust
- Original Enhanced CRB disclosure

3.Induction Policy

3.1 Orientation

It is important to have an orientation to each ward at the beginning of your agency placement - please ask for an orientation if this has not been offered by the client.

Some clients will have their own orientation guidelines, but if not, please use the following to help you, as appropriate to the department/practice into which you are placed.

- Knowledge of how to use any necessary computer system so that consultations, prescribing, templates, protocols, mentor, British National Formulary (BNF), word processing and internal message systems etc can be accessed and utilised
- Systems for Chronic Disease Management: adding to disease registers, familiarity with recall systems, targets, and team roles in their management
- Procedures for incorporating new disease headings into records (paper or electronic)
- Practice procedure for summarising notes
- Familiarity with data retrieval where relevant
- Knowledge of relevant statutory data protection requirements
- Knowledge of any prescribing policy and use of formulary
- Familiarity with NHS net where available
- Familiarity with referral systems used by the practice, main providers and services available, familiarity with Direct Access Booking where available
- Familiarity with in-house services, e.g. Phlebotomy, Electrocardiogram (ECG) etc.
- Knowledge of any special services provided e.g. drug dependence, physiotherapy, counselling, chiropody etc
- Knowledge of any appropriate Trust protocols
- Knowledge of any appropriate National Service Frameworks
- Access to Pathology Links where available
- Procedures for actioning results
- Provided with relevant and necessary telephone contact numbers
- Awareness of any appointment systems and on-call arrangements
- Awareness of internal management systems
- Location of emergency drugs
- Procedures for reporting significant events
- Panic button location and protocol for reporting violent incidents
- Meet other members of the Health Care Team
- Access to a copy of the appropriate 'Clinical Governance Handbook' if applicable

3.2 Risk Assessment

A careful examination of what in your work could cause harm to people, so that you can assess whether you have taken adequate precautions.

Hazard:-Anything that may cause harm or danger Risk:-Anything likely to cause harm or danger probability Five steps to risk assessment (recorded) :

- Identify the hazard
- Identify the risk
- Implement control measure
- Monitor/review/feedback
- Inspect and evaluate

Specific risk assessments must be completed for:-
- Young employees
- Pregnant employees
- Older employees
- Employees with disability

All risk assessments must be carried out by an identified competent person. All risk assessments must be written, recorded and reviewed.

3.3 Infection Control

Each year, in the UK, around 5,000 people die from hospital-acquired infections (more than are killed in road traffic accidents). This statistic emphasises the need for robust Infection Control policies that:-

- Outline procedures
- Train and educate staff
- Establish better standards
- Improve patient care

Health and Safety regulations require that all workers be offered a workplace environment that reduces the risk of exposure to infection. There is a legal requirement to ensure that safe workplace practises are in place, underpinned with up-to-date research and information.

The clinical environment presents a particular risk of the spread of infection, which is most commonly spread by inadequate hygiene and poor maintenance of the environment and equipment

3.3.1 Hand washing

The single most important measure for protection outside of wearing personal protective equipment is handwashing. Washing hands with soap and water is necessary to rid them of protein matter, blood and any other potentially infectious material. Workers should wash their hands vigorously with soap and water as soon as possible after any contact which might carry a risk of infection.

Hands should be washed before significant contact with any patient and following activities likely to cause contamination.

Times when you should wash your hands include:-

- Before starting duty
- Before going home
- Before eating
- Before handling or preparing food
- After direct contact with body fluids
- After going to the toilet
- After handling clinical waste
- After toileting patients

A neutral pH soap should be used for routine hand washing, and the process should take no less than 20 seconds. Hands should then be dried with disposable paper towels.

Gloves are not a replacement for hand washing. In clinical situations gloves should be changed and hands washed after each patient procedure, and also during multiple procedures on the same patient where a risk of cross-contamination exists. In emergencies, an alcoholic anti-microbial preparation may be used.

3.3.2 Sharps

Particular care must be taken when handling and disposing of sharps. Needle stick injuries and infections are a leading cause of injury and potential contamination. Needles and other sharps should be disposed of in sharps boxes as soon as possible after use.

Sharps boxes should be inspected regularly to ensure they are less than 3/4 full and should be replaced at that time. All workers using needles should have appropriate training in the use and disposal of these items.
If needles stick injury occurs:-

- Encourage bleeding from the site
- Rinse thoroughly under cold running water
- Apply waterproof dressing
- Inform supervisor
- Complete an accident report and report to the Agency

3.3.3 Spillages

Spillages of bodily fluids in the workplace present a serious risk. Protective clothing should be applied before attempting to clean up and spillage kits including the use of hydrochloride solution should be employed.

3.3.4 Clinical waste

Disposal of clinical waste is governed by COSHH regulations. It should be disposed of in clearly labelled yellow bags in pedal bins, removed once they are 3/4 full and stored in a secure designated area away from the public, animals and pests.

3.4 Needle stick injuries

Relevant Legislation:-The Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Control of Substances Hazardous to Health Regulations 1999.

What must be done to prevent staff being injured by sharp objects? During routine cleaning operations, house-keeping staff are liable to encounter sharp objects, whether thrown out in waste receptacles, or left discarded in areas being cleaned. To reduce the likely incidence of such injuries it is necessary to understand and control the risk, which is best done through the production of a Risk Assessment. We already know the hazard (the sharp object), the risk associated with it can range from cuts of various sorts and severity requiring first aid or medical attention, to needle stick injuries with potential infection risks from HIV and Hepatitis B and C. It is also important not to forget the risk of Tetanus infection associated with any cut or abrasion.

Awareness of the hazard and risks enables the production of appropriate effective controls such as:-

- identifying which workers are ‘at risk’ of receiving such injuries, to enable the prioritising of training

- Training all ‘at risk’ workers in the appropriate procedures for handling sharp objects, including appropriate methods of disposing of the sharps
- Provision of appropriate protective equipment to enable trained workers to handle sharp objects safely
- All workers at risk of receiving cuts whilst at work should be kept up to date with their Tetanus injections
- Workers who are at risk of being injured by sharp objects (such as needles) contaminated by blood infected with HIV or Hepatitis B/C, should have appropriate vaccinations/ inoculations.
- Workers who are injured by sharp objects (such as needles) contaminated by blood which may be infected with HIV or Hepatitis B/C, should receive appropriate medical attention. It is recommended to have a contingency plan for such events, firstly for the affected worker, so that they receive prompt medical attention and are provided appropriate counselling proportionate to the potential risks. Secondly for identifying as far as practically possible the source of the blood on the sharp object, so that the risk of HIV or Hepatitis B/C infection can be quantified/qualified.
- There should be a procedure for all workers to follow if they come into contact with another person’s body fluids, to limit potential infection from HIV or Hepatitis B/C.

All injuries and accidents incurred at work must be properly investigated, in compliance with local policies, procedures and details recorded in the appropriate accident book.

3.5 Confidentiality / Caldicott Code of Practise

Confidentiality

The following principles concerning confidentiality are to be observed:-

- A patient or client has the right to expect that information given in confidence will be used only for the purpose for which it was given and will not be released to others without their permission;
- You should recognise each patient’s or client’s right to have information about themselves kept secure and private;
- If it is appropriate to share information gained in the course of your work with other health or social work practitioners, you must make sure that as far as is reasonable, the information will be kept in strict professional confidence and be used only for the purpose for which the information was given;
- You are responsible for any decision that you make to release confidential information because you think that this is in the public’s best interest;
- If you choose to break confidentiality because you believe that this is in the public’s best interest, you must have considered the situation carefully enough to justify that decision;
- You should not deliberately break confidentiality other than in exceptional circumstances.

To trust another person with private and personal information about yourself is a significant matter. If the person to whom that information is given is a doctor, the patient or client has a right to believe that this information, given in confidence, will only be used for the purposes for which it was given and will not be released to others without their permission. The death of a patient or client does not give you the right to break confidentiality.

It is impractical to obtain the consent of the patient or client every time you need to share information with other health professionals or other staff involved in the health care of that patient or client. What is important is that the patient or client understands that some information may be made available to others involved in the delivery of their care. However, the patient or client must know who the

information will be shared with. Those who receive confidential information from a patient or client should advise them that the information will be given to the registered practitioner involved in their care. If necessary, this may also include other professionals in the health and social work fields. Registered practitioners must make sure that, where possible, the storage and movement of records within the health care setting does not put the confidentiality of patient information at risk.

3.5.1 Providing information

You always need to obtain explicit consent of a patient or client before you disclose specific information and you must make sure that the patient or client can make an informed response as to whether that information can be disclosed. Confidentiality should only be broken in exceptional circumstances and should only occur after careful consideration that you can justify your action. Disclosure of information occurs:

- with the consent of the patient or client;
- without the consent of the patient or client when the disclosure is required bylaw or by order of a court;
- without the consent of the patient or client when the disclosure is considered to be necessary in the public interest The public interest means the interests of an individual, or groups of individuals or of society as a whole, and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities that place others at serious risk. There is no statutory right to confidentiality but an aggrieved individual can sue through a civil court alleging that confidentiality was broken.

The situation that causes most problems is when your decision to withhold confidential information or give it to a third party has serious consequences. The information may have been given to you in the strictest confidence by a patient or client or by a colleague. You could also discover the information in the course of your work. You may sometimes be under pressure to release information but you must realise that you will be held accountable for this. In all cases where you deliberately release information in what you believe to be the best interests of the public, your decision must be justified. In some circumstances, such as accident and emergency admissions where the police are involved, it may be appropriate to involve senior staff if you do not feel that you are able to deal with the situation alone.

The above circumstances can be particularly stressful, especially if vulnerable groups are concerned, as releasing information may mean that a third party becomes involved, as in the case of children or those with learning disabilities. You should always discuss the matter fully with other professional colleagues and, if appropriate, consult the GMC/GDC or other appropriate membership organisation before making a decision to release information without a patient's permission. There will often be significant consequences, which you must consider carefully. Having made a decision, you should write down the reasons either in the appropriate record or in a special note that can be kept in a separate file. You then have written justification for the action that you took if this becomes necessary and you can also review the decision later in the light of future developments.

3.5.2 Ownership of and access to records

Organisations, who engage professional staff to make records, are the legal owners of these records, but that does not give anyone in that organisation the legal right of access to the information in those records. However, the patient or client can ask to see their records, whether they are written down or on computer. This is as a result of the Data Protection Act 1998, Access Modification (Health) Order 1987 and the Access to Health Records Act 1990.

3.5.3 Computer held records

As far as computer-held records are concerned, you must be satisfied that, as far as possible, the methods you use for recording information are secure. You must also find out which categories of staff have access to records to which they are expected to contribute important personal and confidential information. Local procedures must include ways of checking whether a record is authentic when there is no written signature. All records must clearly indicate the identity of the person who made that record. As more patient and client records are moved and linked between health care settings by computer, you will have to be vigilant in order to make sure that patient or client confidentiality is not broken. This means trying to ensure that the systems used are protected from inappropriate access within your direct area of practise, for example ensuring that personal access codes are kept secure.

The Computer Misuse Act 1990 came into force to secure computer programs and data against unauthorised access or alteration. Authorised users have permission to use certain programs and data. If those users go beyond what is permitted, this is a criminal offence. The Act makes provision for accidentally exceeding your permission and covers fraud, extortion and blackmail. Computerised data on individuals is regulated by the Data Protection Act.

3.5.4 Access to records for teaching, research and audit

If patients' or clients' records need to be used to help students gain the knowledge and skills that they require, the same principles of confidentiality apply to the information. This also applies to those engaged in research and audit. The manager of the health care setting is responsible for the security of the information contained in these records and for making sure that access to the

information is closely supervised. The person providing the training will be responsible for making sure that students understand the need for confidentiality and the need to follow local procedures for handling and storing records. The patient or client should know about the individual having access to their records and should be able to refuse that access if they wish.

3.5.5 Caldicott code of practise regarding data protection

You are responsible for ensuring that:-

- Information obtained directly or indirectly during the course of duty is not disclosed to any person, organisation or body who does not need to know or who does not have an authorised right of access to that information.

- Every use or transfer of personal information, including e-mail, must be clearly defined and justified. Do not use personal information unless it is absolutely necessary.
- Wherever appropriate, personal information will be anonymous, e.g. for statistical reporting.
- All information recorded must be, to the best of your knowledge, accurate and up-to-date and should not be amended or modified unless you are authorised to do so.
- You must not divulge your security password to any other person. If you suspect that your password is known then it is your responsibility to change it immediately and report the security breach to your department IT helpdesk.
- You must not use another person’s password to gain access to information, even if you are authorised to have access. Neither must you attempt to gain access to any part of the system or information that your access privileges do not allow.

3.6 Food Hygiene & Handling

You can pass on germs when you handle food. To prevent this you must:

- Always wash your hands
- Tell your boss if you are unwell

YOUR RESPONSIBILITY AS A FOOD HANDLER

Wash your hands thoroughly using warm water and soap:-

- after using the toilet, at home and at work
- before starting work, and after breaks
- after handling raw food
- after handling rubbish
- dry your hands after you have washed
-

Tell your boss if you:-

- have been sick (vomiting)
- have diarrhoea
- have infected (red, swollen pus-containing) sores or cuts
- feel unwell
- were ill while on holiday
- if anyone in your household is sick or has diarrhoea

If you have sickness or diarrhoea it may be caused by a germ; you must not handle food until you are better. Typhoid and paratyphoid fever are rare but serious illnesses. You must tell your boss if you think you have been in contact with either of these diseases.

YOUR CHECKLIST FOR GOOD HYGIENE PRACTISE Wash and dry your hands thoroughly after going to the toilet and before handling food.

- Do not handle food if you are suffering from diarrhoea and/or vomiting
- Tell your boss if you or anyone in your household is ill
- Tell your boss if you have infected cuts or sores Use bright coloured waterproof coverings for cuts and grazes
- Do not spit, smoke, eat or chew gum when you are handling food
- Make sure your work clothes are clean
- Keep your workplace, especially surfaces and utensils clean
- Tell your boss if you were ill while on holiday
- If you have to visit the doctor, remember to say you are a food handler

4. Health and Safety Policy

United Medicare place the health, safety and welfare of Agency workers and patients as an utmost priority and ensures so far as is reasonably practicable compliance with the relevant legislation. The main statutory provisions are as follows:-

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1999
- Manual Handling Operations Regulations 1992
- Control of Substances Hazardous to Health Regulations 1998
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
- Lifting Operations and Lifting Equipment Regulations 1998
- Provision and Use of Work Equipment Regulations 1998

The Agencies apply a strict set of criteria to ensure and verify that all doctors are properly qualified, experienced and competent to undertake tasks that may be assigned to them. Immunisation records are checked to verify the current status and that the necessary immunisations for practise are current and in line with the recommendations of the UK DoH publication ‘Immunisation Against Infectious Disease’.

Key elements of relevant health and safety guidance are provided below:

Section 4.1

The Health & Safety at Work Act 1974 (HASAWA)

INTRODUCTION Health and Safety at Work legislation forms part of criminal law and therefore must be obeyed. Breaches of legislation can result in fines or imprisonment, which may be imposed on companies, management or individuals.

The framework of this legislation is based on Acts of Parliament, which usually impose broad general duties. Regulations are then made, under the relevant Acts, to cover detailed health and safety requirements which must be observed.

The majority of recent Regulations were made under the Health & Safety at Work Act 1974. However, some earlier legislation, such as the Factories Act 1961, the Offices, Shops and Railway Premises Act 1963 and the Fire Precautions Act 1971 are also relevant.

HEALTH AND SAFETY AT WORK ACT (HASAWA)
It is important that the following main provisions of HASAWA are fully appreciated:

1. The Act applies to all people “at work” (with a few minor exceptions such as domestic servants)
2. There is a duty, so far as is reasonably practicable, to ensure the health, safety and welfare of workers. The duty includes the provision and maintenance of safe systems of work, equipment, the welfare arrangements, safe storing, handling and transporting of goods and materials.
3. Clients (except those with less than five employees) must prepare and bring to the notice of all workers a written statement of their general policy regarding the health and safety at work of workers. The general statement of intent must be revised as often as necessary, and must also set out the organisation and arrangements for the implementation of the policy.
4. The Act provides for regulations giving recognised trade unions power to appoint Safety Representatives from amongst the workers. If requested by 2 Safety Representatives, employers must set up a safety committee.
5. Clients have a duty, so far as is reasonably practicable, to carry out their work in such a way that persons not in their employment, e.g. the general public are not at risk.
6. Persons having control of premises which are used as a place of work by persons who are not their employees have a duty to ensure (so far as is reasonably practicable) that safe access and egress is provided and that any equipment or substances in the premises are safe and without risks to health.
7. Persons having control of premises in which prescribed operations take place must ensure that harmful emissions into the atmosphere are prevented.
8. Each worker has a duty to co-operate and to take reasonable care for the health and safety of himself or herself and of others who may be affected by his or her activities at work.
9. It is an offence for anyone to interfere with or misuse anything provided in the interests of health and safety.
10. Clients cannot charge workers for any measures which they are required to provide under legal requirements in the interests of health and safety.

ENFORCEMENT Health and Safety legislation is enforced by inspectors appointed either by the Health and Safety Executive (HSE) or by local authorities. Inspectors have powers to enter premises at any time if they have a reason to suspect a dangerous situation. They may carry out whatever investigations they consider necessary.

Section 4.2

The Workplace (Health, Safety and Welfare) Regulations 1992

INTRODUCTION Clients have a general duty under section 2 of the Health and Safety at Work Act 1974 to ensure, so far as is reasonably practicable, the health, safety and welfare of workers. There is also a duty under section 4 of the Act towards people who are not workers, but who use their premises.

The Workplace (Health, Safety and Welfare) Regulations 1992 expand on these duties and are intended to protect the health and safety of everyone in the workplace and to ensure that adequate welfare facilities are provided for people at work. For example, that sanitary conveniences are sufficient and suitable, adequately ventilated and lit and kept in a clean and orderly condition.

In addition to welfare facilities, the regulations cover aspects of safety in the workplace, equipment and systems. Finally, the Regulations cover health in the workplace through such subjects as ventilation, temperature and cleanliness. The areas covered by the Regulations are listed below:

1) HEALTH
   Ventilation, temperature, lighting, cleanliness, waste materials, room dimensions and space, work stations and seating.
2) SAFETY
   Maintenance of workplace and equipment, devices and systems, conditions of floor, protection against falls or falling objects, marking of transparent surfaces, design of windows and skylights, doors and gates, safety of escalators and moving walkways.
3) WELFARE
   Sanitary conveniences and washing facilities, drinking water, accommodation for clothing and changing facilities, facilities for rest and to eat meals. It should be remembered that section 8 of the Health and Safety at Work Act 1974 places a duty on the worker not to interfere or misuse any facility or equipment which has been provided for their health, safety or welfare.
4) SMOKING IN THE WORKPLACE
   The Regulations also place a duty on the employer to ensure that workers who do not smoke are not subjected to passive smoking. Smoking is allowed only in designated areas.

Section 4.3

The Management of Health and Safety at Work Regulations 1999

INTRODUCTION The duties imposed under The Management of Health and Safety at Work Regulations in most cases are absolute duties and are of a wide ranging and general nature.

RISK ASSESSMENT Clients are required to make a suitable and sufficient assessment of risks to the health and safety of workers and also to non-employees as a consequence of their work activities, e.g. members of the general public.

AN ASSESSMENT Correctly identifies any significant risk that is reasonably foreseeable. Enables the assessor to decide what action needs to be taken and what the priorities should be, is appropriate for the type of activity and reflects what the client/worker may be expected to know about the risks associated with their undertakings.

An assessment need not be recorded if the task:
1.Could easily be repeated and explained at any time because it is simple and obvious.
2.The operation is straight-forward, of low risk, is going to last a short time and the time taken to record it would be disproportionate to the activity itself.

The time and effort put into an assessment should be proportional to the degree of risk and trivial risks can be ignored. Where an assessment has already been carried out under other regulations i.e. COSHH regulations, then the assessment does not have to be repeated. However, any assessment needs to be reviewed and updated where necessary.

When there are five or more employees the assessment must be recorded and should include the significant hazards found, the control measures in place, who might be exposed together with details of any group of employees or others who may be especially at risk. The assessment may identify where health surveillance is appropriate. However, measures may already be in place under other specific regulations i.e. COSHH.
Health surveillance is intended to detect adverse conditions as early as possible to prevent further harm and if necessary should continue for the term of the workers placement and should only be carried out by a responsible and competent qualified person.
If it is appropriate to carry out health surveillance, then individual health records must be kept.

Under the regulations every client must appoint one or more competent persons to assist in meeting the requirements of Health and Safety legislation. Where there is no competent person within the organisation the worker must be given, or have access to, such information which is necessary to enable them to assist the client in meeting safety legislations, a record of which should be maintained.

The client must have suitable emergency procedures to be followed in the case of serious or imminent danger and those workers who are likely to be exposed must be informed of the nature of the hazards, the control measures in place, the procedures to be followed and the identity of the competent person(s). Procedures must also allow for those who may be exposed to stop work, reach a place of safety and prevent them from returning while such a condition exists.

Section 4.4

The Control of Substances Hazardous to Health Regulations 1999 (COSHH)

INTRODUCTION As a result of their work activities, people may encounter a wide range of substances capable of damaging their health. The Control of Substances Hazardous to Health Regulations 1999 (COSHH) lay down essential requirements for controlling hazardous substances and for protecting people who may be exposed to them. They cover virtually all substances hazardous to health.

What is a substance hazardous to health?

1.Substances labelled as dangerous, that is:
  a. Very Toxic
  b. Toxic
  c. Harmful
  d. Irritant
  e. Corrosive

2. Substances with maximum exposure limits (MEL) or occupational exposure standards (OES)
3. Substantial concentrations of dust
4. Micro organisms which can cause illness (including clinical waste)
5. Any substance not included in the first four categories but which can have a similar risk to health.

THE COSHH REGULATIONS

The regulations require the client to carry out the following procedures:

- Carry out a written assessment about the risk to health arising from work and what precautions are necessary.
- Introduce appropriate measures to prevent or control the risk.
- Ensure that control measures are used and that equipment is properly maintained and procedures observed.
- Where necessary, monitor the exposure of workers and carry out appropriate health surveillance.
- Inform, instruct and train workers about the risks and the precautions to be taken.

Workers have a duty to ensure that any procedures under the regulations are adhered to and to advise management of any new hazards which they may become aware of. It is important that persons carrying out first aid duties are aware of any treatments and emergency procedures related to incidents which are covered by these regulations.

Section 4.5

The Personal Protective Equipment at Work Regulations 1992

Personal Protective Equipment (PPE) means all equipment or clothing which is intended to be worn or held by a worker and which affords protection against one or more risks to health and safety.

PREVENTION OF INJURY TO SKIN, EYES, HANDS AND LIMBS The use of Personal Protective Equipment (PPE) to protect people is the last line of defence and other measures to control the hazards and risks involved should be considered first. All too often there is not enough effort put into reducing or eliminating hazards and too much reliance placed on the use of Personal Protection to prevent the hazards causing injury or ill health.

Where protective clothing is not a practicable solution to a hazard then barrier creams may be used together with a hygiene routine before and after work periods.
Suitability:
Ensure that the PPE is suitable for the work being undertaken and will protect against a particular hazard.
Fit: A good fit is required to ensure full protection on the part of the body being identified as “at risk”.
Period of Use: It is necessary for the equipment to be worn whenever the hazard is present

Training:
Users must know the limitations of the equipment, the correct use, how to achieve a good fit and its inspection and storage. Any loss or defects of PPE must be reported immediately to the appropriate person. It is advisable to keep records of training which have been given to the wearers of PPE.
Maintenance:
All PPE must be regularly cleaned, checked and maintained in serviceable condition. Appropriate accommodation should be provided to PPE when it is not being used.
Workers must make full and proper use of PPE which is provided for them. Where the use of personal protection is a legal requirement, it is an offence for a client to charge a worker for its provision.

Section 4.6

The Provision & Use of Work Equipment Regulations 1998

INTRODUCTION Many workplace tasks involve the use of machines and clinical equipment which can make the job easier, quicker and more efficient. However, if precautions are not taken, work equipment may damage a person's health or cause injury.

The regulations were introduced to ensure the provision of safe working equipment and its use. The client has a duty to provide and maintain suitable and safe work equipment and to ensure that the users of the work equipment receive adequate information, written instructions where necessary and suitable health and safety training, including the risks involved in using the equipment and the precautions necessary.

Where there is a specific risk the use and maintenance of the equipment is restricted to designated persons who have received adequate training in the operations they have been asked to carry out.

Most equipment will have safety devices which are designed to make the job safer. Do not tamper with them or attempt to override them otherwise you may put your safety and the safety of others at risk. Clients must also ensure that work equipment, where appropriate, is provided with clearly identifiable and readily accessible means of isolating it from its energy source and have appropriate markings for the purpose of health and safety.

OTHER SAFETY FACTORS

- Lighting: Suitable and sufficient lighting must be provided which takes into account the operation to be carried out. Personal Protective Equipment: Make sure that you are using or wearing any necessary protective equipment.
- Faults: Report any faults or suspected faults immediately to your supervisor or manager.
- Clothing: Clothes should be close fitting and appropriate shoes should be worn.
- Jewellery in the form of rings, watches, bracelets or chains should not be worn.
- Colleagues: Do not distract people who are using work equipment and in particular do not engage in any horseplay as this is putting your health and that of others at risk.

No matter how safe working equipment is, it is only as safe as the person who is using it. Make sure you have been properly trained in its use and follow safe systems of work.

Section 4.7

Fire - Hazards and Precautions

INTRODUCTION The Fire Precautions Act 1971 The Fire Precautions Act (Work-place)(Amendment) Regulations 1999

Fire is a hazard which can be encountered in almost any work situation. It can result in death or injury. In the UK, fires account for about one thousand deaths and over six thousand serious injuries every year. Loss or damage to property also results and the annual cost is staggering.

This Act imposes duties on the occupiers of most industrial, commercial or public buildings to meet specified requirements and to obtain a fire certificate for the building. There are certain exemptions to this requirement which can only be granted by the fire authority. Premises not required to have a fire certificate must comply with the provisions of the Fire Precautions (Work-place)(Amendment) Regulations 1999 with regard to:

- Means of escape
- Fire detection and warning systems
- Fire fighting equipment

COMMON CAUSES OF FIRE In order to prevent fires, it is important that everyone involved should be aware of potential causes, so as to be able to identify and take action on potential hazards.

Common causes of fire are:

- Malicious or deliberate ignition, often by vandals, persons breaking into and stealing from premises or by children playing with fire;
- Carelessness in smoking, with lighted matches or other naked flames;
- Faulty or misused heating equipment;
- Uncontrolled rubbish burning;

SMOKING

This must be prohibited in areas where a fire danger exists. Notices indicating that smoking is not permitted should be prominently displayed where appropriate. Smokers should however, be given the opportunity to smoke but only in areas and at times when it is not hazardous. Workers must be aware of and adhere to the Client's policy on smoking in the workplace.

COMBUSTION

Three elements must be present in order for a fire to start and spread and these are known as the 'fire triangle'.

OXYGEN HEAT FUEL.

If any one of the three are removed, a fire cannot start or cannot continue to burn.

OXYGEN: Usually comes from the air.
HEAT: Is the ignition source and may be, for example, from a match or other flame, the sun, a spark from a metal sole plate on a shoe etc.
FUEL: Is the material or substance which catches fire and burns.

SPREAD OF FIRE As long as all three elements of the fire triangle are present, the fire will continue to spread. Fire travels by the following four methods:

1. Conduction: Heat travels along a conductor, such as a metal bar, and can ignite material at the other end.
2. Convection: The air above the fire is heated with cold air being drawn in and heated in turn. The hot air can ignite fuel some distance from the original fire.
3. Radiation: Heat travels through a vacuum.
4. Direct Contact: items having a direct contact with an ignition source.

FIRE PREVENTION AND EXTINCTION Fire cannot start if all three elements of the fire triangle are not present. Similarly, fire can be put out by removing any one of the three, thus by:

- Cooling - removal of heat
- Smothering - removal of oxygen
- Starvation - removal of fuel

PREVENTION CONTROLS Heat: Some basic precautions may be taken to prevent enough heat building up to ignite a fire such as:

- Insulating pipes
- Maintenance of equipment
- Control of smoking and no-smoking zones
- Earthing and insulating electrical appliances
- Cooling or insulating hot surfaces

Oxygen: Normally this can be difficult to control since correct ventilation is required in the workplace. However, the ratio of fuel to oxygen is important since fire cannot burn without the correct amounts of each.

Fuel: It is common sense not to allow flammable materials to build up and therefore be a fire hazard, so a basic precaution is good housekeeping. Other sources of fuel which should be controlled might include: sprays, waste, spillage and excess materials.

FIRE PROCEDURE / FIRE DRILLS All premises should have procedures to be carried out in the event of a fire, and everyone should be trained in how to follow them. Regular practises should take place to familiarise people with the system and there should also be signs posted in every room telling occupants what the fire drill is.
The drill should include:

1. what to do if a fire is discovered

2. the action to take on hearing the fire alarm
3. the assembly point on evacuation

N.B. Records of fire drills should be kept and should include the length of time taken to evacuate the building.

FIRE ESCAPES / EXITS Fire exits should be clearly identified with the correct sign (white writing on a green background). They must be unlocked at all times when the building is occupied and must be kept clear and unobstructed. Fire exits should have only one means of opening, usually a crash bar and must open outwards.

FIRE EXTINGUISHERS It is important to use the correct extinguisher for the class of fire. These are now colour coded as follows: all extinguishers are red with the relevant colour coding shown by a label on the extinguisher.

RED - Water - Fires involving solids BLUE - Dry powder - Petrol / Oil BLACK - CO2 - Electrical equipment CREAM - Foam - Burning liquids e.g. chip pans

Legislation states that these should be wall mounted and should be available at all times. They should be kept clear and access to them unobstructed. The correct type should be installed according to the type of work carried out in the location. All fire extinguishers must be inspected at least once every 12 months by a competent person, usually an employee of the manufacturer and records kept of the date of inspection. Extinguishers must also be inspected and refilled if they are used at any time.

FIRE ALARMS A fire alarm can be any recognisable and distinguishable noise which can be clearly heard from any part of the workplace. Examples may include -electrically operated bells, manually operated ringing etc. Fire alarms must be regularly tested and records of testing must be kept. Everyone must be trained to recognise the fire alarm and to react accordingly by following the fire drill and evacuation procedure.

Section 4.8

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

INTRODUCTION The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) require certain injuries incurred at work, and some dangerous occurrences, to be reported to the appropriate enforcing authority. These Regulations also require the reporting of certain diseases which are related to specified types of work. In addition, under the Social Security (Claims & Payments) Regulations 1979, details of all injuries, however minor, must be recorded in an accident book (Form B1 510). The following paragraphs give guidance on this legislation.

INJURIES TO BE REPORTED A report must be made on any injury arising out of, or in connection with work activities (including as a result of physical violence) if those injuries result in any of the following:

1. Death
2. A specified major injury or condition consisting of:

a. Fracture other than to fingers, thumbs or toes
b. Amputation, dislocation of the shoulder, hip, knee or spine.
c. Loss of sight temporary or permanent, chemical or hot metal burn to the eye or penetrating injury to the eye.
d. Injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours.
e. Unconsciousness caused by asphyxia or exposure to a harmful substance or biological agent.
f. Acute illness requiring medical treatment, or causing loss of consciousness due to absorption of any substance by inhalation, ingestion or through the skin.
g. Acute illness requiring medical attention, where it is believed to be caused by exposure to a biological agent or its toxins or infected material.
h. Any other injury leading to hypothermia, heat reduced illness or unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours.
i. Any instances of either verbal or physical abuse are reportable.

Injuries to members of the public as well as to workers are included in this requirement.

- Incapacity for work Any injury which results in an absence from work for more than 3 consecutive days.

- Subsequent death where an employee suffers an injury which results in death within one year, a further report must be made.

DANGEROUS OCCURRENCES TO BE REPORTED
Amongst the dangerous occurrences which must be reported,
the following may be relevant:

- The collapse, overturning or failure of load bearing parts of lifts & lifting equipment.
- Electrical short circuit or overload causing a fire or explosion which results in a stoppage of normal work for more than 24 hours and which might have caused death or major injury.

DISEASES TO BE REPORTED A disease needs to be reported only when a written diagnosis of a scheduled disease is received from a doctor and where the person suffering currently has a work activity in which that disease is a known risk.

METHOD OF REPORTING All the above must be reported by telephone, online, or in writing to:

Incident Contact Centre, Caerphilly Business Park, Caerphilly, CF83 3GG

Tel: 0845 3009923, www.riddor.gov.uk

ACCIDENT BOOKS All injuries incurred at work are to be properly investigated, complying with the client's laid down procedures and details recorded in the appropriate accident book.

Section 4.9

Hazards and Accident Prevention

INTRODUCTION The primary purpose of Health and Safety Legislation is prevention. Its aim is to create workplace standards for the reduction of hazards. There are 3 main objectives in accident prevention:

- MORAL: It is unacceptable to put the health and safety of anyone inside or outside the workplace at risk, for profit or otherwise.
- LEGAL: Failure to comply carries the threat of prosecution or civil action because a reasonable standard of care was not provided
- ECONOMIC: Time loss to the employer and the employee

e.g. increase in insurance premiums, delays, decreased outputs etc. Accidents do not just happen - they are caused! All accidents and near misses in the workplace should be reported to the appropriate person.

DEFINITIONS An accident is an unplanned event which causes death, injury or damage to property. A near miss is an unplanned event which does not cause death, injury or damage to property.

CAUSES OF ACCIDENT The main causes of accidents are threefold:
- Unsafe acts
- Unsafe conditions
- Inadequate training

UNSAFE CONDITIONS
- Badly stored dangerous material
- Bad light, heat, ventilation
- Faulty machinery
- Broken, damaged tools and equipment
- Overcrowding
- Poor maintenance
- Noise
- Slippery, uneven floors
- Untidy work area

Section 4.10

Principles of Accident Prevention

INTRODUCTION In accident prevention we must be proactive and take action before accidents occur. It is vital that all workers are aware of their surroundings and immediately report any hazards that they may discover.

LEGISLATION The Management of Health & Safety at Work Regulations 1999 require every client to carry out risk assessments of all their activities. This will enable them to take appropriate steps to eliminate or reduce the risk of accidents and injuries. There are other regulations which are more specific on the assessments which have to be carried out e.g. COSHH, Manual Handling, Display Screen Equipment.
RISK ASSESSMENT Assessments give a clear picture of what could go wrong and how serious an accident would be, and

generally apply the following principles:

- Identify the hazard and where practicable, remove the hazard or replace it with something less dangerous.
- Assess the risks which could include need for the use of Personal Protective Equipment (PPE)

Training is required for all workers and should emphasise the importance of using the control measures which have been introduced. Training must outline the nature of hazards and risks together with the precautions individuals need to take. Relevant warning notices and instructional posters should be prominently displayed. The assessment needs to be reviewed and recorded every time there are changes in the workplace e.g. new equipment, new location etc. Legislation usually requires that the assessments are in writing.

THE ADOPTION OF CONTROL MEASURES Following a detailed risk assessment of a given activity an employer can adopt suitable control measures. Examples of control measures would include:-Supervision, Relevant Signs, Safe Systems of Work, Training, Personal Protective Equipment (PPE), Welfare Facilities, Good Housekeeping.

Specific areas of work would include the above plus some or all of the following examples:

FIRE HAZARDOUS SUBSTANCES Procedures Inform employees Alarms Substitution
Ventilation CHEMICAL Reduced time Storage Disposal Inspection Emergency
procedure Maintenance
Monitor EQUIPMENT Records kept Usage Medical surveillance Maintenance Layout MANUAL HANDLING
Assessment of task

Section 4.11

Moving and Handling

Moving and Handling error is the single most common cause of harm to people working in healthcare. As such, we take the matter very seriously and urge all our agency workers to ensure that they understand and apply the following policy. We adopt a safe handling policy aimed at reducing to a minimum the likelihood of a person being harmed through handling. We do not expect or advise that an agency worker should bulk bear a person's weight.

To achieve safe handling the following should be taken into account:
• The tasks themselves
• The individuals involved
• The "loads"
• The environment

Handling is not just about lifting, it also includes the following: bending, carrying, moving, pushing, pulling, putting down, posture, stooping, stretching, twisting and turning.

We actively encourage the people that we care for to be as independent as can be reasonably achieved; which includes independence with their mobility. This means ensuring that they have the appropriate aids and encouraging their use to allow those in our care to help themselves as much as possible. The aim being to promote independence and to reduce the handling risk.

Where practical and feasible, suitable and relevant handling aids should be used to reduce to a minimum the likelihood of a person being harmed through handling. All aids should be used in the proper manner and as per training provided.

Where the circumstances dictate, anyone involved in handling those in our care adopt a team handling approach following a handling assessment being carried out.

No one should partake of/or assist in any handling task or use any handling equipment they have not been formally trained to do and/or use.

No one should encourage a person to be involved in a handling task, or use handling equipment which they have not been formally trained to do and/or use.
A handling assessment is essential to our policy of preventing harm through handling.

Tasks:

A handling assessment intends to make handling tasks safer which could include the following practical steps:

- Work surfaces at heights providing for good posture
- Suitable shelving
- Tidiness so that space is available for the task
- Varying work to reduce muscle strain and fatigue
- Furniture that allows for ease of moving and handling

Individuals:

Practical steps in the handling assessment that make handling safer for individuals could include:

- working together and asking for help
- accepting your limitations and not exceeding your capabilities
- thinking before doing and not rushing
- applying training and handling techniques
- applying training in using equipment properly
- checking equipment before you use it
- not wearing jewellery, watches, rings etc. that may harm

Loads:

Handling may involve people and objects, handling assessments identify the potential problems and how we manage them.

Handling assessments as part of a care plan, record matters that affect the handling of service users. An up to date assessment should be kept in the service users care file. This must be referred to prior to any moving or handling being undertaken.

Practical steps that make handling service users safer include:

- Encouraging those in our care to help themselves
- Maintaining and staying familiar with the current care plan
- Awareness of the client's health, behaviour, mood
- Knowing their history - medical, cognitive, falls etc.

Environment:

Handling assessments identify environmental factors which could pose handling risks. In order to manage them the following steps should be taken:

- Good housekeeping, tidiness
- Keeping hallways, passages, work areas etc. obstruction free
- Good lighting
- wearing suitable footwear
- Using steps instead of reaching up
- Cleaning up spillages immediately

Moving and Handling Training

You must not undertake any handling activity or use any handling equipment until you have been trained how to do so safely. We provide moving and handling training related to our service user group and on equipment used to implement those safe techniques. This training will need to be updated on an annual basis in line with current best handling practise.

Handling in a manner contrary to the way you have been trained puts yourself and others at risk will be unacceptable.

Lifting and Handling Equipment

Lifting equipment and handling aids come in various shapes, sizes and styles from a passenger lift to a bath seat. Anything that lifts or assists in moving someone, and was designed for that purpose constitutes lifting and handling equipment.

You are required to check moving and handling assessments prior to moving someone so that you know which equipment or aids are suitable for the task you intend to undertake. It is important that you check for any changes that may have been made to the assessment since you last cared for the client.

Before using handling equipment you should check that it is safe and not damaged. If it is rechargeable, check that it is fully charged and remember to recharge it after use. If you need assistance in using the equipment then wait until you have assistance. Check that the equipment is right for the job.

It is your responsibility to check that every item used for lifting is tested and maintained according to the manufacturer's and

supplier's guidelines and that records of such are kept. Agency workers should not use equipment that is considered to be in an unsafe condition or where evidence of required inspections is unavailable. In all these circumstances a report should be made to the client.

United Medicare

5.Standards of Conduct

United Medicare expect all doctors to act in a professional and appropriate manner at all times. We constantly monitor and review the level of service that we provide for our clients. Should there be a significant decline in the level of service from Agency workers the Agency may consider reviewing the arrangements. This may result in disciplinary action.

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United Medicare require all Agency workers to comply with the following Standards of Conduct:

- Roles & Responsibilities – Agency workers accepting placement with a client shall undertake any tasks that might reasonably be required by the client within the scope of the definition or description of the role being filled. It is your responsibility to ensure that you know what the pay rate will be when you accept the shift.
- Timekeeping / Absenteeism – Agency workers are required to be punctual and to work the hours required by the client within the scope of the definition or description of the role being filled. Any inability to meet timekeeping requirements or absenteeism should be reported to the Agency.
- Working when 'on leave of absence' – Doctors will not make themselves available for Agency work when on paid leave of absence (due to sickness etc) from another employer. 'Employed' Doctors will only seek agency work out of normal working hours or during annual leave and should be aware not to violate contractual terms and conditions issued by their primary employer.
- Record Keeping Requirements - Agency workers accepting placement with a client shall adhere to the client's method and standard of record keeping insofar that these should conform to published professional minimum guidelines.
- Training & Development – Agency workers should ensure currency of statutory training requirements and up-to-date knowledge of best practise.
- Person and Property of Patients and Clients – Agency workers are required to recognise the dignity of each patient and client, to respect their wishes/directions and avoid any abuse of privileged access to their person or property.
- Emergency Procedures - As an agency doctor you are responsible for ensuring that you are aware of the emergency procedures of the ward, unit, surgery etc. at the start of each assignment. You must familiarise yourself with fire procedures, exit and precautions in each establishment. It is your responsibility as an Agency Doctor to familiarise yourself with CPR procedures, and locate relevant contacts, telephone numbers and procedures for use in emergencies.
- Medicines - Agency workers will only administer, assist or support the administration of medicines within their competence and will avoid any abuse of privileged access to medications or other drugs.
- Accidents and Incidents – Agency workers shall comply with all procedures locally in place insofar that such procedures should conform to published professional minimum guidelines. Any accidents or incidents should also be reported to the Agency.
- Complaints – In the event of a complaint, Agency workers will inform clients of the Agency's complaints procedure and not enter into further discussion or dialogue with the Client.
- Sleeping on Duty – Unless permitted by the specific shift; sleeping on duty, at night or day is prohibited by the agency. Any agency worker reported to be asleep on duty will be investigated and appropriate action will be taken.
- Confidentiality – Agency workers are required to protect information concerning patients or clients obtained in the course of professional practise. Breaches of confidentiality are regarded very seriously by the agency.
- Statements to the Media – Agency workers, shall under no circumstances, enter into any communication, provide or make any statements to the media relating to patients, clients, the Agency or any other matter in connection with their placement or registration with the Agency without the express permission of the Agency.
- Indemnity Insurance – Agency workers are required to ensure adequate professional indemnity insurance.
- Gifts – Agency workers shall not accept gifts, favour or hospitality from patients or clients, nor benefit from any legacy or will.
- Equal Opportunities – Agency workers will not take part in, or condone any discriminatory act, attitude or conduct with the public, patients, clients, Agency workers or our employees.
- Timesheets – Agency workers will comply with documented requirements in respect of timesheets which will be valid, accurate and authorised.
- Dress & Appearance – Agency workers shall maintain appropriate standards of dress and appearance as directed by the client within the scope of the definition or description of the role being filled.
- Identity Badges – Agency workers should at all times wear ID badges as provided by the Agency, to be clearly visible and prominently displayed.
- Smoking – We discourage smoking whilst on duty. However we recognise that people may want to smoke, and if so this must be done in a designated smoking area.
- Drug, Alcohol and Substance Abuse – Abuse of drugs and alcohol can interfere with the life of the worker, which can impair the quality of their work and threaten the standards of care we strive to provide. Therefore from health, moral, legal and commercial points of view we take the abuse of drugs and alcohol by workers and those in our care very seriously. We draw a distinction between the taking of drugs and alcohol at work as different from outside of work but consider the consequences of their damaging care standards equally. If you possess, supply or use drugs illegally on our premises and/or whilst on duty we have a legal duty to notify the police and will do so. You will be suspended pending disciplinary

procedure that may lead to your dismissal.

All doctors must notify United Medicare in writing if they are involved in any court case, police investigation, disciplinary or dismissal proceedings at any time. This applies whether the proceedings arise through connection with the Agency or elsewhere. United Medicare endorse and support the Codes of Professional Conduct as issued by the General Medical Council and General Dental Council and require Agency workers to comply with the principles of these codes, which are reproduced in this handbook.

The Agencies operate clearly defined complaints procedures, documented in this handbook, requiring all types of complaints to be recorded and investigated. Violations of the Agencies' standards may result in disciplinary action with any contravention of the professional codes of conduct or instances of professional malpractise being reported to the relevant professional regulatory bodies and/or the police.

6. General Medical Council - Guidance on Good Practise

6.1 The Duties of a Doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and wellbeing. To justify that trust, we as a profession have a duty to maintain a good standard of practise and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- be honest and trustworthy;
- respect and protect confidential information;
- make sure that your personal beliefs do not prejudice your patients' care;
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor;
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

6.2 Good Medical Practise

All patients are entitled to good standards of practise and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.

6.3 Good clinical care

Providing a good standard of practise and care

Good clinical care must include:

- an adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination;
- providing or arranging investigations or treatment where necessary;
- taking suitable and prompt action when necessary;
- referring the patient to another practitioner, when indicated.

In providing care you must:

- recognise and work within the limits of your professional competence;
- be willing to consult colleagues;
- be competent when making diagnoses and when giving or arranging treatment;
- keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;
- keep colleagues well informed when sharing the care of patients;
- provide the necessary care to alleviate pain and distress whether or not curative treatment is possible;
- prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs. You must not give or recommend to patients any investigation or treatment which you know is not in their best interests, nor withhold appropriate treatments or referral;
- report adverse drug reactions as required under the relevant reporting scheme, and co-operate with requests for information from organisations monitoring the public health ;
- make efficient use of the resources available to you.

If you have good reason to think that your ability to treat patients safely is seriously compromised by inadequate premises, equipment, or other resources, you should put the matter right, if that is possible. In all other cases you should draw the matter to the attention of your Trust, or other employing or contracting body. You should record your concerns and the steps you have taken to try to resolve them.

6.4Decisions about access to medical care

1) The investigations or treatment you provide or arrange must be based on your clinical judgement of patients' needs and the likely effectiveness of the treatment. You must not allow your views about patients' lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or social or economic status, to prejudice the treatment you provide or arrange.

2) You must not refuse or delay treatment because you believe that patients' actions have contributed to their condition.

3) You must try to give priority to the investigation and treatment of patients on the basis of clinical need

4) You must not refuse to treat a patient because you may be putting yourself at risk. If patients pose a risk to your health or safety you should take reasonable steps to protect yourself before investigating their condition or providing treatment.

6.5 Treatment in emergencies

In an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide.

6.6 Maintaining good medical practise

Keeping up to date

- You must keep your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which maintain and further develop your competence and performance.
- Some parts of medical practise are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practise.

6.7 Maintaining your performance

You must work with colleagues to monitor and maintain the quality of the care you provide and maintain a high awareness of patient safety. In particular, you must:

- take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practise, for example by undertaking further training;
- respond constructively to the outcome of reviews, assessments or appraisals of your performance;
- take part in confidential enquiries and adverse event recognition and reporting to help reduce risk to patients;

6.8 Teaching and training, appraising and assessing Making assessments and providing references

- You must be honest and objective when appraising or assessing the performance of any doctor including those you have supervised or trained. Patients may be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practise.
- You must provide only honest and justifiable comments when giving references for, or writing reports about, colleagues. When providing references you must include all relevant information which has any bearing on your colleague's competence, performance, and conduct.

6.9 Teaching and training

- You should be willing to contribute to the education of students or colleagues.
- If you have responsibilities for teaching you must develop the skills, attitudes and the practise of a competent teacher. You must also make sure that students and junior colleagues are properly supervised.

6.10 Relationships with patients

Obtaining consent

You must respect the right of patients to be fully involved in decisions about their care. Wherever possible, you must be satisfied, before you provide treatment or investigate a patient's condition, that the patient has understood what is proposed and why, any significant risks or side effects associated with it, and has given consent. You must follow the guidance in "Seeking Patients'

Consent: The Ethical Considerations".

6.11 Respecting confidentiality

You must treat information about patients as confidential. If in exceptional circumstances there are good reasons why you should pass on information without a patient's consent, or against a patient's wishes, you must follow our guidance on "Confidentiality: Protecting and Providing Information" and be prepared to justify your decision to the patient, if appropriate, and to the GMC and the courts, if called on to do so.

6.11.1 Maintaining trust

Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- be polite, considerate and truthful;
- respect patients' privacy and dignity;
- respect the right of patients to decline to take part in teaching or research and ensure that their refusal does not adversely affect your relationship with them;
- respect the right of patients to a second opinion;
- be readily accessible to patients and colleagues when you are on duty.

You must not allow your personal relationships to undermine the trust which patients place in you. In particular, you must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them.

6.11.2 Good Communication

1. Good communication between patients and doctors is essential to effective care and relationships of trust. Good communication involves:

- listening to patients and respecting their views and beliefs;
- giving patients the information they ask for or need about their condition, its treatment and prognosis, in a way they can understand, including, for any drug you prescribe, information about any serious side effects and, where appropriate, dosage ;
- sharing information with patients' partners, close relatives or carers, if they ask you to do so by, having first obtained the patient's consent. When patients cannot give consent, you should share the information which those close to the patient need or want to know, except where you have reason to believe that the patient would object if able to do so.

2. If a patient under your care has suffered harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You must explain fully and promptly to the patient what has happened and the likely long- and short-term effects. When appropriate you should offer an apology. If the patient is an adult who lacks capacity, the explanation should be given to a person with responsibility for the patient, or the patient's partner, close relative or a friend who has been involved in the care of the patient, unless you have reason to believe the patient would have objected to the disclosure. In the case of children the situation should be explained honestly to those with parental responsibility and to the child, if the child has the maturity to understand the issues.

3. If a child under your care has died you must explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility. Similarly, if an adult patient has died, you should provide this information to the patient's partner, close relative or a friend who has been involved in the care of the patient, unless you have reason to believe that the patient would have objected.

6.11.3 Ending professional relationships with patients

1. Rarely, there may be circumstances, for example where a patient has been violent to you or a colleague, has stolen from the premises, or has persistently acted inconsiderately or unreasonably, in which the trust between you and the patient has been broken and you find it necessary to end a professional relationship with a patient. In such circumstances, you must be satisfied your decision is fair and does not contravene the guidance in paragraph 5; you must be prepared to justify your decision if called on to do so. You should not end relationships with patients solely because they have made a complaint about you or your team or because of the financial impact of their care or treatment on your practice.
2. You should inform the patient, orally or in writing, why you have decided to end the professional relationship.
3. You must also take steps to ensure that arrangements are made quickly for the continuing care of the patient, and hand over records to the patient's new doctors as soon as possible.

6.11.4 Dealing with problems in professional practice - Conduct or performance of colleagues

You must protect patients from risk of harm posed by another doctor's, or other health care professional's, conduct, performance or health, including problems arising from alcohol or other substance abuse. The safety of patients must come first at all times. Where there are serious concerns about a colleague's performance, health or conduct, it is essential that steps are taken without delay to investigate the concerns to establish whether they are well-founded, and to protect patients.

If you have grounds to believe that a doctor or other healthcare professional may be putting patients at risk, you must give an honest explanation of your concerns to an appropriate person from the employing authority, such as the medical director, nursing director or chief executive, or the director of public health, or an officer of your local medical committee, following any procedures set by the employer. If there are no appropriate local systems, or local systems cannot resolve the problem, and you remain concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation or the GMC for advice.

If you have management responsibilities you should ensure that mechanisms are in place through which colleagues can raise concerns about risks to patients. Further guidance is provided in "Management in Health Care: The Role of Doctors"

6.11.5 Complaints and formal inquiries

1. Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response. This will include an explanation of what has happened, and where appropriate, an apology. You must not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient.
2. You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure which applies to your work. You must give, to those who are entitled to ask for it, any relevant information in connection with an investigation into your own, or another health care professional's, conduct, performance or health.
3. If you are suspended from a post, or have restrictions put on your practise because of concerns about your performance or conduct, you must inform any other organisations for whom you undertake work of a similar nature. You must also inform any patients you see independently of such organisations, if the treatment you provide is within the area of concern to which the suspension or restriction relates.
4. Similarly, you must assist the coroner or procurator fiscal, by responding to inquiries, and by offering all relevant information to an inquest or inquiry into a patient's death. Only where your evidence may lead to criminal proceedings being taken against you are you entitled to remain silent.

6.11.6 Indemnity insurance

In your own interests, and those of your patients, you must obtain adequate insurance or professional indemnity cover for any part of your practise not covered by an employer's indemnity scheme.

6.11.7 Working with Colleagues - Treating colleagues fairly

- You must always treat your colleagues fairly. In accordance with the law, you must not discriminate against colleagues, including those applying for posts, on grounds of their sex, race or disability. And you must not allow your views of colleagues' lifestyle, culture, beliefs, colour, gender, sexuality, or age to prejudice your professional relationship with them.
- You must not undermine patients' trust in the care or treatment they receive, or in the judgment of those treating them, by making malicious or unfounded criticisms of colleagues.

6.11.8 Working in teams

Healthcare is increasingly provided by multi-disciplinary teams. Working in a team does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you must:

- respect the skills and contributions of your colleagues;
- maintain professional relationships with patients;
- communicate effectively with colleagues within and outside the team;
- make sure that your patients and colleagues understand your professional status and specialty, your role and responsibilities in the team and who is responsible for each aspect of patients' care;
- participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies;
- be willing to deal openly and supportively with problems in the performance, conduct or health of team members.

6.11.9 Leading teams

If you lead a team, you must ensure that:

- medical team members meet the standards of conduct and care set in this guidance;
- any problems that might prevent colleagues from other professions following guidance from their own regulatory bodies are brought to your attention and addressed

- all team members understand their personal and collective responsibility for the safety of patients, and for openly and honestly recording and discussing problems;
- each patient's care is properly co-ordinated and managed and that patients know who to contact if they have questions or concerns;
- arrangements are in place to provide cover at all times;
- regular reviews and audit of the standards and performance of the team are undertaken and any deficiencies are addressed;
- systems are in place for dealing supportively with problems in the performance, conduct or health of team members.

Further advice on working in teams is provided in "Maintaining Good Medical Practice" and "Management in Health Care - The Role of Doctors".

6.11.10 Arranging cover

- You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective hand-over procedures and clear communication between doctors.
- If you arrange cover for your own practice, you must satisfy yourself that doctors who stand in for you have the qualifications, experience, knowledge and skills to perform the duties for which they will be responsible. Deputising doctors and locums are directly accountable to the GMC for the care of patients while on duty.

6.11.11Taking up appointments

You must take up any post, including a locum post, you have formally accepted unless the employer has adequate time to make other arrangements.

6.11.12 Sharing information with colleagues

- It is in patients' best interests for one doctor, usually a general practitioner, to be fully informed about, and responsible for maintaining continuity of, a patient's medical care.
- You should ensure that patients are informed about how information is shared within teams and between those who will be providing their care. If a patient objects to such disclosures you should explain the benefits to their own care of information being shared, but you must not disclose information if a patient maintains such objections. For further advice see our guidance "Confidentiality: Protecting and Providing Information".
- When you refer a patient, you should provide all relevant information about the patient's history and current condition.
- If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects. If the patient has not been referred to you by a general practitioner, you should inform the general practitioner before starting treatment, except in emergencies or when it is impracticable to do so. If you do not tell the patient's general practitioner, before or after providing treatment, you will be responsible for providing or arranging all necessary after care until another doctor agrees to take over.

6.11.13 Delegation and referral

- Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.
- Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that any health care professional to whom you refer a patient is accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.

6.12 Probity

6.12.1 Providing information about your services

- If you publish information about the services you provide, the information must be factual and verifiable. It must be published in a way that conforms with the law and with the guidance issued by the "Advertising Standards Authority".
- The information you publish must not make unjustifiable claims about the quality of your services. It must not, in any way, offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.
- Information you publish about your services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly you must not advertise your services by visiting or telephoning prospective patients, either in person or through a deputy.

6.12.2 Writing reports, giving evidence and signing documents

You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information. If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.

6.12.3 Research

If you participate in research you must put the care and safety of patients first. You must ensure that approval has been obtained for research from an independent research ethics committee and that patients have given consent. You must conduct all research with honesty and integrity. More detailed advice on the ethical responsibilities of doctors working in research is published in “Research - The Role and Responsibilities of Doctors”.

6.12 4 Financial and commercial dealings

You must be honest and open in any financial arrangements with patients. In particular:

- you should provide information about fees and charges before obtaining patients’ consent to treatment, wherever possible;
- you must not exploit patients’ vulnerability or lack of medical knowledge when making charges for treatment or services;
- you must not encourage your patients to give, lend or bequeath money or gifts which will directly or indirectly benefit you. You must not put pressure on patients or their families to make donations to other people or organisations;
- you must not put pressure on patients to accept private treatment;
- if you charge fees, you must tell patients if any part of the fee goes to another doctor.

You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

- if you manage finances, you must make sure that the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances;
- before taking part in discussions about buying goods or services, you must declare any relevant financial or commercial interest which you or your family might have in the purchase.

6.12.5 Conflicts of interest

You must act in your patients’ best interests when making referrals and providing or arranging treatment or care. So you must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgement. You should not offer such inducements to colleagues.

6.12.6 Financial interests in hospitals, nursing homes and other medical organisations

- If you have financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way you prescribe for, treat or refer patients.
- If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the health care purchase
- Treating patients in an institution in which you or members of your immediate family have a financial or commercial interest may lead to serious conflicts of interest. If you do so, your patients and anyone funding their treatment must be made aware of the financial interest. In addition, if you offer specialist services, you must not accept patients unless they have been referred by another doctor who will have overall responsibility for managing the patient’s care. If you are a general practitioner with a financial interest in a residential or nursing home, it is inadvisable to provide primary care services for patients in that home, unless the patient asks you to do so or there are no alternatives. If you do this, you must be prepared to justify your decision.

6.13 Health

6.13.1 If there is a risk your health may affect patients

- If you know that you have a serious condition which you could pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness, or its treatment, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practise. Do not rely on your own assessment of the risk to patients.
- If you think you have a serious condition which you could pass on to patients, you must have all the necessary tests and act on the advice given to you by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practise.

This guidance is not exhaustive. It cannot cover all forms of professional practise or misconduct which may bring your registration into question. You must therefore always be prepared to explain and justify your actions and decisions.

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7. General Dental Council - Guidance to Dentists on Professional and Personal Conduct

7.1.1 Registering with the General Dental Council

1.1 It is the responsibility of a dentist who intends to practise to register with the GDC before beginning to practise and to renew that registration annually. Failure to do so may lead to disciplinary proceedings.

A dentist should not practise dentistry in a name other than that which appears in the Dentists Register.

It is unlawful for anyone to give or to suggest that they are prepared to give any advice or treatment such as is normally given by a dentist, unless that person is registered in the Dentists Register or the Medical Register. Advice or treatment includes the fitting, insertion or fixing of dentures, artificial teeth or other dental appliances.

Those who supervise students undertaking the dental treatment of patients must be on the Dentists Register.

Enrolled dental hygienists and dental therapists may only practise under the direction of a registered dentist to the extent permitted by the relevant Regulations.

7.1.2 Obtaining Indemnity

1.2 A dentist involved in advising or treating patients must either hold appropriate membership of a defence organisation or otherwise be indemnified against claims for professional negligence. This is in the interest both of patients, who may have a right to compensation and of dentists, who may require professional and legal advice. A lack of appropriate defence organisation membership or adequate indemnity cover which includes professional and legal advice, would almost certainly lead to a charge of serious professional misconduct.

7.1.3 Keeping up-to-date

1.3 In the interests of patients, a dentist must continue professional education on a regular and frequent basis throughout professional life.

The recording of all continuing professional development (CPD) activity is the responsibility of the individual dentist. Records must be accurate and must be retained, together with external verification where relevant. Records and verification must be produced when requested by the Council.

A dentist who fails to maintain and update professional knowledge and skills and who, as a result, provides treatment which falls short of the standards which the public and the profession have a right to expect, may be liable to a charge of serious professional misconduct.

7.1.4 The use of Qualifications and Titles

1.4 A dentist may use in connection with dental practise only those qualifications which are entered against that dentist's name in the Dentists Register and any specialist lists, and the description 'dentist', 'dental practitioner' or 'dental surgeon'.

A dentist who uses the courtesy title 'doctor' has a duty to ensure that it is not used in a way which misleads the public.

Additional qualifications which are generally recognised for inclusion in the Dentists Register are listed in the preliminary pages of the Dentists Register. Further guidance may be obtained from the GDC's Registration Department.

7.1.5 Specialist Lists

1.5 Only a dentist whose name is entered in a specialist list is entitled to use the title prescribed in connection with that list; no

dentist should imply possession of specialist status in terms which could mislead patients. See also 7.6

Specialist lists held by the GDC are indicative, not restrictive. This means that holders of prescribed specialist titles remain free to practise across the whole spectrum of dentistry within their acknowledged competence.

7.2 What the Public Expects

7.2.1 Personal Behavior

2.1 A dentist must adhere to the appropriate standards of personal as well as professional conduct.

Any behavior or activity by a dentist which is liable to bring the profession into disrepute or to undermine public confidence in the profession may lead to a charge of serious professional misconduct.

Behavior which reflects adversely on the profession such as dishonesty, indecency or violence, may also lead to a charge of serious professional misconduct even if such behavior is not directly connected with the dentist's professional practise.

7.2.2 Alcohol and Drugs

2.2 Complaints of drunkenness or the misuse of drugs, particularly if this involves an abuse of a dentist's prescribing powers, may lead to a charge of serious professional misconduct, even if the offence has not been the subject of criminal proceedings.

Problems with alcohol and/or drug dependency could lead to a dentist being referred to the Health Committee.

A dentist should prescribe drugs only in connection with the provision of bona fide treatment. See also 4.5

7.2.3 Improper Statements or Certificates and Misleading Announcements

2.3 A dentist should not make a statement or declaration that is untrue or misleading or unethical, nor induce any other person to do so.

Any act or omission by a dentist in connection with dental practise which is liable to mislead the public may lead to a charge of serious professional misconduct.

A dentist should not, for example, demand or receive fees for which there is no entitlement nor persuade a patient to accept private treatment by giving incorrect information.

7.2.4 Protecting Patients

- A dentist must act to protect patients when there is reason to believe that they are threatened by a colleague's conduct, performance or health. The safety of patients must come first at all times and should over-ride personal and professional loyalties. As soon as a dentist becomes aware of any situation which puts patients at risk, the matter should be discussed with a senior colleague or an appropriate professional body.
- A dentist who is suffering from physical impairment which might jeopardise the wellbeing of patients should seek medical advice, and, if necessary, restrict the scope of his or her dental practise. The conduct of a dentist who wilfully continues to practise when a physical impairment may be expected to prejudice the safety of patients may be regarded as serious professional misconduct.

7.3 What the Patient Expects

7.3.1Acting in the Best Interests of Patients

3.1 As a member of a caring profession, a dentist has a responsibility to put the interests of patients first. The professional relationship between dentist and patient relies on trust and the assumption that a dentist will act in the best interests of the patient. Abuses of this professional relationship may lead to a charge of serious professional misconduct.

Providing a High Standard of Care

3.2 A patient is entitled to expect that a dentist will provide a high standard of care. The Council takes a serious view of any neglect of a dentist's professional responsibilities to patients for their care and treatment.

Making a Referral

3.3 When accepting a patient a dentist assumes a duty of care which includes the obligation to refer the patient for further professional advice or treatment if it transpires that the task in hand is beyond the dentist's own skills. A patient is entitled to a referral for a second opinion at any time and the dentist is under an obligation to accede to the request and to do so promptly. See also 4.18

Accepting a Referral

3.4 It is the responsibility of a dentist when accepting a referral to ensure that the request is fully understood. The treatment or advice requested should only be provided where this is felt to be appropriate. If this is not the case, there is an obligation on the dentist to discuss the matter, prior to commencing treatment, with the referring practitioner and the patient. See also 4.19

Maintaining Confidentiality

3.5 The dentist/patient relationship is founded on trust and a dentist should not disclose to a third party information about a patient acquired in a professional capacity without the permission of the patient. To do so may lead to a charge of serious professional misconduct. A dentist should also be aware that the duty of confidentiality extends to other members of the dental team.

Where information is held on computer, a dentist should also have regard to the provisions of the Data Protection Act. See also 6.5 There may, however, be circumstances in which the public interest outweighs a dentist's duty of confidentiality and in which disclosure would be justified. A dentist in such a situation should consult a defence or professional organisation or other appropriate adviser.

Communications with patients should not compromise patient confidentiality. In the interests of security and confidentiality, for example, it is advisable that all postal communications to patients are sent in sealed envelopes.

Explaining Treatment and Costs

3.6 It is the responsibility of a dentist to explain clearly to the patient the nature of the contract and in particular whether the patient is being accepted for treatment under a particular scheme, including the NHS, or under some other arrangement.

The charge for an initial consultation and the probable cost of the subsequent treatment must be made clear to the patient at the outset.

A written treatment plan and estimate will avoid misunderstandings and should always be provided for extensive or expensive courses of treatment. A dentist who obtains the patient's agreement to these terms in writing is better placed to refute an allegation that a patient has been misled with regard to the nature of the contract or the type or cost of treatment provided.

If it becomes apparent to the dentist, after the estimate has been agreed, that a modified treatment plan will become necessary the Council would expect the dentist to discuss this with the patient; obtain the patient's consent to the further treatment and additional cost; and provide a written, amended estimate before proceeding further.

Patients are entitled to an itemised account of treatment received and should normally be provided with one.

Consent

3.7 A dentist must explain to the patient the treatment proposed, the risks involved and alternative treatments and ensure that appropriate consent is obtained.

If a general anaesthetic or sedation is to be given, all procedures must be explained to the patient. The onus is on the dentist to ensure that all necessary information and explanations have been given either personally or by the anaesthetist/sedationist. In this situation written consent must be obtained. See also 4.12 and 4.20

Having a Third Party Present

3.8 A dentist should normally be assisted by a dental nurse. When attending a patient, a dentist would be well advised to have a member of the dental team or other person present at all times in the operating room and in the recovery room. When general anaesthesia or sedation is being used, such an arrangement is mandatory. See also 4.14, 4.22 and 4.23

Domiciliary Treatment

3.9 Dental treatment provided on a domiciliary basis should be appropriate within that setting, taking into account the nature of the problem, the facilities available and the welfare of the patient. Having a third party present is particularly relevant in this environment.

Treating Difficult Patients and Children

3.10 There can be no justification for intimidation or, other than in the most exceptional circumstances, for the use of physical restraint in dealing with a difficult patient.

When faced with a child who is uncontrollable for whatever reason, the dentist should consider ceasing treatment, making an appropriate explanation to the parent or representative and arranging necessary future treatment for the child, rather than continuing in these circumstances.

Providing for Dental Emergencies and Out of Hours Care

3.11 A dentist working in any branch of dentistry must make appropriate arrangements to ensure that patients, for whom responsibility has been accepted, have access to emergency treatment outside normal working hours and that such arrangements are made known to those patients.

While a sympathetic response to patients in pain is to be expected, it is extremely difficult to define what constitutes a dental emergency. If a patient has an acute spreading infection, or a dental haemorrhage which is difficult to control, or has suffered damage to a tooth or jaws as a result of external trauma, it is the dentist's duty to provide, or make arrangements for the patient to receive, advice or treatment within a reasonable time.

Extended Absence from Practise

3.12 If a dentist is absent from a practise for an extended period, arrangements should be made to notify patients and for them to receive care as appropriate.

Handling Complaints

3.13 If a patient has cause to complain about the service provided, every effort should be made to resolve the matter at practice level. The complaint may relate to the treatment provided or some other matter such as the payment of fees or the attitude of a member of the dental team.

The Council endorses the detailed guidance on handling complaints which has been issued by the NHS Executive and the British Dental Association and would expect compliance.

Complaints of Rudeness and Discourtesy

3.14 The Council receives complaints from patients about rudeness and discourtesy on the part of dentists. While such behaviour may not, of itself, amount to serious professional misconduct it is of concern. The Council may, with the patient's consent, seek the observations of the dentist on an informal basis.

7.4 What the Profession Expects

Dealing with Cross Infection

4.1 There has always existed the risk of cross-infection in dental treatment. Therefore, a dentist has a duty to take appropriate precautions to protect patients and other members of the dental team from that risk. The publicity surrounding the spread of HIV infection has served to highlight the precautions which a dentist should already have been taking and which are now more important than ever. Detailed guidance on cross-infection control has been issued by the Health Departments and the British Dental Association, and is endorsed by the Council.

It is unethical for a dentist to refuse to treat a patient solely on the grounds that the person has a blood borne virus or any other transmissible disease or infection.

Failure to employ adequate methods of cross-infection control would almost certainly render a dentist liable to a charge of serious professional misconduct.

Dealing with Transmissible Disease

4.2 A dentist who is aware of being infected with a blood borne virus or any other transmissible disease or infection which might jeopardise the well being of patients and takes no action is behaving unethically. The Council would take the same view if a dentist took no action when having reason to believe that such infection may be present. It is the responsibility of a dentist in either situation to obtain medical advice which may result in appropriate testing and, if a dentist is found to be infected, regular medical supervision. The medical advice may include the necessity to cease the practise of dentistry altogether, to exclude exposure prone procedures or to modify practise in some other way.

Failure to obtain such advice or to act upon it would almost certainly lead to a charge of serious professional misconduct.

Contemporaneous Records
4.3 A dentist must always obtain a medical history of a patient before commencing treatment and check the history for any changes at subsequent visits. Changes must be recorded on the patient's notes.

Full contemporaneous records should be kept for all dental treatment. See also 4.13 and 4.21.

Dental Radiography and Radiation Protection
4.4 A dentist has a number of statutory duties in relation to radiation protection during dental radiography.

A dentist who owns or operates an X-ray machine must ensure full compliance with the Regulations and safe radiological practise for the protection of the patient, members of the dental team and others. Failure to do so may lead to a charge of serious professional misconduct.

A dentist who delegates the taking of dental radiographs must ensure that the person to whom this task is delegated has received training in accordance with the Regulations.

Prescribing
4.5 The Council takes the view that a dentist should only prescribe drugs in connection with the provision of bona fide treatment. The right to prescribe is a privilege conferred upon a registered dentist by legislation and should be regarded in that light. See also 2.2

A dentist should not self-prescribe.

Misleading Claims
4.6 The Council takes a very serious view of any misleading claims made by a dentist in relation to treatment. This may be with regard to the efficacy of any treatment, or to misleading claims about a dentist's own skill or expertise in relation to a

particular treatment. The Council is also concerned about forms of treatment or therapy not amounting to the practise of dentistry but which a dentist chooses to perform as ancillary aspects of dental practise. A dentist should take particular care when employing techniques and forms of therapy which are unproven.

A dentist wishing to publicise views on a particular concept of dentistry should subject those views to challenge and scrutiny by professional colleagues through the medium of professional journals and any other forum of dental debate. See also 7.5

Resuscitation Dealing with Medical Emergencies
4.7 A medical emergency could occur at any time in premises where dental treatment takes place. It is, therefore, imperative that a dentist ensures that all members of the dental team are properly trained, have available the necessary resources, and are prepared to deal with an emergency, including a collapsed patient. Training should include preparing for medical emergencies, including the use of emergency drugs, and practise of resuscitation routines in a simulated emergency.

It is essential that all premises where dental treatment takes place have available and in working order: portable suction apparatus to clear the oropharynx, oral airways to maintain the natural airway, equipment with appropriate attachments to provide intermittent positive pressure ventilation of the lungs, and a portable source of oxygen together with emergency drugs.

Practitioners have an obligation to be conversant with current guidelines such as those issued by the Resuscitation Council (UK)

Pain and Anxiety Control Duty and Expectations
4.8 Dentists have a duty to provide and patients have a right to expect adequate and appropriate pain and anxiety control. Pharmacological methods of pain and anxiety control include local anaesthesia and conscious sedation techniques.

The provision of pain and anxiety control carries responsibilities and a dentist who undertakes treatment on a patient without ensuring that the following conditions are met is liable to a charge of serious professional misconduct.
Behavioural Management
4.9 In assessing the needs of an individual patient, due regard should be given to all aspects of behavioural management before deciding to refer, to prescribe or to proceed with treatment.

Local Anaesthesia
4.10 Local anaesthesia is the mainstay of pain control during dental treatment. A dentist has a duty to use the most appropriate

and effective method of local anaesthesia for each patient. The technique chosen must take into account the patient's medical and dental history as well as the physical and pharmacological properties of the agent used.

Conscious Sedation

4.11 Conscious sedation can be an effective method of facilitating dental treatment and is normally used in conjunction with appropriate local anaesthesia.

Conscious sedation is defined as:

- A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely.

The level of sedation must be such that the patient remains conscious, retains protective reflexes, and is able to understand and to respond to verbal commands. 'Deep sedation' in which these criteria are not fulfilled must be regarded as general anaesthesia. In the case of patients who are unable to respond to verbal contact even when fully conscious the normal method of communicating with them must be maintained.

Assessment, Consent and Instructions

4.12 A careful assessment of the patient, including a full medical and dental history, must be made before the decision to treat or to refer for treatment under conscious sedation can be taken. An explanation of the conscious sedation technique proposed and of appropriate alternative methods of pain and anxiety control must be given.

In advance of the procedure the patient must be given clear and comprehensive pre- and post-operative instructions in writing, and written consent must be obtained.

Record Keeping

4.13 Careful contemporaneous records must be kept including details of the techniques and drugs used in the control of pain and anxiety. See also 4.3

Responsibilities, Education and Skills

4.14 Dentists have a duty of care, in accordance with section 3.3, to administer conscious sedation only within the limits of their knowledge, training, skills and experience.

A dentist who assumes the dual responsibility of sedating the patient as well as providing treatment must:
have completed relevant postgraduate education and training;

- have a demonstrable commitment to relevant continuing education and training;
- ensure that the method and nature of the conscious sedation chosen is the most appropriate to enable treatment to be carried out for the patient as an individual, taking into account specific factors such as age, state of health, social circumstances and special needs. The choice of techniques and drugs used should be governed by the principle of minimum intervention and the amount of any drug administered should be the minimum necessary to achieve the desired effect. In general only one sedative drug (administered by the oral, inhalational or intravenous route) will be necessary for the vast majority of patients. Combinations of sedative drugs may only be justified in exceptional circumstances. Intravenous conscious sedation is rarely justified in children;
- be able to justify the use of the method selected with reference to current guidelines such as those listed in the Bibliography;
- have clinical experience of the particular conscious sedation technique employed;
- be assisted by a second appropriately trained person who is present throughout and is capable of monitoring the clinical condition of the patient and assisting the dentist in the event of any complication.

Where a second dental or medical practitioner is providing conscious sedation for a patient, the treating dentist must ensure that the person acting as the person giving sedation has undertaken relevant postgraduate education and training, accepts the definition of conscious sedation given in paragraph 4.11 and the principle of minimum intervention, and has specific experience of the use of conscious sedation in dentistry as described above.

Equipment, Drugs and Monitoring

4.15 Conscious sedation must only be administered when suitable equipment and adequate facilities including appropriate drugs for treating complications are immediately available at the chairside.

All staff must be trained in the use of the relevant conscious sedation techniques and must train as a team in the management of sedation-related complications. See also 4.7

Contemporary standards of monitoring must be adopted.

Fitness for Discharge

4.16 Patients who have received conscious sedation should be appropriately protected and monitored in adequate and supervised recovery facilities. When, in the opinion of the person giving sedation, they are sufficiently recovered to leave the premises, the patient must be accompanied by a responsible adult. A dentist may exercise discretion as to whether an adult patient may be discharged unaccompanied when nitrous oxide/oxygen sedation alone is used. Due regard must be given to both the pharmacology of the drugs administered and the patient's response to the sedative before the patient is discharged.

All patients must be assessed for their suitability for discharge. Patients and escorts must be given post-operative advice specific to the individual regarding after care arrangements. See also 4.12.

General Anaesthesia Risk of General Anaesthesia

4.17 General anaesthesia is a procedure which is never without risk. In assessing the needs of an individual patient, due regard should be given to all aspects of behavioural management and anxiety control before deciding to treat or refer for treatment under general anaesthesia. General anaesthesia for dental treatment should only be administered in a hospital setting with critical care facilities.

All dentists involved in arranging or providing treatment under general anaesthesia should discuss with the patient advice and treatment options to avoid or reduce future episodes of general anaesthesia

A dentist who refers a patient for treatment or carries out treatment on a patient under general anaesthesia without ensuring that the relevant conditions set out below are met is liable to a charge of serious professional misconduct.

Duties of the Referring Dentist Decision to Refer

4.18 The decision to refer a patient for treatment under general anaesthesia should not be taken lightly. As part of this decision, a full medical history of the patient must be taken and agreement to refer obtained following a thorough and clear explanation of the risks involved and the alternative methods of pain control available. Clear justification for the use of general anaesthesia, together with details of the relevant medical and dental histories of the patient, must be contained in the referral letter. The referring dentist must retain a copy of this letter. See also 3.3

Duties of the Treating Dentist Decision to Treat

4.19 The decision to treat a patient under general anaesthesia should not be taken lightly. As part of this decision the treating dentist must satisfy him or herself that it is necessary and appropriate to carry out the proposed treatment under general anaesthesia. Before carrying out treatment under general anaesthesia the patient must be given a thorough and clear explanation of the risks involved and the alternative methods of pain control available. See also 3.4

Consent

4.20 When the decision to carry out treatment under general anaesthesia has been finally agreed by the patient, dentist and anaesthetist, written consent must be obtained. See also 3.7

Instructions and Records

4.21 In advance of the procedure patients must be given clear and comprehensive pre- and post-operative instructions in writing. Careful contemporaneous records must be kept of all the procedures undertaken. See also 4.3
4.22 Dentists with responsibilities for the provision of dental treatment under general anaesthesia must:

Responsibilities of Those Providing Dental Treatment Under General Anaesthesia

- ensure that the facilities and arrangements (including location) for the general anaesthesia meet contemporary requirements.
- ensure that they have the assistance of an appropriately trained dental nurse.
- See also 3.8 ensure that the general anaesthetic is administered by an individual who:
- is on the specialist register of the General Medical Council as an anaesthetist. Such specialists are advised to comply with the voluntary Continuing Medical Education requirements of the Royal College of Anaesthetists, or is a trainee working under supervision as part of a Royal College of Anaesthetists' approved training programme, or
- is a non-consultant career grade anaesthetist with an NHS appointment, for example staff grade or associate specialist, working under the supervision of a named consultant anaesthetist who must be a member of the NHS anaesthetic department where the non-consultant career grade anaesthetist is employed.

- is supported by an individual specifically trained and experienced in the necessary skills to assist in monitoring the patient's condition and in any emergency. Contemporary standards of monitoring should be adopted; the current Recommendations for Standards of Monitoring During Anaesthesia and Recovery issued by the Association of Anaesthetists of Great Britain and Ireland are appropriate.
- be satisfied that there is a written protocol, arranged in conjunction with, and agreed by the anaesthetist, for the provision for immediate critical care. In this connection the current guidelines issued by the Resuscitation Council (UK) are appropriate. The protocol must include appropriate arrangements for the supervised transfer of a patient to a high dependency unit (HDU) or intensive care unit (ICU), which may be on a separate site. Such arrangements must be agreed between the parties providing the treatment and the HDU and ICU.

Recovery and Discharge

4.23 Patients who are recovering from general anaesthesia must be appropriately protected and monitored continuously in adequate recovery facilities. Monitoring must be undertaken by the anaesthetist or a dedicated individual who is appropriately trained and directly responsible to the anaesthetist. When, in the opinion of the anaesthetist, the patient is sufficiently recovered to leave the premises, the patient must be accompanied by a responsible adult.

All patients must be assessed specifically for fitness for discharge and must be given post-operative advice specific to the individual regarding after care arrangements. See also 3.8

Training

4.24 All those involved in the provision of general anaesthesia or the supervision of patients during recovery must train together as a team to deal with an emergency. Resuscitation procedures must be practised frequently in a simulated emergency as a routine training exercise. Current guidelines such as those issued by the Resuscitation Council (UK) should be adopted.

Extract from - Guidance to Dentists on Professional and Personal Conduct

General Dental Council 37 Wimpole Street London W1G 8DQ Telephone: 020 7887 3800 Fax: 020 7224 3294

8. Roles and Responsibilities of Doctors

United Medicare apply a strict set of recruitment criteria so that we can ensure that all doctors are properly qualified, experienced and competent. The Agencies will not place doctors whose skills are inappropriate to the specified needs of the client.

Agency workers accepting placement with a client are expected to undertake any tasks that might reasonably be required by the client within the scope of the role being filled and should not refuse to carry out particular tasks or elements of the role.

Likewise, clients are required not to request Agency workers to perform duties which contravene any Code of Professional Conduct or fall outside of the position into which they were placed, as originally specified by the client, even though they may be qualified or competent to perform such tasks. Any change in the client's requirement should be communicated to and managed via your local office, including a request to move to a different clinical area in line with your competencies. Agency workers should perform all tasks and duties required by the client in line with the client's own policies and procedures, and conform to the client's standards and levels of service.

Agency workers are reminded that defined minimum standards, codes of professional practise/conduct and statutory regulation take precedence at all times. Any concerns or conflict of interest should be reported to your local office.

9. Record Keeping Requirements

The quality of your record keeping is a reflection of the standard of your professional practise and also of the quality of doctors and services available from United Medicare. All doctors are required to be familiar with and adhere to the principles detailed by their appropriate professional bodies.

Good record keeping helps to safeguard the welfare of patients and Agency workers through the promotion of :

- high standards of clinical care
- continuity of care
- improved communication and sharing of information
- an accurate account of treatment and care planning
- improved detection of problems or changes in a patient's condition

Agency workers should be particularly diligent in the recording, maintenance and retention of their own 'handover notes' which might provide valuable reference documentation in the future. You are accountable and responsible for the notes you take and how you retain them. They are legal documents and confidentiality must be maintained.

The following guidelines should be observed:-

1. Content and style

Patient records should be:-

- factual, consistent and accurate
- written as soon as possible after an event has occurred
- written clearly and in a manner that text cannot be erased
- timed, dated and signed
- alteration or additions are dated and signed in such a way that the original entry can be read clearly
- free from abbreviations, jargon, meaningless phrases, speculation or subjective statements
- written in terms that are easily understood
- identify problems and actions taken to rectify them

2. Legal matters and complaints

Agency workers have a professional duty of care to patients. Record keeping should be able to demonstrate:-

- a full account of the assessment, the care planned and provided
- the condition of the patient at any given time and the steps taken to respond to their needs
- evidence that you have understood and honoured your duty of care, that you have taken all reasonable steps to care for the patient and that any actions on your part have not compromised their safety in any way
- any arrangements for the continuing care of the patient

3. Access and ownership

Where Agency workers are placed with a client, all patients' requests to gain access to records should be managed through that client's own procedures. It should be remembered that patients have a legal right of access to their records. Whilst these records may be the property of the client organisation, patients can request to see them at any time.

In certain special cases it may be deemed necessary to withhold information from a patient. This should only ever be considered where it could cause serious harm to the physical or mental well-being of the patient or would breach the confidentiality of another patient. Any decision to withhold information must be able to be justified and it must be Recorded.

United Medicare

10. Timesheets and Payments

United Medicare utilise timesheets as a primary system of record for the invoicing of clients and payment of Agency workers.

There are a number of specific requirements for the correct and accurate completion of timesheets. All Agency workers should adhere to these requirements in order to ensure prompt and accurate payroll processing.

- It is your responsibility to ensure that you know what the pay rate will be when you accept the shift
- Each section of every timesheet is to be completed fully and accurately
- One timesheet should be completed each week for each client
- All timesheets should be signed by a duly authorised representative of the client
- The relevant copy of 4 part timesheets should be detached and left with the client for their records
- Timesheets must be originals; faxed or copied timesheets will not be accepted, nor should any other form of paper be used as a timesheet
- Mileage claims must be accurate and submitted on the timesheet to which they apply. Mileage claims cannot be backdated
- Breaks appropriate to the shifts worked will be automatically deducted from timesheets unless otherwise noted on the timesheet. If breaks are not taken this must be clearly noted on the relevant timesheet. A line through the breaks column is not acceptable, it must be documented as none, nil, or no break

A 'timesheet week' runs from Monday through to the following Sunday. Payment is made weekly by BACS transfer direct to your bank or building society.

As timesheets are used to calculate charges and generate invoices for clients, it is important to stress to clients their responsibility for ensuring the accuracy and validity of all timesheets that they sign.

In the event of any error or omission, doctors should not make retrospective changes to timesheets once they have been authorised by the client. In such circumstances a new timesheet should be completed for authorisation and the original destroyed.

United Medicare have implemented an ongoing system of internal controls in order to minimise the processing of invalid or inaccurate timesheets. Any falsification of timesheets by doctors is regarded as a disciplinary offence.

The Inland Revenue rules that if an agency has not made a payment to someone registered with it for a period of 13 weeks, then the agency must issue the worker with a P45. This does NOT mean that you cannot continue to be registered with the agency. We can continue to offer work that is available whenever you are free. Please contact your local office with your availabilities.

The Agency commits to process timesheets and make payments to Agency workers by the Tuesday following the week in which timesheets are submitted. In order to meet this commitment the Agency requires completed timesheets to be submitted by Agency workers no later than midday on the Wednesday following the week in which shifts are worked. Clients are required to ensure that timesheets can be appropriately authorised to allow the submission, processing and subsequent payment of Agency workers in a timely fashion.

11. Development

United Medicare provide a quality service to our patients and clients by ensuring that Agency workers meet our specific criteria and are of the highest calibre.

All Agency workers are required to maintain training and development in their core competencies as appropriate and to keep abreast of current practise in the following areas:

• Manual Handling
• Fire procedures
• Lone Worker Training
• Handling of Violence and aggression
• Risk Incident Reporting
• The Caldicott Principles
• Complaints Handling

An ongoing programme of training is provided to all Agency workers in these areas through our interactive education and training system available online at www.nlsandumr.com which is made available to enable Agency workers to keep up-to-date with current best practise.

Additionally Agency workers are also required to ensure familiarity with all appropriate health and safety regulations as documented in this handbook, including such areas as COSHH, RIDDOR and infection control.

United Medicare

12. Indemnity Insurance

United Medicare have insurance policies which provide cover appropriate to the day-to-day operation of our business. The Agencies do not provide generic professional indemnity insurance for Registered Doctors who are Agency workers.

All Registered Doctors who are Agency workers are personally responsible for ensuring that they have adequate and up to date professional indemnity insurance.

Agency workers who do not have adequate indemnity insurance may find themselves personally liable to meet the cost of any legal actions or damages in the event of claims being found against them. We urge all Agency workers confirm the availability, level and extent of any indemnity insurance cover.

Professional Indemnity Insurance can be obtained by contacting

MDU on 0800 716376 (www.the-mdu.com) MPS on 0845 718 7187 (www.mps-group.org) MDDUS on 0141 221 3663 (www.mddus.com)

13. Holiday Entitlements

Current UK employment legislation provides workers who are not self employed or working through a limited company with an entitlement to paid holidays. In summary this statutory entitlement provides a 13:1 ratio of time worked to holiday entitlement i.e. 4 weeks of paid holiday in a 52 week working year pro rata.

Due to the nature and flexibility of work provided through the Agency, with the associated need for the Agency to administer and maintain accurate records of hours worked and holiday taken, United Medicare discharge this statutory obligation by the addition of a holiday pay element to the basic hourly rate paid to all Agency workers. This holiday pay currently equates to an additional 8.33% pay for every hour worked.

Paying holiday pay ‘up-front’ in this way allows Agency workers flexibility to take holiday breaks as and when they choose.

The Agency urges all staff to take their agency paid holiday entitlement in full.

14. Injury or Illness Notification Procedures

United Medicare place the health, safety and well being of Agency workers as an utmost priority. The Agency takes all reasonable steps to have in place policies and procedures in respect of recruitment and work placement to ensure, as far as possible, the protection of Agency workers from injury or illness.

Agency workers placed with a client will be covered by that client's obligations under the terms of the Health and Safety at Work Act requiring that all necessary precautions be taken to ensure a safe and healthy working environment.

In the unfortunate event of Agency workers suffering a work related injury or illness including needle stick injuries, the following procedures should be observed:-

- Any injury or illness should be reported to the client and documented in line with the client's own policies and procedures
- Injuries or illnesses should also be reported to the Agency via your local office
- Notification to the client and the Agency should be as prompt as possible depending on the individual circumstances
- In the event of accident or injury, doctors should endeavour to obtain details and signatures of any witnesses
- Specific illnesses, accidents or injuries will be subject to the regulations covering control of hazardous substances (COSHH) and/or diseases and dangerous occurrences (RIDDOR). The client's internal procedures should cover such instances, however the Agency can provide guidance via your local office

Following a period of unavailability through sickness or injury, the Agency will require evidence. This evidence should be a doctor's note, or a return to work assessment by authorised occupational health consultant, to confirm fitness to return to work prior to placement of Agency Workers with a client.

In certain circumstances Agency workers may be eligible to receive statutory sick pay. Eligibility is dependent on a number of factors and will need to be determined on an individual basis by contacting the Payroll Department during office hours.

The Agency will endeavour to provide advice, assistance and support to Agency workers who suffer an injury or illness at work.

15. Pregnancy

Pregnancy should not automatically present any particular constraints on the type of placement offered to Agency workers. United Medicare recognise that pregnancy affect different people in different ways, and aim to support workers who become pregnant by finding them work in suitable areas. It is important that Agency workers who become pregnant inform the Agency in a timely manner in order that we can continue to place doctors in appropriate roles.

United Medicare place the health and wellbeing of Agency workers as an utmost priority.

Agency workers have a responsibility to ensure that they are fit and able to work and should continue to update the Agency and any clients with whom they may be placed. Specifically, Agency workers should notify the Agency of any restrictions advised by their doctor or midwife etc.

In certain circumstances Agency workers may be eligible to receive maternity pay. Eligibility is dependent on a number of factors and will need to be determined on an individual basis by contacting the Payroll Department during office hours.

16. Standards of Dress and Appearance

United Medicare requires all Agency workers to maintain the high standards of professionalism and good reputation of the Agency through appropriate standards of dress and appearance whilst working at client premises. Failure to do so may result in disciplinary action.

The agencies do not prescribe any specific uniform, however agency workers are required to comply with any requirements as specified by the client or as appropriate to the task being undertaken.

Identity badges are provided to all Agency workers and these must be worn and clearly displayed at all times.

United Medicare

17. ‘Gifts’ Policy

In order to avoid ambiguity and promote professional independence and objectivity, United Medicare have a very clear gifts policy:

- ,Agency workers shall not accept gifts, favour or hospitality from patients or clients, nor benefit from any legacy or will.

The intention of this policy is primarily to protect Agency workers, through the provision of a clear policy statement, in the event of any malicious allegations or the questioning of professional conduct etc.

United Medicare treat very seriously the upholding of the Agency’s good name and the quality and professional services provided. Any Agency workers determined to be in violation of this policy will be subject to disciplinary action.

18. Abuse Policy

United Medicare treat any allegations of abuse with the utmost seriousness and will not hesitate in providing appropriate assistance in respect of any investigations into allegations of abuse.

Allegations received of abuse against patients, clients or Agency workers will be initially documented and processed in accordance with the Agencies' complaints procedure.

Any allegations against Agency workers will result in suspension from the Agency register pending the outcome of any internal, professional and/or criminal enquiries.

Any proven allegations of abuse by Agency workers will constitute a gross violation of the Agencies' standards of conduct and will result in immediate removal from the Agencies register. The Agency will also provide any assistance as appropriate to any GMC/GDC/Trust or police investigations, which may result in removal from the professional register or criminal proceedings.

19. Administration of Medicine Policy

This Policy is designed to act as a guide for doctors who are registered with and placed by United Medicare, and should not be seen as a replacement for statutory provision or client policy.

The Agency will endeavour to obtain and provide access to drug administration policies on a client by client basis (including during induction process). In the event that this cannot be achieved, e.g. short notice or emergency placement, doctors have the individual responsibility to ensure they obtain, read and comply with client drug administration policies.

In the event of a drug error the doctor responsible or the doctor discovering the error must ensure:

- Patients condition/safety is closely monitored, any change in condition recorded and appropriate emergency treatment carried out.
- The relevant medical practitioner/senior doctor is advised of the error and the patient seen and evaluated as soon as possible.
- Any local incident reporting documentation should be completed along with a written explanation of the events that led to the drug error or its discovery. In the absence of any reporting documentation the relevant doctor should detail the incident in the patient care record and pass a copy of the information to the Agency.
- The Agency is informed of the incident as soon as it is practicable and a copy of the completed documentation provided to the agency.
- The doctor may be required to facilitate any enquiry carried out by the hospital, nursing home, care establishment or nursing agency etc. Each doctor has the right to be represented in the event of an investigation by a person of their choosing.

This policy is reviewed on an ongoing basis, and at least annually or as necessary in line with legislation or best practise guidance.

20. Confidentiality Policy

United Medicare exercise extreme discretion in the access and provision of information in all areas of the Agencies' business. Information relating to Agency workers and client records are considered to be confidential and utilised only for legitimate purposes by appropriate personnel. The Agencies are registered data controllers and endeavour to comply with the terms and principles of the Data Protection Act 1998.

United Medicare require that all Agency workers protect confidential information concerning patients and/or clients obtained in the course of professional practise.

Violation of a patient's or client's right to confidentiality will be viewed as a serious contravention of the Agencies' standards of conduct and may lead to disciplinary action and/or reporting to the GMC/GDC as appropriate.

The Agencies' confidentiality policy states:

- All information that is or has been acquired by you during, or in the course of your duties, or has otherwise been acquired by you in confidence,
- All information that relates particularly to our business, our clients and all persons in their care, or that of other persons or bodies with whom we have dealings of any sort, and
- All information that has not been made public by, or with our authority shall be confidential, and (save in the course of our business or as required by law) you shall not at any time, whether before or after work with the Agency, disclose such information to any person without our written consent.
- You are to exercise reasonable care to keep safe all documentary or other material containing confidential information, and shall at the time of ceasing work through the Agency, or at any other time upon demand, return to us any such material in your possession.

21. Computer Misuse Policy

It is anticipated that clients will operate their own clearly defined policies and procedures in respect of access to, operation and use of computer equipment. However where such policies do not exist and in order to determine a minimum standard United Medicare operate the following computer misuse policy:

21.1 Virus Protection

In order to prevent virus contamination of IT systems the following must be observed:-

- The loading, installation or other use of unauthorised software and data, including public domain software, 'magazine cover' or Internet/World Wide Web downloads is not permitted
- All software must be virus checked using standard testing procedures before being loaded, installed or used

21.2 E-Mail

There are a number of complex issues that can arise out of the use of E-Mail. In order to protect the interests of Clients, Patients, the Agency and Agency workers **YOU MUST NOT:**

- Respond to 'junk mail'
- Forward or respond to 'chain letter' type E-Mail
- Create or send E-Mails which make comment, or statements which could in any way be contrived to be defamatory
- Include anything within an E-Mail which is protected by copyright without the explicit consent of the author
- Initiate or forward an E-Mail which contains obscene or pornographic material
- Initiate or forward E-Mail which could be considered to constitute an act of harassment or discrimination on any grounds
- Disclose information which is embargoed or could in any way be considered confidential
- Make any statements which intentionally or unintentionally create a binding contract or make negligent statements.

21.3 Internet usage

Access to the Internet should be for business purposes only and use must be restricted and appropriate to the requirements and instructions of the Client and/or the Agency.

21.4 Computers and the Law

The Computer Misuse Act identifies and classifies a number of specific activities which are deemed to be criminal offences in respect of the access to and use of computer systems, these include:

- The unauthorised access or attempted unauthorised access to computer systems, data or software.
- The attempted, unauthorised or malicious alteration, manipulation or destruction of computer systems, software or data.
- Any failure to comply with the Agencies' policy may be regarded as misconduct and lead to disciplinary action.

22. Race, Sex, Age and Disability

We are keen not to discriminate, even unwittingly, towards workers, those in our care, visitors, contractors, potential new clients or whoever due to their race, sex or disability.

It is on that basis we consider ourselves to be an equal opportunities organisation and in particular with reference to recruiting and promoting the best person available for the tasks required.

Racial Policy
When recruiting, selecting or promoting workers we make no distinction between persons due to their colour, race, nationality or ethnic origin.

When considering new persons coming into our care we make no distinction between persons due to their colour, race, nationality or ethnic origin.

We consider the same standards to be the minimum standard in any dealing we have with visitors, contractors etc.

Sexual Policy
When recruiting, selecting or promoting workers we make no distinction due to their being male, female, transsexual or their sexual orientation.

The same applies according to the nature of the work that a worker may be required to carry out. However, we are sensitive to the rights of privacy a vulnerable person in our care has and our responsibilities to them. We may have to take into account reasonable demands by a person in our care as relates to these issues and keep suitable records of such.

Whilst those in our care have rights to express their sexuality we also need to be sensitive to and tackle issues of abuse, which are strictly forbidden.

Sexual harassment in our workplace is strictly forbidden and offenders may face summary dismissal.

Disabled Policy
Anyone with physical or mental impairment, where their ability to carry out day to day activities is affected adversely by that impairment for the foreseeable long term is considered disabled. This is wide ranging and could include epilepsy, diabetes, multiple sclerosis, depression etc.

Adjustments may need to be made to support someone affected by disability to operate within our jurisdiction which could include:

- Reallocating duties
- Retraining
- Adjustments such as ramps, moving switches, changing working hours etc.

Taking into account legitimate material circumstances and reasonable adjustments to such we make no distinction based upon a person's disability when recruiting, selecting or promoting.

We take into account the safety of disabled persons to protect them from situations that may expose them to different levels of risk due to their disability.

Victimisation
We do not tolerate any form of discrimination towards any person with whom we have contact under any circumstances whether intentional or not. If you are victimised or feel victimised you should report this to the person in charge in the first instance, which may be in confidence if you wish.

If this does not prove satisfactory our advice is to talk to the Citizen's Advice Bureau.

Where a member of staff has been victimised we will investigate the matter with all parties concerned carefully and sensitively. If victimisation is established, those responsible will face disciplinary action and may be summarily dismissed for gross misconduct.

Age

Our policy is to recruit the best possible person for the job required irrespective of their age (subject to obligations under National Minimum Standards). Therefore, we do not discriminate against persons because of their age. Furthermore, we appreciate a wide range of ages can be beneficial to those we care for.

23. Whistle Blowing

The formal phrase for "blowing the whistle" is Public Interest Disclosure. It is a legal right to which the law offers you protection for doing so.

Its purpose is to protect the interests of those in our care where error has gone unchecked, therefore it is not "betrayal".

Where you have concerns relating to safety or health dangers at work, where there may be oversight relating to legal obligations, care standards or practises etc. you should raise the matter with the appropriate manager at your place of work.

If the matter is not resolved satisfactorily you should make your concerns known again but this time in writing to the appropriate manager at your place of work.

If you have acted in good faith, not seeking personal gain out of the situation the law is on your side and it is illegal for us to cause you detriment by raising your legitimate concerns.

Should we be unable to satisfy the concerns raised, you are entitled to take the matter to any appropriate representative. You may do this without notifying us first but only where you have good grounds for not having notified the Agency.

24. Changes in Personal Details

United Medicare utilise the latest technology to ensure the matching of client requirements with the most suitable Agency resources. In order to ensure that the Agency is best able to meet the joint requirements of both clients and Agency workers it is important to ensure the Agency's records are accurate and maintained in a timely manner.

Any changes in personal details such as contact information, skills, experience, qualifications, placement preferences etc should be passed to the Agency in order that appropriate updates can be made to our records.

All doctor data is held in the strictest confidence in our computerised database system, with access restricted only to specified individuals within the organisation. We endeavour to maintain the highest standards of computer operational procedures in line with the principles of the information security management standard ISO 17799 and are appropriately registered as required by the Data Protection Act 1998.

24.1 Complaints Procedure

United Medicare operate a complaints procedure in order that service users, patients and Agency workers can make complaints about the Agency, Agency workers, clients or patients and can be confident that complaints will be recorded and actions taken.

We ask all clients, patients or Agency workers to proceed as follows in case of enquiry, comment, complaint or untoward incident.

- In the first instance your concerns should be registered with a member of our Call Centre team, available 24 hours a day throughout the year. Details will be recorded and passed to a shift supervisor immediately.
- If further detail or information is required, you may be contacted by the supervisor on duty. You may also be asked to put your concerns in writing.
- Within 24 hours, or a reasonable timescale, your comments will be passed to our dedicated complaints staff and documented in the complaints book. All parties will be notified of any complaint against them within 24 hours, or a reasonable timescale.
- Initial enquiries will be made within 24 hours, or a reasonable timescale, and all parties may be asked to provide their responses in writing. Copies of 'handover notes' or other supporting documentation may also be requested.
- Complaints are reviewed twice weekly to ensure every effort is being made to bring about a conclusion as soon as possible.
- All complaints are logged, coded and audited quarterly to identify trends.
- United Medicare aim to comply with all relevant regulations and statutory obligations in relation to Doctors Agencies including complaints about the Agency or Agency workers.

Agency workers wishing to make a complaint about the Agency, other Agency workers or employees can register the details with your local office as outlined above. Alternatively, if the nature or content of the complaint renders the standard contact procedures inappropriate you should contact the Operations Director or another member of the Senior Management Team.

25. Disciplinary Procedures

Any failure of Agency workers to comply with the Agency's Policies, Procedures, Standards of Conduct or relevant Professional Practise guidelines may result in disciplinary action.

Disciplinary incidents are the responsibility of the Agency's Senior Operations Manager and will be dealt with on an individual basis and in a manner appropriate to the complaint or incident as follows:

- Minor disciplinary incidents will result in a written warning, detailing the incident and underlining any requirement to comply with the Agencies', or relevant professional bodies', standards and codes of conduct.
- More serious or multiple disciplinary incidents will result in a final written warning and possible referral to the relevant professional body for further investigation.
- Gross or ongoing violation of the Agencies' standards of conduct will result in removal from the Agency register and possible referral to the relevant professional body for further investigation.
- Gross violation of professional codes of conduct or malpractise will result in immediate removal from the Agency register. The Agency will also provide any assistance as appropriate to any GMC/GDC/Trust inquiry, which may result in removal from the professional register.

United Medicare will endeavour in all cases to act with fairness, discretion and in confidence as far as appropriate, in respect of any complaint, investigation or incident involving Agency workers. The Agency will liaise with any union or professional body who may be representing an Agency worker.

Depending on the circumstances of an individual complaint or incident the Agency will not hesitate to act to protect patients, clients or the Agency's good name by involving the relevant professional bodies and/or the police.

26. Guidance for reporting Fraud and Corruption

We are committed to promoting and maintaining an absolute standard of honesty and integrity in dealing with the assets of the NHS. We are therefore also committed to the elimination of fraud or illegal acts (such as theft) within the NHS , to the rigorous investigation and punishment of any such cases, and where fraud or illegality is proven to ensure that prompt action is taken in line with the Disciplinary Policy and Rules. Appropriate steps to recover any assets lost as a result of fraud and other illegal acts will be taken.

There are established procedures designed to minimise the risk of the client suffering as a result of fraud or corruption, and a response plan to be followed in the event of suspected wrongdoing being recorded.

For the purposes of this guidance the following are being defined:

Fraud is the “intentional distortion of financial statements or other records, carried out to conceal the misappropriation of assets or otherwise for gain.”

Corruption is “the offering, giving, soliciting or acceptance of any inducement or reward which may influence a person to act against the interests of the organisation”.

United Medicare wishes to encourage anyone having reasonable suspicions of irregularities to report them. This policy, which will be rigorously enforced, is that no agency worker should suffer as a result of reporting reasonably held suspicions. Any contravention of this policy should be reported to your manager or else senior /supervising Management staff.

What to do if you have concern:-

1. Make an immediate note of your concern. Document all relevant details, such as what was said in telephone or other conversations, the date, time and the name of any parties involved.

2. Convey your suspicions promptly, in the first place, to your manager – unless you suspect the manager of involvement in the wrongdoing, in which case you should go the next most senior person. Your Manager will report the matter to the next senior management.

3. Alternatively, you may first discuss the matter confidentially and anonymously with a more senior manager.

On no account should you

1. Do nothing

2. Be afraid of raising your concerns. You will not suffer any recrimination as a result of voicing a reasonably held suspicion regardless of whether any subsequent investigation substantiates that concern.

3. Approach or accuse any individual directly

4. Try to investigate the matter yourself. Remember there are special rules surrounding the gathering of evidence for use in criminal cases. Any attempt to gather evidence by staff who are unfamiliar with these rules may destroy the case.

5. Convey your suspicions to anyone other than those with the proper authority

6. Speak to representatives of the press, radio, TV and other third party unless expressly authorised by the Chief Executive.

What Happens Next?

If your manager and the Director of Finance`s enquiries support the suspicions the Director of Finance will report the matter to the Chief Executive and the Directors of Internal Audit and Personnel. It will then be followed by the Fraud and Corruption Response Plan to investigate and take further action.

Definition of fraud and related Terms

Fraud, a commonly used term, does not have an actual definition in law. As a term it has become accepted into general use, mainly through news media headlines and popular television.

Fraud is effectively a form of theft that goes beyond the basic taking of someone else`s property. The table below provides only a very basic definition of fraud. This definition is not formally recognised in law but is provided here to assist in providing a basic understanding.

Theft	Robbery	Fraud
Theft is clearly defined within the 1968 Theft Act. Section1 (1) states A person is guilty if they: Dishonesty appropriate property belonging to another with the intention of permanently depriving the other of it.	May be simplistically described as theft with violence, (actual, perceived or threatened)	Theft supported by Deception Conspiracy

General terms

Deception
Making a third party believe an item or statement to be something other than what it really is. Deception may be committed equally by action not taken (allowing someone to believe something without properly advised) as it is through action taken (adding or changing figures on a cheque for example)

Conspiracy
An offence is committed if two or more people agree to take action, which is intended to result in a loss to a third party or inappropriate gain to themselves.

Irregularities
The following items events or actions may indicate the existence of a fraud and should be reported to your manager
The making of changes to any document or instrument by any person be it the original author or another. Examples may include:-

- Changing a timesheet
- Altering figures on any document to give a false impression
- Creating a false record
- Altering any instrument (Instruments includes any document whether formal or informal,
- Cheques, postal order, stamp data storage device, driving licence, Certificate of Birth, Death or Marriage etc.).
- Using a false record for personal benefit. (This may include the completion of self certified sickness records or other sickness issues)
- Evasion of liability by deception (non payment of prescription charges through the incorrect claiming of exemptions)

Due to the nature of the work place and the increasing use of Computers a person may be guilty of an offence under the Computer Misuse Act 1990 if he:-

- Causes the computer to perform any function with intent to secure a access to any program or data held in any computer.
- The access he intends to secure is unauthorised; and
- He knows at the time that this is the case.
- Irregular activities may therefore include
- The use of another`s password
- Use of unauthorised software
- Unauthorised use of the Internet and the downloading of data or programs.

An offence will probably gave been committed if a person attempts any of the above (Criminal Attempts Act 1981) or agrees with another to attempt or to achieve any of the above Statutory Conspiracy Criminal Law Act 1977 or Common Law Conspiracy (s12. Criminal Justice Act 1987)

27. A Guide to Safeguarding Children?

WHAT IF I DONT SEE PATIENTS OR CHILDREN?

The Children Act 1989 states a child is anyone up to their 18th birthday. As such children are seen in many adult departments of the Trust. You may also see children as relatives and visitors of your patients, or in the corridors and public areas of the NHS, or in your home life.

All NHS staff, whatever their role in the organisation, have a legal duty to safeguard and promote the welfare if children (newborn up to 18th birthday). This includes staff who are employed through Agencies, and applies whether they work with patients or colleagues who are parents, patients or colleagues who are pregnant or expectant fathers, Grandparents/aunts/uncles/siblings, patients who are children or young people.

If you have concerns, it is YOUR RESPONSIBLITY to adhere to the local procedures and to make a referral as required.

HOW DO I RECOGNISE ABUSE?

Below are some key indicators of the four recognised categories of abuse. The lists are key indicators are not exhaustive but can help you in your thoughts. Key points to remember are:

Is the reported mechanism consistent with the injury seen?

Does the reported mechanism fit with the age and development of the child?

Are there any unusual patterns in the injuries?

Are you concerned about the behaviour of the child/adults?

Physical Abuse

Unexplained injuries /burns

Unlikely reason given for the injury / conflicting stories given concerning injuries

Refusal to discuss injuries

Bruises – different ages in the same place, fingertip, outline, consider development of child

Frequency of attendances at the A & E or Fracture Clinic

Scars- indication of untreated injuries, unusual shape, large number of different aged scars.

Fractures – especially in children under 1, alleged unnoticed fractures.

Inappropriate delay in seeking medical advice.

Neglect:

Constant hunger

Poor Personal hygiene

Severe nappy rash/bed sores/ulcers

Constant tiredness lethargy

Pale & undernourished

Frequent lateness or non-attendance at school

Untreated medical problems

Low self-esteem

Poor social skills

Failure to thrive

Non attendance at medical appointments where chronic illnesses present

Emotional:

Developmental delay-physical, mental & emotional

Over reaction to mistakes

Fear of new situations

Neurotic behaviour/autistic tendencies

Self mutilation

Fear of parental/carer contact

Sexual:

Disclosure

Genital injuries, including unexplained bruises around the genital /anal area

Sexually transmitted diseases

Sexual play / masturbation which is inappropriate to the child`s age & development

KEY ISSUES TO CONSIDER

Children left home alone-there is no legal age that a child can be left alone, but parents can be charged with abandonment or neglect.

Consider: Is the child safe? Couth they remain safe if the house caught fire? What arrangements are in place to monitor the child? How competent is the child to act if an issue arose? Is the child alone while the parent is on hospital-how long will the adult be in the hospital for

Children attending hospital alone-Again there is no legal requirement that a child is accompanied, but where consent is required for treatment the child must by Fraser Competent or an adult must consent on their behalf.

Consider: Does the parent know the child has or is attending appointments alone? What is the child attending for and why are they alone? Is their responsible adult aware they are at the hospital? The child must only be discharged from hospital directly into the care of a responsible adult.

Children cared for outside dedicated children`s services-for example the 16 to 18 years who are seen in adult A & E and admitted to an adult ward.

WHAT SHOULD I DO IF I HAVE A CONCERN

Contact the Trusts Safeguarding Children Team

WHAT PAPERWORK IS AVAILABLE

In all key clinical areas there are referral forms known as “Form A”. These are used for all referrals including those from adult areas. WHAT IF I AM NOT SURE HOW TO COMPLETE THE A FORM?

Ask a permanent staff member for assistance or telephone the Safeguarding Children Team for help.

28. Useful Addresses

The General Medical Council
Regent's Place
350 Euston Road
London
NW1 3JN

Tel: 0845 357 8001
http://www.gmc-uk.org

The General Medical Council - Scotland
Napier House
35 Thistle Street
Edinburgh
EH2 1DY

Tel: 0131 240 6410
http://www.gmc-uk.org

The General Dental Council
37 Wimpole Street
London
W1G 8DQ

Tel: 020 7224 3294
http://www.gdc-uk.org

British Medical Association
BMA House
Tavistock Square
London
WC1H 9JP

Tel: 020 7387 4499
http://www.bma.org.uk

Home Office Direct Communications Unit
2 Marsham Street London SW1P 4DF

Tel: 0870 000 1585

http://www.homeoffice.gov.uk

Criminal Records Bureau Customer Services
PO Box 110 Liverpool L69 3EF

Tel: 0870 9090 811 http://www.crb.gov.uk

Joint Committee for Postgraduate Training in General Practice
1st Floor 19 Buckingham Street London WC2N 6EF

Tel: 020 7930 7228 http://www.jcptgp.org.uk

United Medicare

29. Contact Details

United Medicare Limited

23, Pickford Road
Bexleyheath
Kent DA7 4AT
Tel: 020 8306 2806
Fax: 020 8306 7779
email: doctor@unitedmedicare.com