The Rehab Group
Policy on Policies

Applies Jurisdiction:	☒ ALL
Division:	☒ ALL
Reference Number:	COR-POL-001
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Date:	June 2017
Title:	Policy Coordinator
Approver(s):	Pauline Newnham
Date:	July 2017
Title:	Director of Quality & Governance
Signature:	
Effective From:	July 2017
Review Date:	July 2021

Rehab Group – Policy on Policies

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Rehab Group – Policy on Policies

1.0 POLICY STATEMENT

1.1 It is the responsibility of all Managers i.e. Senior Management Team, ROO's ISM's, Line Managers, Specialist Leads with designated responsibility for services and projects, to ensure that policies directing and describing the practices and behaviours for which they are accountable and are relevant to them or their staff members, or volunteers, are developed and distributed appropriately.

1.2 All Rehab Group Policies, Procedures, Protocols/ SOPs and Guidelines (PPPG) must be developed in keeping with the agreed process and format described herein, authorised by the relevant corporate lead or their designee and reviewed every three years unless legislation or changes in practice require an earlier review.

1.3 All policies must be developed and make reference to any pertinent current legislation, regulation and/ or professional evidence-based best-practice guidelines.

2.0 PURPOSE

To direct staff at Rehab in the processes required for the development, registration, distribution and document control of all Policies, Procedures, Protocols/ SOPs and Guidelines (PPPG) in order to ensure that only current, accurate and comprehensive documents are available to guide staff, volunteers, People who use are services and members of the public. Where a national policy exists related to our service delivery a shortened version will be developed for organisational use, applying the policy framework described here with links to the relevant national policy website.

The purpose of the PPPG is to:

- Promote best practice
- Standardise practice and service delivery
- Ensure that legislative and regulatory requirements are met
- Ensure employees and line managers are clear on their roles and responsibilities

- Facilitate effective staff induction
- Act as education tools
- Act as a basis for audit and evaluation

3.0 SCOPE

3.1 Policies, Procedures, Protocols/ SOPs and Guidelines (PPPG) are necessary for the delivery of safe, evidence based, and measurable person centred service. Providing access for staff, volunteers, people who use are services and or members of the public to current, comprehensive and accurate policies and guidance improves the safety and quality of people who use are services, informs staff, supports best practices and provides staff with a standard by which services can be evaluated and improved.

3.2 This policy applies equally to all jurisdictions, divisions', staff and volunteers of the Rehab Group, and specifically to **staff** involved in implementation for Policies and all related Protocols/ SOPs Procedures and Guidelines (PPPG).

3.3 This document directs the practices for the development, review, authorisation and registration for all of the Rehab Group Policies, Procedures, Protocols/ SOPs and Guidelines (PPPG). From this point on, the term 'Policy' will be used to describe all related documents.

4.0 GLOSSARY OF TERMS/ DEFINITIONS

A Policy

- A policy states **<u>what</u>** the organisation's position is on a particular topic
- It does so through setting out guiding principles, obligations or rules that direct the decisions and actions of the organisation and must be adhered to by all staff

- Policies lead to and shape Procedures and Guidelines.

Compliance is mandatory.

(See Appendix 1 – Control Sheet/ Policy Template)

A Procedure

- A procedure sets out **<u>how</u>** a policy will be implemented, through providing instructions that must be adhered to and/or steps that must be followed. Procedures do not provide room for interpretation – they must be followed literally by the person implementing the procedure
- Procedures usually only relate to one area of activity/practice, and are often written to the level that they act as a training tool

Compliance is mandatory.

** Procedures may cater for jurisdictional differences but where this is not possible a jurisdiction specific policy will need to be considered.*

A Protocol/ Service Specific Procedure

- A protocol is a description of a mutually agreed method for carrying out a process or procedure. It describes the specific actions or steps by which a policy or practice is to be executed.

Compliance is mandatory.

Where deviation is required, staff must bring to the attention of the Protocol Author.

A Guideline

- A guideline provides important background or ancillary information that may be advisory in nature and support the implementation of best practice to guide the actions of the users, thereby promoting predictability and improved outcomes
- There may be some room for interpretation by the person following a guideline, but only within the context of the relevant policy.

Compliance is not mandatory but staff is required to adhere to guidelines where possible.

**Where there is a requirement by funders and or regulators to localise a policy procedure for divisional services, a Protocol/ Service Specific Procedure should be introduced.*

5.0 GENERAL PROVISIONS

Policy Framework

In line with our strategy, the Rehab Group is committed to developing and implementing a policy framework to enhance efficiency and enable proper management.

The objectives of the policy framework are to:

- Identify and fill policy gaps with practical fit for purpose policies
- Ensure consistencies in content, formatting, etc.
- Log and manage differences in divisional practice, *as required*
- Eliminate duplication
- Support good governance
- Provide clarity of the organisation's rules
- Provide easy and consistent access to current policies
- Ensure that services have the opportunity to input and drive policies that affect them.

All policy material developed within this framework will in the main, take the form of a policy, procedure, protocol/ SOP or guideline.

5.1 Policy Issue

When it is identified that there is an issue with a policy (new policy required/ user problems/ change in legislation/ new strategy/ new initiatives etc.) author/ approver/ the staff member should inform the Policy Coordinator who supports the process of change.

5.2 Policy Development

It is the responsibility of the Managers/ Staff and or the Specialist Lead to ensure there are policies in place to direct and/ or guide the processes for which they are responsible. It is the responsibility of all staff to co-operate and assist in the development of policies.

Once the need for the policy or review is identified the author is required to identify and seek cooperation from representatives of other divisions/ jurisdictions involved or affected by the policy content. Within the process authors and approvers will need to be aware of varying jurisdictions.

Policy research must reflect all relevant current legislative and regulatory requirements, best practice and relevant professionals' guidelines (e.g. HIQA, HSE, QQ1, Department for Work and Pensions (DWP), Care Quality Commission, Care Inspectorate Scotland).

All documentation relating to the policy review (emails, letters, and feedback) must be saved within the dedicated folder on the g-drive by the author so that any queries in the future regarding the rationale can be answered.

All authors should identify training requirements, time frames and realistic resources if required to implement same. When a policy is issued either new/ reviewed and changes within effect another

policy area the policy that requires change should be flagged with the Policy Coordinator to be included on the review list.

On development of policies all templates can be found at the following link –
G:\Rehab Policies\11 - Shared Policy Info\Templates

Or please contact:- policyandcordinationteam@rehab.ie

5.3 Policy Content

The policy title must clearly reflect the practice or process that it governs. Policies should sit under one of the key Policy Folder Areas;

- Health & Social Care (Red Branding)
- Training & Employment (Purple Branding)
- Human Resource Management (Dark Yellow Branding)
- Corporate Affairs (Dark Blue Branding)
- Finance (Light Yellow Branding)
- Information & Technology (Light Green Branding)
- Fundraising (Light Blue Branding)
- Enterprise (Dark Green Branding)
- Transport (Orange Branding)
- Property (Grey Branding).

Lead Directors of the Senior Leadership Team (SLT) have allocated governance for each folder and have identified individual staff members who are responsible for coordinating the suite of folders in each location/ business throughout the Rehab Group.

Every new policy area will be issued by the Policy Coordinator (based in the Quality & Governance Directorate) with a policy number established from a three level structure as follows;

- The relevant Business area
- The Subject Activity code
- Numeric Identifier

The language used within the policy must be concise, factual, legible and easily understood. Care should be taken when using

abbreviations to ensure that they are explained and that they do not overlap with others used previously. The use of flow charts and narrative boxes is encouraged.

Each policy document must contain a Control Sheet (Policy Cover) with the following information;

- Business Area
- Reference Number
- Revision Number
- An Author
- An Approver –(Named Individual and/ or Named Committee)
- Effective Date
- Review Date

Each control sheet must contain the date from which it is effective, due for revision and the document version number. Policy documents must include an index of headings, which clearly outline and define the procedures to take. A sample of a Control Sheet is provided in the appendices ***(See Appendix 1 –Control Sheet).***

Examples of headings are;

- **Policy Statement** – this is a statement that clearly indicates the position of the organisation regarding the PPPG e.g. it is the policy of the Rehab Group to use this procedure in the development of all policies. It clearly indicates the position and values of the organisation on a given subject. Related policies can be listed here along with the reference section.

- **Purpose** – this describes the objectives for writing the policy. It provides rationale for why the policy is required. It should be comprehensive and concise in its meaning.

- **Scope** – identifies who and what is governed by the policy.

- **Definitions** – explanation of key technical terms or terminology that is referred to in the policy.

- **General Provisions /Procedure**– the instruction or direction for staff clearly defining what must be done and by whom.

- **Roles & Responsibilities** – who is responsible and/ or authorised to undertake the direction in the policy.

- **Flowcharts** – flowcharts should be used where possible instead of text as it can be a more effective way to visualise something graphically than it is to describe with words. Flowcharts explain a process clearly through symbols and text and give you the gist of the process flow in a single glance.

- **References – (including legislation/ other related policies)** All policies must cross reference other associated policies, procedures or guidelines using full title and reference number. This information must be included in the bibliography.

- **Appendices** – additional information is included in this section that will support and provide a rationale for policy. Each of these should be incrementally numbered.

  This could include;
  - Relevant diagrams
  - Application forms
  - Flow charts
  - Models
  - Protocols
  - Further related detail required-eg-definitions/procedure
  - List of Policy Reviewers

5.4 Policy Format

All policies must be written in;
- Verdana 14
- Size 16 for headings

Align the text throughout the document to the left/ justified.

Single line spacing and double spacing between paragraphs.

Each section (beginning with the documents 'Introduction') must be numbered sequentially.

All acronyms must be spelled when first used.

Bold font must be used for titles and to draw specific attention or emphasis information. The use of italics and underlining for this purpose is prohibited.

Paragraphs are structured so that each main sub-heading represents a separate heading.

Each sub-heading is represented by equal indentation.

When working with draft documents ensure that draft number and date is identified clearly on the table of contents. The practice of using a proof reader for the final draft is advised.

5.5 Policy Review

The final draft of the policy must be circulated by the policy author to reviewers.

Consultation – the purpose of a consultation session is to consult with management and/ or union shop stewards (where applicable) regarding the policy area and its development / review to reach agreement on decisions, processes and procedures. A copy of the draft policy should be circulated prior to the session. (It is essential that all draft copies of policies have the watermark 'draft' to ensure there is no confusion).

The reviewer(s) must be invited to respond with all suggested inclusions and/ or amendments by an agreed date.

5.6 Policy Training

Policy training requirements must be set out by the author(s) as part of the implementation and in turn will inform the approver for ratification at SLT committee meeting.

5.7 Policy Approval

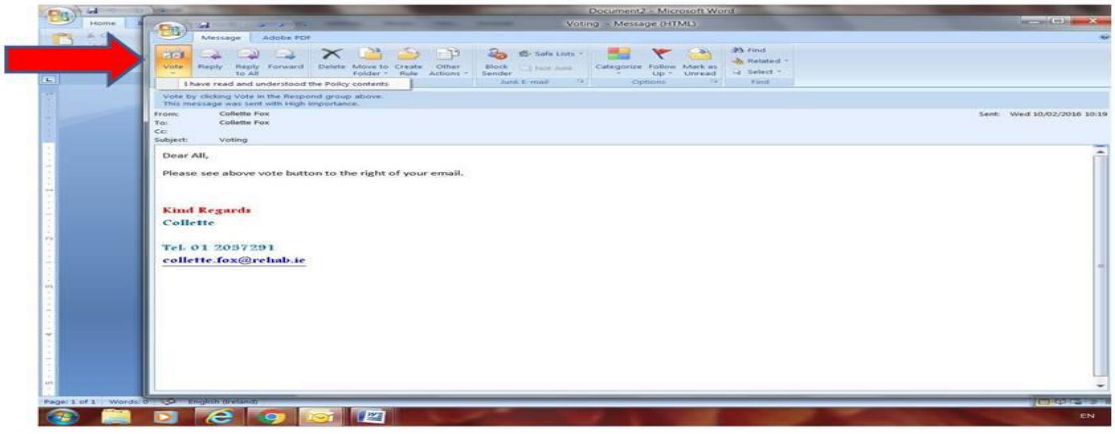
Once reviewed the policy must be sent to the appropriate approver for authorisation. Please note that ONLY Lead Directors of the Senior Leadership Team or their designee can approve policies. Sub committees of the board can also be part of the approval process and regular updates of policy development will be tabled and endorsed during meetings of the Senior Leadership Team.

5.8 Issuing of Policies

The Policy Coordinator prior to distribution will convert all policies to PDF format.

The Policy Coordinator (Quality & Governance Directorate) is responsible for distribution prior to the launch date of the policy. This distribution will take place via a dedicated email 'Policy Distribution', where acknowledgement by the receiver to implement and disseminate the policy can be made by using the vote button.

Please see the following screen shot for a visual of the vote button.



Copies of the notification emails/ acceptance receipts must be kept for evaluation and audit purposes by each of the responsible person(s), this which will be completed on a quarterly basis by the Policy Coordinator.

The ROO's/ ISM's/ PA's and Managers and/ or nominated persons are responsible for communicating policy updates and changes to their staff to ensure they are informed and make themselves familiar with these policies. The ROO's/ ISM's/ PA's and Managers and responsible nominated persons must use the voting button to acknowledge receipt of all policy updates and that they agree to inform all of their team members of policies, especially those relevant to their particular area.

The Policy Coordinator will upload the PDF policy document to the Rehab Group SharePoint Policy Page –

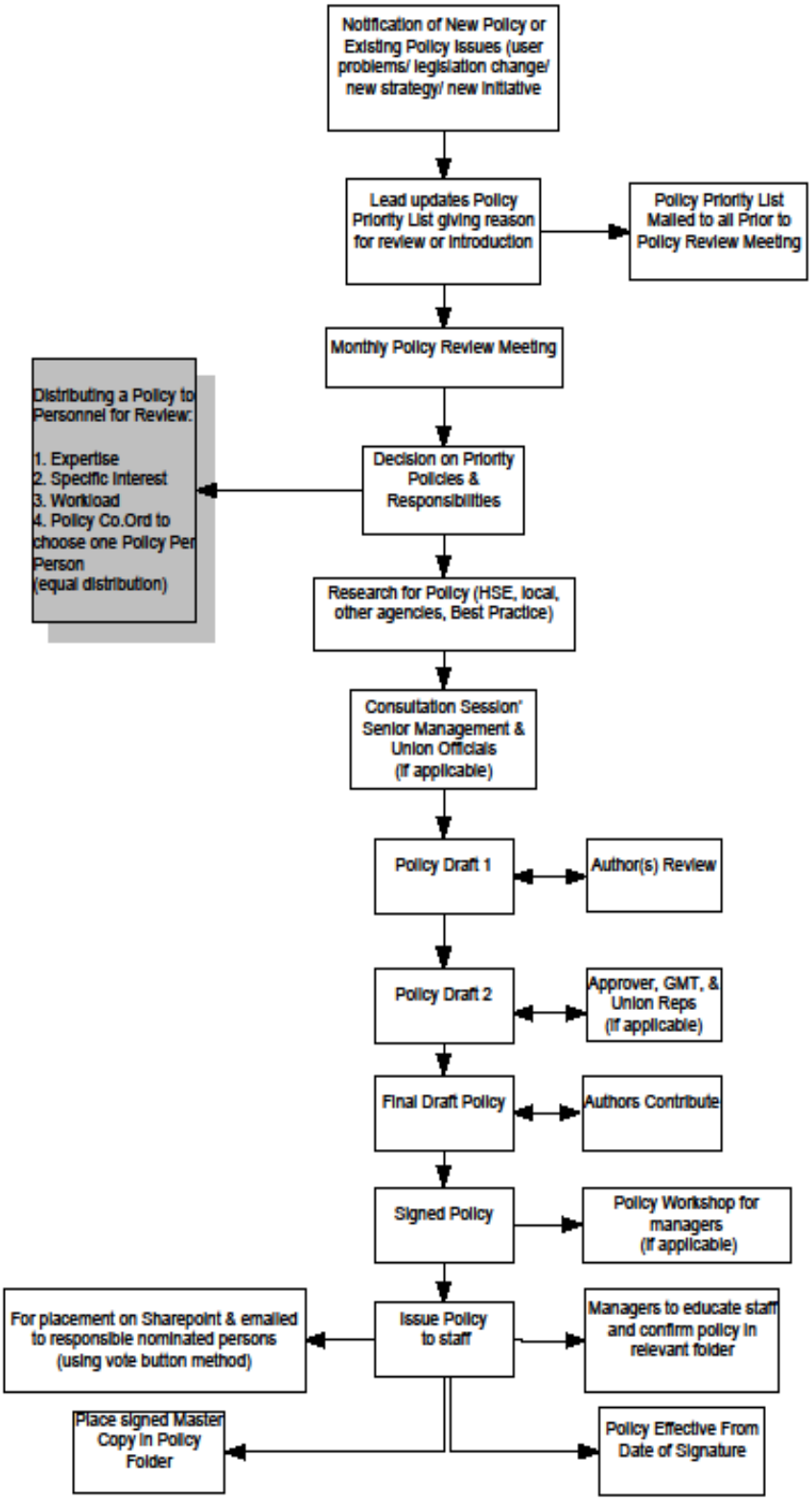
http://sharepoint/GroupPolicies/default.aspx

***This is the primary source for all policies.**

It is the responsibility of all The ROO's/ ISM's/ PA's and Managers and responsible nominated persons to ensure that staff are aware of all current policies and how to access them. This should be included in local induction processes.

A Read & Understood sheet is provided in the Appendices for all policies, this document will need to be supplied to staff members for every policy, ***(See Appendix 2 - Read & Understood).***

Flow Chart for New/ Reviewed Policies Process



*Time Frames need to be agreed by the Approver and confirmed with the Policy Coordinator

5.9 Policy Storage

The Policy Coordinator will save the original signed control sheet for storage in the policy master folder on the policy g-drive and relevant folder. Version control is overseen by the Policy Coordinator.

Hard copies of the policies are available from the Policy Folders located in every service/ location throughout Group. The manager /designee will ensure version control of the suite of folders and that it remains current at all times and old policies are disposed of by shredding. Hard Copy Folders should be kept to minimum with one set per service/ location where possible.

The Policy Coordinator must ensure that only current policies are available on SharePoint.

5.10 Policy Compliance

It is the responsibility of the policy author and approver to ensure that the method by which compliance with the action(s) directed in the policy will be monitored are included in the document. (Ref: 6.0 Roles & Responsibilities).

It is the responsibility of Senior/ Regional and local management to ensure that compliance is monitored as identified in the policy, and all incidences of non-compliance are addressed appropriately.

5.11 Policy Revision

Policies must be assessed to determine their effectiveness and appropriateness and amended to reflect any changes in best practice, law, organisational, professional or academic change every three years.

Where short comings are highlighted following an audit, serious incident, organisational structural change, scope, changes internally of best practice or legislation identifies the need to up-date the policy within the three year time frame, a review should take place.

When a policy is nearing its renewal date or where legislation requires changes prior to this date, it is the responsibility of the relevant Directors nominee to alert the author for renewal in a timely fashion. Good practice would also encourage a Rag Rating of policies to facilitate timely renewal, which should be held and monitored by the relevant nominee for each policy area.

The list will be coded using a traffic light system; authors/ approvers should take note of the status of their policy areas and should initiate review to meet their review deadline as it may fall into red by the next quarter.

Authors/ approvers should feed back to the Policy Coordinator if an extension of deadline for a policy area has been agreed.

5.12 Document Control

Implications of Policy Changes
It is the responsibility of the author of the policy to ensure that other documentation that may reference the policy is changed e.g. Contract of Employment

Freedom of Information Requests
The public may request access to PPPG and public bodies may be called on to publish such documents under Freedom of Information Acts (1997).

6 .0 Roles & Responsibilities

Policy Author
The author must be the individual referred to by the position title. The author is responsible for the accuracy, layout of the content, the development process. The policy author's name will be required to be added to the control sheet.

Policy Reviewer(s)
The reviewers should be a small number of individuals selected by the author and or approver, who are best placed to provide feedback on policy content and implementation. For a specific

group of policies review maybe confined to Directors of the Senior Leadership Team. All policies will confirm a list of Reviewers supplied within the appendices *(See Appendix 4).*

Policy Approver (Authorisation)

This must be a member of the Senior Leadership Team or designee appropriate to the division, discipline and the scale and level of staff the policy governs. The approver is also responsible for the accuracy and layout of the policy content. When the approver authorises a policy he/ she is sanctioning every practice activity and component of the policy and is taking responsibility for its implementation. The approver must be referred to by their position, title and name. The approver must sign the original master copy for the master folder.

Manager(s)

Must assist and cooperate in the development of policies.

Managers must ensure that team members are aware of new policies and ensure that they understand their roles and responsibilities under the policy. This can be completed via the regular team meetings/ SMTs or/ and facilitating training where necessary. They must ensure all new staff members are informed as part of their induction process. They must set a good example, promote and monitor the behaviour. To respond promptly to any breaches of the policy.

If a policy folder is in their area to ensure that they are accessible to all employees and volunteers, and that only current policies are available within.

Employee(s)

Cooperate and assist in the development of policies.

To ensure they are aware of new policies areas and to inform themselves of the impact of same.

Each employee is accountable for their actions. This means being answerable for decisions she/ he makes and being prepared to make explicit the rationale for those decisions and justify them in the context of legislation, case law, professional standards,

guidelines evidence based practice professional and ethical conduct.

Union Shop Stewards' Responsibilities

Co-operate and assist in the development of policies if applicable.

Policy Coordinator

The role of the Policy Coordinator is to assist with the processing and distribution of policies.

The Policy Coordinator will issue a review list on a quarterly basis to all authors/ approvers to inform them of policy areas to be activated for review.

The Policy Coordinator will maintain SharePoint for all current policies.

The Policy Coordinator will maintain the master folder for all approved policies.

7.00 Evaluation and Audit

This Policy will be reviewed every three years or as required.

The Rehab Group and approved eternal bodies (e.g. HIQA, QQ1, Department for Work and Pensions (DWP), Care Quality Commission, Care Inspectorate Scotland etc) may carry out audits.

A yearly review/ audit of the vote button procedure will be carried out by the Quality and Governance Directorate.

8.0 References

An Organisation – wide Policy for the Development and Management of Procedural Documents; NHS Litigation Authority (2008)
Appraising the Quality of Clinical Guidelines; Scottish Intercollegiate Guidelines Network (2002) Available http://wwwsign.ac.uk

http://www.nice.org.uk/niceMedia/pdf/GDP_An_Overview_for_Stakeholders_the_Public_and_the_HS.pdf
HSE Circulars - HSE Procedure for developing Policies, Procedures, Protocols and Guidelines. March 2012.

9.0 Appendices

Appendix 1 – Control Sheet
Appendix 2 – Read & Understand
Appendix 3 – Protocol/ Service Specific Procedure Sample
Appendix 4 – List of Reviewers

Appendix 1 – Control Sheet/ Policy Template

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The Rehab Group
CONTROL SHEET

Applies Jurisdiction: ☒ ALL

Division(s): ☒ ALL

Reference Number:

Version Number:

Author(s):
Date:
Title:

Approver(s):
Title:
Date:
Signature:

Effective From:
Review Date:

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Appendix 1 – Control Sheet/ Policy Template

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APPENDIX 2 – Read & Understood

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I have read, understand and agree to adhere to the attached Policy, Procedure, Protocol/ SOP or Guideline:

Print Name	Signature	Date

APPENDIX 3 – Protocol/ Service Specific Procedure

Insert Service Name Missing Service User Procedure

RehabCare

SAMPLE

In the event of a service user going missing from LOCATION – insert service name in all places and after a thorough search of the house and garden has been conducted, the following procedure will guide staff actions. At all times staff will follow the missing service user policy, obtain and follow the direction of the manager/on call manager.

Action	Description	Who Responsible
Notification	1. The staff member who discovers or is alerted to the fact that a service user is missing will notify the LOCATION service manager or team leader on duty. If no immediate manager/team leader on duty the on-call manager should be contacted (On call manager name and contact number are available on the white board in staff office).	Staff on shift
	2. Service manager will contact Gardaí, service user's family and communications and public affairs team if appropriate. LOCATION staff should contact Gardaí if it is not possible to contact manager/on call manager and assistance of Gardaí is required promptly.	Service Manager/Team Leader or senior staff on duty.
Search	3. Staff must ensure that an appropriate level of staff presence remains at the house while a search is being undertaken. This staff level will be determined by the number of service users present at the service at the time.	Shift Leader as per handover document to select staff for the search.
	4. Staff may be available from LOCATION service to assist with the search and should be asked to be observant on the main road from LOCATION if responding to a call for assistance.	As above Staff assigned to search

LOCATION Management of work related Violence and Aggression Procedure – Service User

RehabCare

SAMPLE

In the event of a service user directing violence/aggression at staff the following procedure will guide staff actions.
At all times staff will follow the Service User's BTC guidelines, the Behaviours That Challenge Policy & Restrictive Practices Policy, also obtain and follow the direction of Manager/On call Manager.

Action	Description	Who Responsible
Pro active management	• The potential for violence/aggression directed at staff from service users is assessed individually as necessary. These risk assessments are filed in the file? Section? And should inform staff of the control measures in place. • Staff on identifying an increased risk of violence/aggression will advise manager/on call manager of the possible need for additional resources. • Staff will contact **LOCATION** service to establish what assistance may be available from them to support in the event of escalation • Staff will reduce demands on the service user and will adopt a supportive approach as per MAPA • Staff, where possible, will offer activities to other service users off site to reduce the number of people exposed to possible aggression.	Staff on shift/Shift Leader
Reactive management	• Staff will manage each incident of violence/aggression as per service user's behaviour support plan/behaviour support guidelines. • De- escalation techniques will be used as per MAPA training. • Should injury result from the incident first aid will be provided as appropriate. • Emergency services will be contacted as appropriate	
Resources	• Staff will contact manager/ On Call Manager	Staff on shift following

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Protocol Example

- **Introduction**
- **Background to Protocol**
- **Aims of the Protocol**

Instructions	

Appendix 4 – List of Reviewers

Authors List for New/ Reviewed Policy Area

The following names individual authors/ reviewers to this policy area.

Division/Other	Name(s)
National Learning Network	David Muldoon
RehabCare	Michael O'Connor
Quality & Governance	Pauline Newnham Collette Fox Seamus Dillon Alisande Healy-Orme

*Note that it is not obligatory for each division to be involved in a new policy/ review if the policy is not relevant; this should be decided by each division on a case-by-case basis.