Policy:

MD 007 Falls (in-patient and residential areas)

Executive or Associate Director lead	Executive Medical Director
Policy author/ lead	Falls Lead/AHP Professional Lead
Feedback on implementation to	Falls Lead/AHP Professional Lead

Date of draft	October 2018
Dates of consultation period	October – December 2018
Date of ratification	7 February 2019
Ratified by	Executive Directors Group
Date of issue	15 February 2019
Date for review	31 December 2021

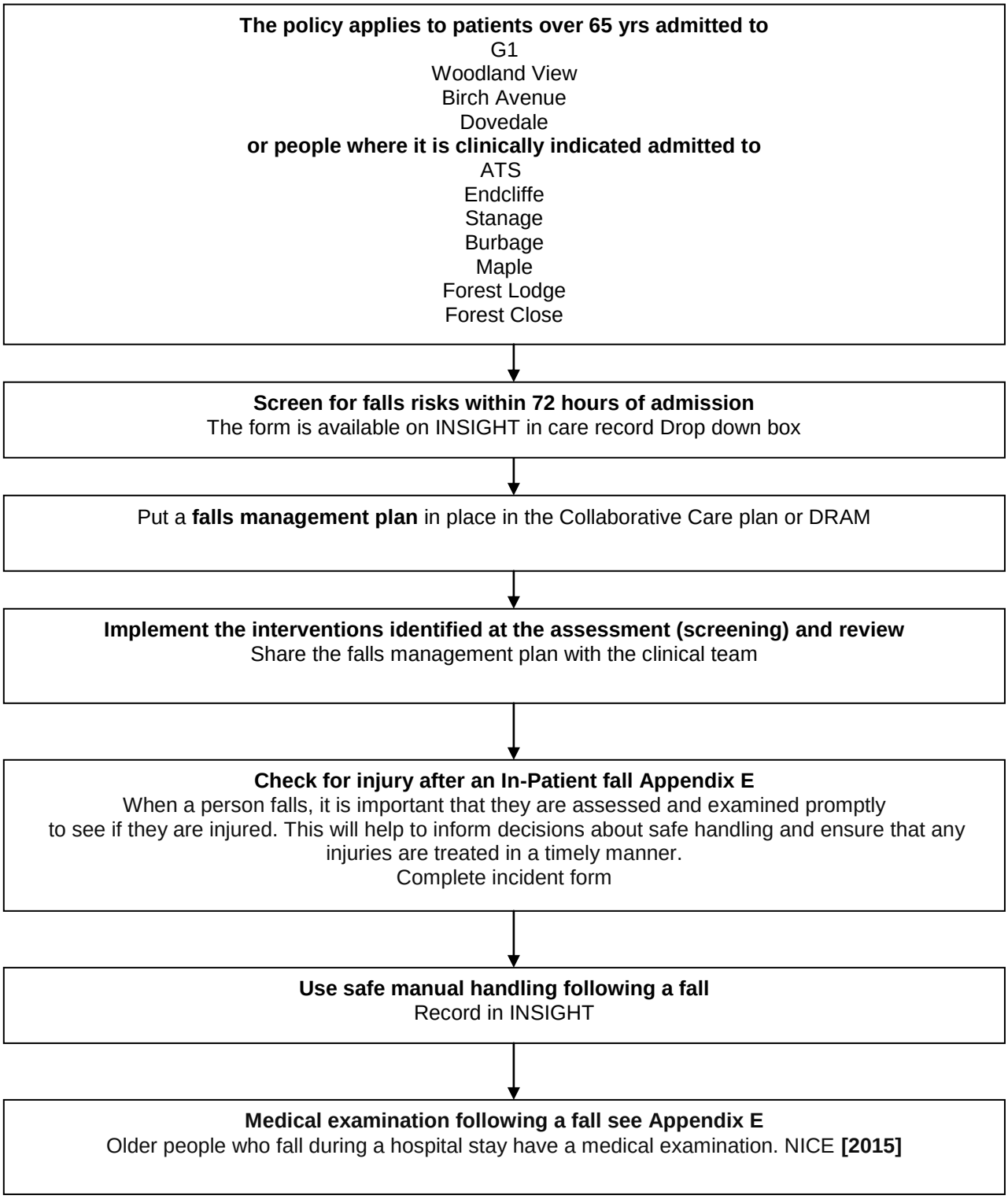
Target audience	Staff in inpatient or residential areas

Policy Version and advice on document history, availability and storage
Policy Version 2 Amended October 2018
The policy is stored on the SHSC intranet and internet.
The policy is the second version of the stand-alone policy for service user slips trips and falls

Please note version 1 of this policy was named: Service User Falls (inpatient and residential). It has been renamed to ensure clearer labelling. Previous versions of this policy should be destroyed.

Contents

Flowchart: On Admission



1. Introduction

The aim of this policy is to detail the Trusts responsibility and processes for the assessment prevention or management of patient falls within adult services (people aged 18 years and over) within Sheffield Health and Social care NHS Trust (SHSC).

The National Institute for Clinical Excellence (NICE) issued guidelines for the assessment and prevention of falls in older people 2004 which were reviewed in June 2013 and the NICE clinical guideline 161 issued. The guideline was further reviewed in January 2017 and standards added.
The Falls NICE guideline 2017 is an extension to the remit of NICE clinical guideline 21 (published November 2004) it includes assessment and prevention of falls in older people during a hospital stay (inpatients) and sits alongside the original guideline.
The guidelines amended in 2013 added that, the guidelines also apply to younger people and learning disabled people where it is clinically indicated. It is important to emphasise that all of the 2004 recommendations are just as relevant and important now as they were when they were originally published.

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling,

- 30% of people older than 65 fall
- 50% of people older than 80 fall at least once a year.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall.
Falls are estimated to cost the NHS more than £2.3 billion per year and can have significant impact on quality of life and future health.

Slip, trips and fall incidents can be cut dramatically through good planning, positive management and good housekeeping. The consequences of not doing this, increases the risk of

- Serious injuries to patients
- Higher medical costs and longer waiting lists
- Increase costs of litigation

Slips trips and falls are the most common reported risk incidents in the Trust. Patient falling is also the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from in-patient services across Britain. In June 2010 NSPA arranged a “falls reminder” to NHS organisations to follow guidelines aimed at reducing falls. This reminder was in response to a publication of data 283,438 reported slips trips or falls between October 2008 and September 2009.

National reporting and Learning System (NRLS) recommends that each patient at risk of falling should receive multifaceted clinical and environmental interventions that could reduce the risk of falls. To achieve this NHS organisations must:-

- Ensure that circumstances of falls are properly described on local incident forms
- Analyse and use reports of falls to learn about contributing factors
- Base falls prevention policies on the evidence described in its report
- Have appropriate guidance for staff.

Legislative requirements

The care Quality Commission (CQC) requirements
The CQC have specified in their Core Standards, that: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff visitors and their property and the physical assets of the organisation.

NHSLA Risk management Standards
The NHSLA Standards Risk management Standards require organisations to have an approved documented process for managing the risk associated with slips trips and falls involving service users, staff and others that is implemented and monitored.

2. Scope of the policy

- People aged 65 or older admitted to Sheffield Health and Social Care Trust (SHSC) wards, and nursing homes.

- People who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition are also covered by the Prevention of Falls NICE guideline (2017) and recommendations and this policy.

This is a Trust wide policy which applies to all staff employed by the Trust and others who work in Sheffield Health and Social Care wards and nursing homes

3. Definitions

- Falls are usually defined as “unintentionally coming to rest on the ground floor or other lower level and so encompass faints epileptic seizures and collapses as well as slips and trips.” NPSA 2010

4. Purpose

The purpose of this policy is:

- For SHSC to gain assurance that a guide to the management of falls is available for staff to use when a person is admitted.
- For staff to be guided on how to manage falls by screening, planning and implementing the actions to reduce falls.

5. Duties:

Trust Board
The Trust Board has ultimate responsibility for managing the implementation of health and safety within the Trust.

Executive Directors Group (EDG)
Is responsible for the ratification of this policy and ensuring it is adopted and implemented by all clinical and corporate service directors

Service Directors/Operational Managers
Each Director /Operational Manager has responsibility for ensuring compliance with the requirements of this policy and that this policy is implemented as appropriate within their services.

6. Procedure Clinical staff

All clinical staff who work in the in- patient areas and nursing homes have a responsibility to ensure that they comply with the Trust Policy.

- **Screen for falls**: Multi factorial screening for falls on admission within 72 hours and keep a record on the INSIGHT notes of the falls screen. Appendix B
  Learning Disability services use appendix D
- **Falls management plan**: from the screening information formulate a falls multi factorial management plan and record electronically in the collaborative care plan or DRAM. Guidance appendix C
- **Implement** the falls management plan and review, record in electronic notes.
- **Communicate** the falls management plan with staff in the clinical area.
- **Following a fall,** follow the guidance see flow chart p3, appendix E: Management of a person found on the floor.
- **Use safe manual handling** procedures and record how the person has been moved and handled following a fall.
- **Refer for medical advice** following a fall (NICE guidance 2017)
- **Report:** All falls by patients to be reported immediately via the incident reporting system. This must be in line with the Trust incident reporting and investigation policy and procedure.

6.1 Falls screening tools are

- Available on INSIGHT in the care record drop down box and called
  Falls screening tool.

6.2 Review the falls information -Teams

- Teams will be expected to review the falls data (that is provided quarterly to the teams) and in the local governance meetings discuss and take action to reduce the number of falls in their clinical area
- Falls data – audits are reported quarterly to the Service User Safety group

7. Dissemination, storage and archiving (Control)

A communication will be issued to all staff via the Communication Digest immediately within 5 working days following issue. At the same time, a communication will also be sent to Education, Training and Development to review training provision in relation the revised policy.

This policy will be available to all staff via the Sheffield Health and Social Care NHS Trust Intranet and Trust website. The previous version of Patient Falls V1 Issued 2017 should be destroyed if a hard copy is required and replaced by V2 this policy.

A separate policy covers staff and visitors falls i.e. Slip trips and falls (Staff and public) Policy.

8. Training and other resource implications

Training associated with this policy is outlined in the Trusts Mandatory Training Policy and identified within the Trusts training needs analysis.

- Falls training will be provided on induction and 3 yearly thereafter
- In specific clinical areas falls training will be provided by the clinicians

9. Audit, monitoring and review: Compliance to falls NICE guidance

- Falls data -quarterly reports are provided to the Service user Safety Group
- Audit 2017-18 compliance to falls NICE guidelines (2017)

NHSLA Risk Management Standards - Monitoring Compliance of standards for fall screening –Falls NICE Guidelines(2013)						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Screen for falls within 72 of admission	Quarterly reports	Central services	Quarterly	Service user safety group	Falls Steering group	Service user safety group
Falls Policy	Service User safety Group			3 yearly Or if changes made to the guidelines		
Falls training specific to clinical area	Yearly reports	Education training and development	Yearly	Yearly	Service User safety group	

10. Implementation plan

The falls patient policy review in 2018
Governance of falls management and implementation of the NICE guidelines to be reported in local team governance reports.
Reports to the service user safety group

11. Links to other policies, standards and legislation (associated documents)

- Risk Management Strategy
- Health and Safety Policy
- Incident Reporting Policy
- Slips Trips and Falls (Staff and the Public) Policy
- Back Care and Manual Handling Policy.

12. Contact details

Title	***Name***	***Email***
Professional Lead OT and lead for falls	Elaine Hall	Elaine.Hall@shsc.nhs.uk
Physiotherapy Team Leader in Learning Disability Services	Kate Scott	Kate.scott@shsc.nhs.uk
Senior Physiotherapist	Angela Howard	Angela.howard@shsc.nhs.uk

13. References

Falls: The assessment and prevention of falls NICE guideline (2017) DH

Appendix A – Version Control and Amendment Log

Version	Type of Change	Date	Description of change(s)
1	Development	October 2016	New stand-along policy for service users developed, following internal audit report. This replaced generic policy for staff and service users.
1	Approval	November 2016	Policy issued following ratifcation.
2	Amendment	July 2018	Following changes to Falls NICE guidance January 2017
2	Amendment	October 2018	Further amendments following comments received during consultation.

Appendix B

The falls screening tool - to be used in all in patient areas, nursing homes and is available on INSIGHT in care record drop down box

FALLS and OSTEOPOROSIS SCREENING TOOL
To be completed within 72 hours of admission

Location: **Consultant:** **Person Completing:** **Name:** **Date of Birth:** **Insight Number:** **Time**					
The following ten factors are indicated in the Falls NICE Guidelines as being the most predictive of falling					
	Yes	**No**		**Yes**	**No**
1) History of any Fall in the last year?			**6) Does the person have any visual/hearing difficulties?**		
2) Does the person have / report any problems with their gait or balance?			**7) Does the person have any urinary incontinence?**		
3) Does the person need to use their arms when rising from a dining chair? (indicating muscle weakness)			**8) Does the person have Impaired Judgement?** (e.g. confused, forgets limitations, memory problems)		
4) Is the person taking four or more medications per day?			**9) Is the person afraid of falling?**		
5) Does the person have a history of Stroke or Parkinson's Disease?			**10) Are there any apparent slip/trip hazards in the environment?**		
If the answer to Questions 1 or 2 is YES, OR if there are 3 or more positive answers **Refer to the falls guidance in care record to inform the Falls Management plan**					
OSTEOPOROSIS SCREEN (Please write NK if information not known) *Osteoporosis is a disease resulting in loss of bone density and greatly increases the risk of fracture following a fall. It is therefore important to identify if a person is likely to suffer from osteoporosis.*					
History of fragility fracture (e.g. a fracture caused by a fall from a standing position)			**Long term use of oral steroids**		
Family history of osteoporosis (e.g. maternal hip fracture)			**Early menopause/hysterectomy** (under age 45)		
Smoker (now or previously)					
Where there are one or more risk factors for osteoporosis consider referral to medical staff for further investigation and treatment (e.g. calcium and Vitamin D therapy)					

Appendix C - FALLS and Osteoporosis Assessment Guidance

In support of falls & osteoporosis screening

RISK FACTOR	GUIDANCE
History of Falls: one or more falls in last year or one or more falls since admission	• Review incident(s) with person and carer if appropriate, advising on how to prevent further falls - Complete falls Log
	• Referral for Physiotherapy / Occupational Therapy assessment / Falls awareness group
	• If the fall was a result of a blackout, refer to medical staff for assessment
	• Any dizziness before falling, check lying and standing BP and refer to medical staff if necessary
Balance, Transfers and Walking: e.g. Difficulty moving from bed to chair. Shuffling/unsteady gait. Uses arms to rise from a chair. Is mobility aid appropriate and used safely?	• Referral to physiotherapy for mobility and balance assessment / intervention/aids
	• Consider referral to OT for advice on changes to environment.
	• Ensure any equipment is fitted and used correctly e.g. bed leavers
	• Ensure any walking aids are left within reach and used correctly
	• Any dizziness on standing or turning check lying and standing BP. Advise to take time when getting up, before setting off to walk.
	• Keep environment free from clutter.
	• Ensure necessary items are within easy reach e.g. spectacles, drinks etc.
	• Attend falls awareness group.
Fear of Falling Concern affecting mobility / lifestyle. Unable to summon help. Unable to get off floor.	• Reinforce falls prevention advice.
	• Consider referral to Physiotherapist / Occupational Therapist for advice on coping strategies to deal with fear of falling.
	• Consider city wide care alarm on discharge.
Pain: Is pain affecting mobility?	• Ensure regular administration of prescribed analgesics.
	• Ref to Dr for analgesia review if required.
Judgement: Agitation/Confusion Memory problems Reduced awareness of own limitations.	• If the person is acutely confused and a physical cause, e.g. UTI / Constipation, is suspected, refer to medical staff for assessment.
	• Consider & determine level of observation required. Assess supervision needs in toilet / bathroom
	• Ensure bed rails are only prescribed as per SHSC Restraint Policy: Keep bed at lowest height and consider appropriate bed.
	• Consider use of assistive technology.
Vision: Significant visual Impairment. Wears bifocals.	• Ensure spectacles are kept clean, within reach and worn appropriately.
	• Advise concentration while walking and ensure orientated to ward environment.
	• Advise caution with bi/varifocal glasses (increased risk of falls on steps and stairs).
	• Advise regular eyesight test / consider referral to optician.
Hearing: Has difficulty hearing conversational speech.	• If hearing aid is worn, check it is correctly worn and that it is working
	• Check for ear wax.
	• Refer for hearing test if necessary.

RISK FACTOR	GUIDANCE
Feet / Footwear Poorly fitting shoes / slippers Condition of feet / oedema.	• Ensure wear well fitting shoes/slippers
	• Check when last seen by Podiatrist, and refer if necessary
Medication e.g. Diuretics Strong analgesics Sedatives/Hypnotic Anti-Hypertensive Antidepressants Antipsychotics Anti-Parkinson	• If the fall is due to dizziness / sleepiness and medication is suspected refer to medical staff for review.
	• If mobility has deteriorated or gait has changed following change in medication refer to medical staff for review.
Continence Suffers from urgency / frequency / incontinence	• Advise regular fluid intake
	• Ensure person knows how to summon help when required: Nurse as close as possible to a toilet. Provide commode / urinal as appropriate, within easy reach and check person knows how to use them: Consider regular prompts to use toilet.
	• Consider referral to Continence service
Hydration Any signs of dehydration?	• Recommend 8 (250mls) glasses of fluid a day. (if not contraindicated by an existing medical condition).
Nutrition Reduced diet?	• Complete MUST, devise nutrition care plan.
Alcohol. Is intake above recommended units? (m-21 / f-14 units)	• Explain the increased risk of falls and other risks due to alcohol use
	• Provide advice on sensible drinking
	• Consider referral to appropriate service
Environmental	• Advise on keeping environment free from clutter
	• Consider referral to occupational therapy for home safety check prior to discharge
Osteoporosis	• Offer Lifestyle advice (healthy diet, physical activity, not smoking, etc) as part of General Health Promotion
	• For clients with one or more risk factors for osteoporosis, refer to medical staff for further assessment / investigation / Vitamin D and Calcium therapy if appropriate.

APPENDIX D: FALLS SCREENING TOOL FOR LEARNING DISABIILITY SERVICE

FALLS & OSTEOPOROSIS SCREENING TOOL Learning Disability Service

Name: **Date of Birth:** **Insight Number:** **Unit address:** **Registered GP:** **Covering GP:**	
Information sources accessed in completing risk profile:	Person: Case Notes: Carer/relative: Social Worker: Other (specify):

FALLS SCREEN
The following ten factors are indicated in the NICE Guidelines as being the most predictive of falling:

	Yes	No		Yes	No
1) History of any Fall in the last year?			**6) Does the person have any visual difficulties?**		
2) Does the person have / report any problems with their gait or balance?			**7) Does the person have any urinary incontinence?**		
3) Does the person need to use their arms when rising from a dining chair? (indicating muscle weakness)			**8) Does the person have Impaired Judgement?** (e.g. confused, forgets limitations, memory problems)		
4) Is the person taking four or more medications per day? (particularly sedative and antipsychotic drugs)			**9) Is the person afraid of falling?**		
5) Does the person have a history of Stroke or Parkinson's Disease?			**10) Are there any apparent slip/trip hazards in the home environment?** (see Note 1)		
If the answer to Questions 1 or 2 is YES, OR if there are 3 or more positive answers **Please continue to** formulating a care plan					
Any other apparent problems which may increase the risk of falls (e.g. leg oedema, walking aid needed but not provided)	**Leg Oedema, Parkinson's, Alzheimer's** **CT Scan shows previous frontal lobe infarct**				

OSTEOPOROSIS SCREEN (Please write **NK** if information not known)

History of fragility fracture (e.g. a fracture caused by a fall from a standing position)			**Long term use of corticosteroids** (see Note 3)		
Family history of osteoporosis (e.g. maternal hip fracture)			**Early menopause/hysterectomy** (under age 45)		
Smoker (now or previously)					

Explanatory Notes:
Slips/Trip hazards: e.g. trailing wires, loose rugs, clutter on the floor, pets, 'sloppy slippers' etc.
Osteoporosis is a disease resulting in loss of bone density and greatly increases the risk of fracture following a fall. It is therefore important to identify if a person is likely to suffer from osteoporosis.
Cortico-steroids: e.g. Prednisolone, Hydrocortisone etc, used in inflammatory and allergic conditions such as rheumatoid arthritis, asthma etc. side effects include osteoporosis and fractures. Long term use would be more than three months.

Completed by: **Designation:** **Date**

Appendix E: Management of a Person Found on Floor (In-Patients)

LEAVE ON FLOOR → **Call for help**

Check level of consciousness**:** Alert Responds to Voice, Pain, Unresponsive

And start BLS (Basic Life support) assessment

Check condition – Airway, Breathing, Circulation Disability Exposure

If unresponsive –Send helper to call emergency ambulance Tel:2222

If possible ask what happened

Try to ascertain what has happened -Is there bruising or other injury? Is the person in pain? Could the person have hit their head? Consider the potential for a spinal injury

DO NOT ATTEMPT TO MOVE THE PERSON UNTIL FULLY ASSESSED BY THE APPROPRIATE PERSON

SUSPECTED FRACTURE

There may be:

- Deformity (out of shape)
- Irregularity (shortening of limb)
- Pain or tenderness
- Loss of power
- Swelling and/bruising
- Unnatural movement
- Crepitus (grating)
- open wound

If suspected or in doubt send a helper to call an ambulance Tel 2222-give specific details

e.g. suspected fracture of the upper leg

- Continue to monitor Response and breathing
- Be aware of possibility of shock
- Tell casualty to keep still
- Steady the limb with your hands above and below fracture site
- DO NOT give anything to eat or drink

DO NOT move unnecessarily

SUSPECTED HEAD INJURY

If conscious carry out observations using The Early Warning Score (EWS) and /or Glasgow Coma Scale (GCS) AVPU and pupils and Blood sugar

Consider contacting a Doctor or if concerned consider emergency ambulance Tel: 2222

30 MINUTES AFTER BEING FOUND

Carry out observations using the EWS/GCS -Is there a deterioration? Increased confusion, agitation, dizziness, vomiting?

If concerned consider calling an emergency ambulance Tel: 2222

Continue with 30 minute EWS and AVPU (Alert Voice Pain Unresponsive) observations

2 HOURS AFTER BEING FOUND

Look for any changes in the person's condition. Carry out observations as above and continue hourly thereafter until reviewed by appropriately qualified person

Look for signs of head injury e.g. vomiting, persistent headaches

If still concerned call an emergency ambulance Tel:2222

If there is **NO INJURY** suspected follow manual handling procedures

If there is any pain or change in condition when moving STOP and reassess

Continue to monitor for any deterioration

COMPLETE AN INCIDENT FORM AND OTHER RELEVANT DOCUMENTS

Record on Electronic notes

Supplementary Section A - Stage One Equality Impact Assessment Form

Please refer back to section 6.5 for additional information

1. Have you identified any areas where implementation of this policy would impact upon any of the categories below? If so, please give details of the evidence you have for this?

Grounds / Area of impact	People / Issues to consider	Type of impact		Description of impact and reason / evidence
		Negative (it could disadvantage)	Positive (it could advantage	
Race	People from various racial groups (e.g. contained within the census)	No	No	
Gender	Male, Female or transsexual/transgender. Also consider caring, parenting responsibilities, flexible working and equal pay concerns	No	No	
Disability	The Disability Discrimination Act 1995 defines disability as *'a physical or mental impairment which has a substantial and long-term effect on a person's ability to carry out normal day-to-day activities'.* This includes sensory impairment. Disabilities may be visible or non visible	No	Yes	The falls management has raised awareness about the physical issues that can impact on falls.
Sexual Orientation	Lesbians, gay men, people who are bisexual	No	No	
Age	Children, young , old and middle aged people	No	No	
Religion or belief	People who have religious belief, are atheist or agnostic or have a philosophical belief that affects their view of the world. Consider faith categories individually and collectively when considering possible positive and negative impacts.	No	No	

2. If you have identified that there may be a <u>negative impact</u> for any of the groups above please complete questions 2a-2e below.

2a. The negative impact identified is **intended** ☐ **OR 2b**. The negative impact identified **not intended** ☐

2c. The negative impact identified is **legal** ☐ **OR 2d**. The negative impact identified is **illegal** ☐ **OR (see 2e)**
(i.e. does it breach antidiscrimination legislation either directly or indirectly?)

2e. I **don't know** whether the negative impact identified is legal or not ☐
(If unsure you must take legal advice to ascertain the legality of the policy)

3. What is the level of impact?

☐ HIGH - Complete a **FULL** Impact Assessment (see end of this form for details of how to do this)

☐ MEDIUM - Complete a **FULL** Impact Assessment (see end of this form for details of how to do this)

☐ LOW - Consider questions 4-6 below

4. Can any low level negative impacts be removed (if so, give details of which ones and how)

5. If you have not identified any negative impacts, can any of the positive impacts be improved? (if so, give details of which ones and how)

6. If there is no evidence that the policy promotes equality and equal opportunity or improves relations with any of the above groups, could the policy be developed or changed so that it does?

7. Having considered the assessment, is any specific action required - Please outline this using the pro forma action plan below
(The lead for the policy is responsible for putting mechanisms in place to ensure that the proposed action is undertaken)

Issue	Action proposed	Lead	Deadline

8. Lead person Declaration:

8a. Stage One assessment completed by : ……..……(name) ……..……(signature) ……(date)

8b. Stage One assessment form received by Patient experience and Equality Team ……..(date)

8c**.** Stage One assessment outcome agreed ☐ ……*(sign here)*……..….. *(*Head of Patient Experience and Equality)

OR …… (date agreed)

8d. Stage One assessment outcome need review ☐ …….. ……*(sign here)*……..….. *(*Head of Patient Experience and Equality)

…….. (date returned to policy lead for amendment)

(if review required – please give details in text box below)

If a full EQIA is required the stage 1 assessment form should be retained and a completed EQIA report submitted to the relevant governance group for agreement by the chair. The chair will forward the completed reports to the Patient Experience and Equality team for publication.

Any questions relating to the completion of this form should be directed to the Head of Patient Experience and Equality.

Supplementary Section B - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.sct.nhs.uk/humanrights-273.asp (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

☑ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☑ **No, no further action needed.**

☐ **Yes, go to question 3**

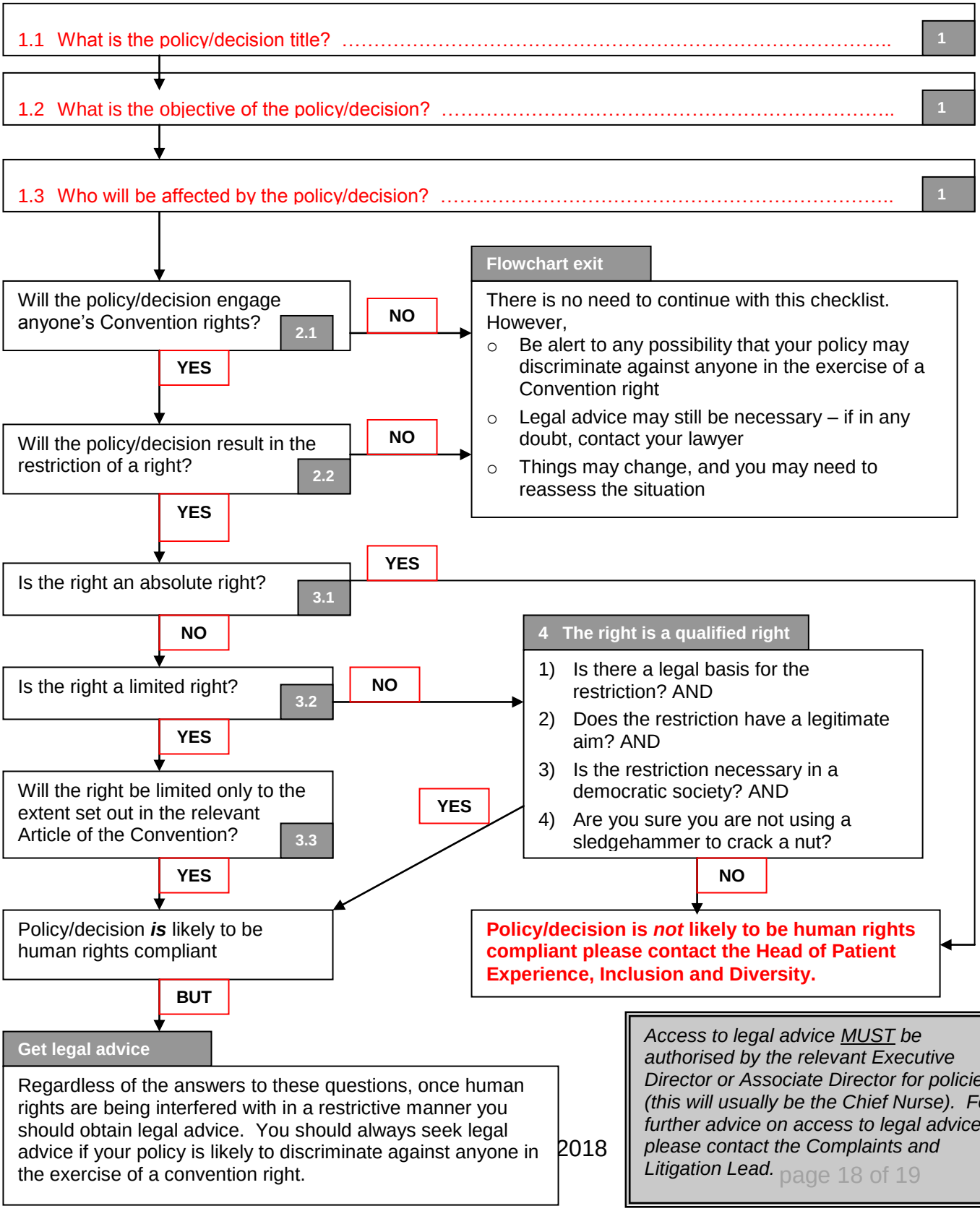
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix F – Development, Consultation and Verification

Development:

The management of falls inpatient policy has been reviewed and amended to include the NICE quality standards (2017). The previous NICE guidelines from 2004 sit alongside the additions to the guidance in 2013 and 2017.

The current policy includes all the guidelines.

The previous stand- alone service user falls policy was issued in 2016 with a review date of 2019.

Consultation:

This policy has been consulted upon via the Service User Safety Group (commencing July 2018). Comments/amendments were requested and incorporated and the policy referred back to the Group in October 2018.

Verification

The Service User Safety Group verified this policy at their meeting on 11 October 2018. The policy was then taken to the Policy Governance Group on 14 January 2019, for onward ratification by the Executive Directors Group.