Standard Operating Procedure for the role of the
Named Nurse within
Adult Mental Health Inpatient Services
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1. **Aim**

In 1992 the Department of Health issued the Patients Charter in which the requirement for all inpatients to have a designated Named Nurse was specifically mentioned. More recently the Francis report into Mid Staffordshire (2013) also highlighted the advantages of having such a system in place but took the requirement further by stating that a Named Nurse needed to be designated for each shift. This was welcomed by the Royal College of Nursing that believes that the Named Nurse model provides a useful way to organise work around the needs of the patient (RCN, 2014).

Within Adult Mental Health services it is expected that in the delivery of care to patients staff will adhere to the following four principles that underpin person-centred care:

- **Affording people dignity, compassion and respect** – ‘experience standards’ that are basic human rights enshrined in the NHS Constitution.
- **Offering coordinated care, support or treatment** – across multiple episodes and over time; this is critically important at the transitions between services.
- **Offering personalised care, support or treatment** – paying attention to what matters to the individual, their family and carers.
- **Being enabling** – so that people are supported to build on their own capabilities. (Health Foundation, 2014).

The aim of this Standard Operating Procedure (SOP) is to set out the minimum standards to which Named Nurses are expected to work within the Adult Mental Health inpatients services and the process for auditing compliance with the standards.

A Named Nurse roles and responsibilities booklet has also been developed by the Adult Mental Health Inpatient services which compliments and is to be read in conjunction with this standard operating procedure.

2. **Scope**

This standard operating procedure applies to all clinical staff working within the Adult Mental Health Inpatient wards. Whilst the qualified nurses on the inpatient wards will need to have a detailed knowledge of the expected minimum standards in relation to their role as Named Nurse, other clinical staff on both the inpatient wards and in community services, including medical and therapy staff will need to have an awareness so that they are able to answer any queries which patients may raise with them in relation to the role of the Named Nurse.
3. **Link to Overarching Policy Documents.**

As the Named Nurse role is key to the delivery of safe and effective care to patients during an episode of inpatient care this standard operating procedure. This SOP links to the overarching:

- **Clinical Risk Assessment and Management Policy**

However staff also need to be familiar with the following procedural documents,

- Adult Mental Health Standard Operating Procedure for the Admission of a Patient to one of the Adult Mental Health Inpatient Wards.
- Trust Discharge Procedure.
- Standard Operating Procedure for the Discharge or Transfer of a Patient from an Adult Mental Health Inpatient Ward.
- Trust CPA Procedure.
- Adult Mental Health Services Standard Operating Procedure for the Granting of Leave to Patients.
- Trust Policy for the Provision of an Age-appropriate Environment and Guidelines to Inpatient Staff on the Care and Treatment of Patients under the age of 18.
- Adult Mental Health services Named Nurse roles and responsibilities booklet.
- Clinical Record Keeping - Adult Mental Health Services Standard Operating Procedure.

4. **Procedure**

4.1 **What are the recognised benefits of the Named Nurse role in relation to patient care?**

A review of the literature shows that there are a number of benefits to the provision of inpatient care through a Named Nurse model, for example it:

- Can enhance transparency around decision making and provide a much clearer sense of accountability between the patient and the nursing team.
- Enables patients to identify one nurse who is specifically and consistently responsible for their overall nursing care.
- Is linked to positive patient outcomes.
- Has been shown to improve staff satisfaction.
- Promotes autonomy amongst nursing staff.
- Provides an ideal opportunity for the allocated named nurse to build a detailed knowledge of the patient and maximise their
therapeutic relationship (Duffield et al., 2010, and Pearson et al., 2006).

In addition the Named Nurse also provides an important role in relation to liaising with and supporting the relatives and carers of the patients they are responsible for.

However as the Named Nurse is part of a wider multi-disciplinary team it is vital that they maintain accurate clinical records of their interactions with the patient and their carers /relatives and provide a verbal handover of any issues of risk to other clinical staff in a timely manner.

4.2 Process for Named Nurse allocation.

For continuity of care wherever possible the admitting nurse should take on the role of Named Nurse. However if the current case load of the admitting nurse makes this difficult the Ward Manager will allocate another staff member to take on the role.

Additionally when allocating a Named Nurse consideration should also be given to the following:

- The gender of the patient.
- Any stated preference the patient may have in relation to the gender of their named nurse.
- Any presenting clinical risks which may require the Named Nurse to be of a specific gender.
- For patients who have had previous episodes of inpatient care it may be beneficial if they are allocated to their previous Named Nurse.

However the allocated Named Nurse must be on duty within 24 hours of the patients’ admission and should not be imminently due to take any annual leave or other planned absence of more than two days from the ward.

Once a Named Nurse has been allocated the patient is to be informed and the patient information board which is situated in the patient’s bedroom is to be completed with the name of the allocated Named Nurse and also that of their Consultant Psychiatrist.

4.3 Action to be taken during the Named Nurse’s first meeting with the patient

At their first meeting with the patient the Named Nurse will:

- Introduce themself to the patient as their Named Nurse at the earliest opportunity, and explain their role. This contact will be
documented in the patient’s clinical records as first Named Nurse contact.

- Inform the patient that they have a right to be involved in discussions and decisions about their care and treatment, and to be given information to enable them to do this. Including how to engage the services of an advocate.

- Ascertain from the patient what level of contact they wish to have with their relatives /carers, and what information they wish to be shared in relation to their care and treatment whilst on the ward. This is to be recorded on the carers contact sheet. In the event that the patient refuses to give consent for any information to be shared the Named Nurse needs to make it clear that such a refusal will not prevent discussion taking place with their relatives/carers to enable them to pass on any information that the relatives/carers may wish to share.

- Ascertain if the patient has any responsibility for the care of a child or other person. If yes the Named Nurse will need to ensure that safe alternative arrangements are in place for the duration of the admission.

- Give the patient one of the Named Nurse cards which are available on the wards. These cards provide written Named Nurse information to patients.

- Check that the patient’s clinical records and admission paperwork is fully completed. This includes the completion of any required risk assessments.

- Review the patient’s care plan/s with them.

4.4 Named Nurse responsibilities during a patient’s episode of inpatient care.

The allocated Named Nurse has overall accountability for the continuity and co-ordination of the patients’ episode of care whilst on the ward. To achieve this they will actively engage with both the patient and their relatives/carers and be the main conduit for information both to and from the rest of the multi-disciplinary team. Other responsibilities are to:

4.4.1 For all patients.

- Liaise with the allocated Community Care Coordinator /Lead Clinician throughout the patient's inpatient stay if the patient is already known to a community treatment team.

- Take on the functions of the Care Coordinator under CPA for patients not previously known to a community treatment team until
the point at which a Care Coordinator is appointed or the patient is discharged.

- Be flexible in their approach to the delivery of patient care.
- Develop a therapeutic relationship with the patient.
- Ensure that all care plans have review dates which are timed to suit the needs of each individual patient. However these review dates are the minimum time in which the plan of care is to be evaluated and it is expected that the care plans will form the basis of the ward multi-disciplinary team reviews. In addition to this should there be a significant change to the patients’ presentation or social circumstances a review of the care plan must be undertaken, and it is also important that a review of the care plan is undertaken during any transition of care, for example when a patient is transferred to another service or discharged to the care of the community services.
- Use the care plan review process to support the patient in seeing what progress they have made in respect of their recovery and to evaluate the effectiveness of the treatment programme.
- When making an entry in the clinical record which relates to a care plan review the clinician must record the number(s) of the care plan which the entry relates to.
- Provide the patient with copies of their care plans.
- Provide the patient with any other information which may help them make decisions in relation to their care and treatment.
- Ensure that copies of any previous health records held by either the Trust or other organisations are requested so that they can be used to inform decisions around future care delivery during the patient’s stay on the ward.
- Offer to meet with the patient for Named Nurse 1-1 sessions of at least an hour during each shift on duty. If the patient declines this is to be recorded in the clinical records.
- On the acute wards as a minimum review the patients’ FACE risk assessment on a weekly basis with other members of the multi-disciplinary team for the first month of admission, then monthly thereafter, and on the Rehabilitation wards at the agreed intervals, or in the event of:-

  o There being a change to the patient's mental state and presentation.
  o Leave being planned from the inpatient ward.
  o Information coming to light that indicates a change to any identified level of risk.

- Monitor the patient’s treatment compliance and response to medication, including any side effects they may be experiencing and report this to the medical team.
• Ensure that all clinical staff involved in the patient’s care are kept informed of the patient’s progress and any significant changes in presentation/circumstances.
• Make contact and offer a face to face meeting with the patient’s relatives/carers within the first 72 hours of admission. (Staff are to refer to section 4-12 of this document for guidance on confidentiality and information sharing with relatives).
• As far as possible attend any multi-disciplinary team reviews which are held for the patient.
• Be involved in any decision making in relation to periods of leave, or discharge from the ward.

4.4.2 Patients subject to detention under the Mental Health Act 1983

Explanation to the patient of their legal rights.

In the case of patients who are subject to detention under the Mental Health Act 1983 whilst it is not expected that they will undertake the task on every occasion it is the responsibility of the allocated Named Nurse to ensure that the patient has their legal rights explained to them at regular intervals throughout their inpatient stay. The minimum requirements are stated below but staff are to refer to the Trust procedure for informing patients of their legal rights under Section 132 of the Mental Health Act 1983 for full details, and if due to capacity issues it is felt that the patient needs to have their legal rights explained at more frequent intervals this is to be addressed in the care plan.

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<th>Section</th>
<th>Initial Frequency</th>
<th>On-going frequency</th>
<th>Who By</th>
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<td>Section 2</td>
<td>At the time of the section being applied then twice weekly for the first two weeks of detention.</td>
<td>Weekly for the remaining period of detention.</td>
<td>Named Nurse or other nominated Registered Clinical Staff.</td>
</tr>
<tr>
<td>Section 3</td>
<td>At the time of the section being applied then once a week for the first month of detention.</td>
<td>Monthly for the remaining period of detention.</td>
<td>Named Nurse, Care Co-ordinator or other nominated Registered Clinical Staff.</td>
</tr>
<tr>
<td>Section 37</td>
<td>At the time of the section being applied then once a week for the first month of detention.</td>
<td>Monthly for the remaining period of detention.</td>
<td>Named Nurse, Care Co-ordinator or other nominated Registered Clinical Staff.</td>
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If the patient is a child under the age of 16 their legal rights under section 132 are to be explained to them in the presence of the person who holds parental responsibility. A copy of the appropriate rights leaflet will also be given to this person.

Providing information and supporting detained patients at Tribunals and/or Managers meetings.

Where possible it is the responsibility of the Named Nurse to:

- Prepare any required reports.
- Discuss the content of the report with the patient prior to submission.
- Get their report signed off by the Ward Sister/Charge Nurse.
- Submit the signed off report to the Mental Health Act office for distribution in advance of the hearing or tribunal.
- Attend the Tribunal or Managers Hearing with the patient.

In the event that a Named Nurse is unable to attend a hearing they must arrange for one of their colleagues to attend on their behalf and:

- Ensure that they are fully briefed and have all the necessary information.
- Inform the patient of the fact that they are unable to attend and who will be going in their place.
- Arrange for their colleague to meet with the patient prior to the hearing so that they can talk through the main issues.

4.4.3 Patients admitted who are under the age of 18

On occasion patients under the age of 18 are admitted to one of the Trusts Adult Mental Health wards if the person is aged 17-18 and has:

- The capacity.
- The level of maturity
- Previous contact with the services through the Early Intervention Team.

And accepts admission to an adult ward they are to be admitted onto the Adult Acute Care pathway. However in these circumstances the Named Nurse must consider the need to adapt some aspects of the pathway/intervention and information provided to take account of the persons age.

For any child admitted to the ward even though their stay on the adult inpatient ward will be for a short time pending transfer to a more age appropriate environment they will still be allocated to a Named Nurse
and the standards in this document adhered to. However the Named Nurse will need to liaise very closely with the specialist Child and Adolescent Mental Health Team to ensure that any required treatment /therapy interventions/information are age appropriate.

Additionally if the child is not Gillick/Fraser Competent the person with parental responsibility is to be provided with information and consulted with as they are, in some circumstances able to consent on the person’s behalf.

4.4.4 Patients admitted who are subject to care under the Learning Disability and Mental Health Shared Care Protocol

If a patient who has a mild learning disability and mental health problems can be supported via reasonable adjustments they should access the adult mental health wards, and staff are to refer to the Shared Care Protocol for Adult Mental Health and Learning Disability Services.

The level of support required from the Learning Disability Services will be different for each patient and determined through their individual need. The allocated Named Nurse will be responsible for liaising with the Learning Disability Service to agree the following as part of the patients care plan:

- The frequency of contact from the Learning Disability Services whilst the patient remains on the ward.
- Who will provide this contact?
- Who to contact in the event of staff having any queries in respect of the patient’s learning disability needs?
- Who needs to be involved in the planning of the patient’s discharge?

4.5 Specific responsibilities in relation to the planning of leave, discharge or transfer of patients.

As the expected outcome of any admission to the Adult wards is safe discharge back into the community the planning for this should begin at the point of admission. With respect to the Named Nurses specific responsibilities around leave, transfer or discharge planning this should occur in liaison with the Community Care Coordinator:

- With the patient’s consent liaise with their relatives/ carers about any plans for leave or discharge. For guidance on action to take if patient declines consent please refer to section 4.12.
- Take steps to ensure that the accommodation to which the patient is taking their leave/ being discharged to is suitable and ready.
• Where appropriate, in conjunction with the multi-disciplinary team encourage the patient to utilise periods of home leave in order to assess their readiness for discharge.
• Where identified as being appropriate liaise with the Home Treatment Team as to patient’s suitability for an early facilitated discharge.
• Review the risk assessment and risk management plan to take account of any new or increased risks once the patient leaves the ward.
• Have in place appropriate care plans for any planned periods of leave, or discharge from the ward.
• Ensure that any required support is in place prior to the patient going on leave or being discharged, and that the patient and where appropriate relatives /carers are aware of the support arrangements.
• Provide the patient with contact details which can be used in the event of an emergency/crisis arising.
• Provide details of any appropriate support groups that the patient may wish to attend.
• Make sure the patient has supplies of all their required medication and knows how to administer it.
• In the case of leave periods to:
  o In the case of detained patients ensure that a valid section 17 is in place, and that the relevant people have been given a copy.
  o Gain and record in the clinical records the patient’s perspective as to how well or not the leave has gone.
  o Gain feedback from their relatives/carers as to how successful or not they feel the period of leave was, and ensure that this is recorded in the clinical record. Staff need to be aware that gaining this information from relatives or carers and listening to any concerns they may have does not breach patient confidentiality.
• In the case of discharge:
  o In preparation for discharge discuss with the patient the benefits of them developing a Wellness Recovery Action Plan (WRAP)
  o For any patients identified as being eligible at the point of admission for weight management or smoking cessation services, but declined a referral revisit this decision with them prior to their discharge.
  o Agree the 48hr/seven day follow up arrangements.

4.6 Record keeping standards for named nurses.
At admission to the Adult Mental Health inpatient wards all patients will have both a physical health and social needs and clinical risk assessment completed. These will inform the contents of the care plan, and the Named Nurses is responsible for:

- Ascertaining if the patient has any form of advance plan in place e.g. crisis plan, advance statement, WRAP, which can be used to support their recovery and inform staff of their preferences in respect of their care and treatment as an inpatient.

- Outlining the care that will be provided to the patient during their admission.

- In the case of any patients where there is an identified risk ensuring that all care plans include risk management plans

- Keeping all care plans up to date, relevant, and personalised, by ensuring that the following are carried out:

  - Spending meaningful 1:1 time with the patient for a minimum of one hour during each shift that they are on duty. This contact should be clearly indicated in the patient’s clinical record as a named nurse contact.
  
  - Providing each patient with a copy of their care plan and a care plan folder

- Risk Assessments and Care plans are as a minimum to be evaluated weekly by the multi-disciplinary team during the first month of admission then monthly thereafter, or in the event of:

  - There being a change to the patient’s mental state and presentation.
  - Leave being planned from the inpatient ward.
  - Information coming to light that indicates a change to any identified level of risk.

- All changes will be made on the relevant section of the patient’s electronic record, and the date of the risk assessment /care plan are to be amended to reflect the review.

All care plans must;

- Be personalised to meet the identified needs of each individual patient.
- Take account of all protected characteristics in equality law: ethnicity, gender, disability, religion or belief, sexual orientation, age, gender reassignment and where relevant, pregnancy and maternity.
• Include the patient’s perception of their identified needs, and their preferences as to how their care will be delivered and recovery supported.
• Include how any identified needs will be met, particularly in relation to employment/education housing, finance, social, psychological and physical health needs.
• Include the views of the patient’s carers/relatives
• Have achievable goals relating to identified needs which are current and relevant.
• Consider how continuity of care and relapse prevention will be supported following discharge
• Have an evaluation date.
• Be signed by both the member of staff and the patient

There must be a separate care plan for each area of concern, and it is important that all aspects of a patient’s care are fully communicated within the nursing team, with the named nurse ensuring that their team are aware of the prescribed plan of care for their patient.

4.7 Action if Named Nurse is on leave or absent from work for more than a two day period.

4.7.1 Planned absence

In the event that a Named Nurse is due to take any planned absence from work for a period exceeding two days, they are to arrange for one of their colleagues to provide Named Nurse cover to their patients and must:

• Provide their colleague with a full handover, including issues of clinical risk. A record of this handover is to be made in the patients’ clinical record.
• Be clear if there are any specific tasks which require completion whilst they are off work such as side effect monitoring, appointment planning, or care plan/risk assessment reviews and the time frame for completion.
• Inform the patient and their carers/relatives that they will be away from work and who will be providing cover in their absence.
• On their return to work arrange to meet with their colleague for a full handover of the patient’s progress during their absence.

4.7.2 Unplanned absence

In the event that a Named Nurse has to take any unplanned absence from work which is expected to last more than two days the Ward Sister / Charge Nurse will:

• Allocate the role of Named Nurse to another member of staff.
• Meet with the patient and inform of the fact that they have been allocated to another Named Nurse and the reason why.
• Inform the patients carer/relative of the fact that another Named Nurse has been allocated and the reason why.

In the case of unplanned absence which lasts over 4 weeks on the return to duty of the original Named Nurse a discussion needs to take place with the patient to determine if for continuity of care purposes they would prefer to remain under the care of the current Named Nurse for the remainder of their inpatient stay.

4.8 Process for named worker allocation during shifts when a patient’s Named Nurse is not on duty.

At the start of each shift any patient whose designated Named Nurse is not on duty will be allocated to a specific named staff member by the Nurse in Charge of the shift, who will see them during the shift and be a point of contact for the patient.

Details as to which patients’ staff members will be taking on this responsibility during the shift will be recorded on the ward staff and patient information board.

4.9 Action if patient requests a change of Named Nurse

There may be a number of reasons for a patient requesting a change of Named Nurse and all such requests are to be reviewed. In the first instance the Ward Sister/Charge Nurse should meet with the patient to discuss their request and see if action can be taken to resolve any issues/concerns. If the matter cannot be resolved the multi-disciplinary team should then consider the request and weigh up if it is in the best interest of the patient to change Named Nurse. If a decision is made to allocate a new Named Nurse the Ward Sister/Charge Nurse will determine who this should be and communicate this to the patient. If a decision is made not to allocate a new Named Nurse, the reasoning for this should be communicated to the patient by the Ward Sister.

A full handover meeting is to take place between the previous and new Named Nurse. The newly allocated Named Nurse will then:

• Introduce themselves to the patient.
• Change the Named Nurse details on the patient information board.
• Review the patient’s care plan/s, and risk assessment with them.
• Introduce themselves to the patient’s carers/relatives.

4.10 Action if a patient repeatedly declines a meeting with their Named Nurse
If any patient declines to attend planned meetings with their Named Nurse on three consecutive occasions the Named Nurse is in the first instance to try and discuss with the patient their reasons for not engaging. Where possible steps should be taken to try and engage the patient but if this is not possible the matter is to be discussed at the next multi-disciplinary team meeting and action agreed to try and reengage the patient. This may include the need to reallocate to a new Named Nurse.

4.11 Information to be provided to patients.

To enable patients to be involved in decisions about their care and treatment it is important that they are provided with information which is relevant, up to date and in a format they can understand.

As the clinical needs of each individual patient will be different it is not possible to have a set list of information which is to be made available, however as a minimum every patient will receive the following at the relevant points during their episode of inpatient care:

- A copy of the admission pack.
- Copies of all care plans.
- Copies of relevant treatment/medication leaflets.
- A copy of the leave pack (including crisis card).
- A copy of the discharge pack (including crisis card).

4.12 Information sharing with relatives/carers whilst still respecting patient confidentiality.

It is important that clinical staff establish patients consent to both information sharing with their cares/relatives and the level of information which they are in agreement can be shared. The gaining of this consent is not a one off event and should be revisited at regular intervals throughout the patients episode of inpatient care and there may be times when even if a patient has given their consent and signed the carers information sharing form, the sensitive nature of certain aspects of the information may require that a more detailed discussion takes place with the patient before the information is shared.

In relation to patients who refuse to give their consent, whilst the patients we care for are predominantly adults and have the right to request that no information in relation to their care and treatment is shared with their relatives this does not mean that staff are unable to have any interaction with carers/relatives as it is possible to include them without breaching patient confidentiality.

The Mental Health Act Code of Practice 2015 chapter 10 provides the following guidance to clinical staff.
Section 10.11. “Simply asking for information from carers, relatives, friends or other people about a patient without that patients’ consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any personal confidential information about the patient which the carer, relative, friend or other person being asked would not legitimately know.”

Whenever information is shared with, or obtained from relatives/carers a full record is to be made in the patients’ clinical record.

4.12.1 Benefits of sharing information with carers/relatives

There are number of recognised benefits in the sharing of information with the main ones being that:

- Relatives and carers can provide useful information in relation to previous response’s to treatment, what does and does not work, how periods of leave have gone and any areas of risk that they have concern about.
- Relatives and carers can also provide details of patients’ personal preferences around diet, religious and spiritual belief, any physical health care needs, and other relevant information regarding their usual daily routine.
- Listening to relatives and carers can help preserve relationships during stressful periods.
- It is useful for clinical staff to be able to see the patients’ current presentation in their usual social context.

4.12.2 When can disclosure of information without consent take place

There are exceptional circumstances when it may be appropriate to share confidential information without a patient’s consent. In broad terms they usually fall into 4 main areas: where information needs to be disclosed to comply with the law or a Court Order; where the patient lacks capacity and it is deemed to be in the patient’s best interests; where non-consensual disclosure is in the public interest. In relation to public interest, it could include issues in relation to child protection, dealing with serious crime or to protect the patient from serious harm.

For patients detained under the Mental Health Act 1983 the Code of Practice 2015 chapter 10 provides the following guidance to clinical staff.

Section 10.15. “Although information may be disclosed only in line with the law, professional and agencies may need to share information to manage any serious risks which certain patients pose to others.”
Section 10.16. “Where the issue is the management of the risk of serious harm, the judgment required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in confidential service.”

Additionally if a patient has an advance directive in place in which they have made clear that in the event of them becoming acutely unwell and at that point declining to have any information shared with their relative/carer that their request is to be ignored and appropriate information shared.

However where staff have any doubt they are to seek advice from either a Senior Clinical Manager, the Trust Information Governance Team or the Caldicott Guardian.

4.12.3 What support should be routinely offered to relatives/carers

In all cases the Named Nurse should provide the following to the patient's relatives/carers.

- A copy of the carers pack which contains general information about mental Health problems, the services available, ward visiting times, local support groups and contact details.
- Information about how to request a carer's assessment.

4.13 How staff will be made aware of their responsibilities in relation to this Standard Operating Procedure.

There are no specific training needs in relation to this procedure, but clinical staff in the Adult Mental Health Inpatient services will need to be familiar with its contents:

As this is a new procedure this will be achieved by:

- Every qualified staff member on the adult mental health inpatient wards being given a copy of this policy and the associated Named Nurse roles and responsibilities booklet.
- All qualified staff who join the Trust as a new starter will receive a copy as part of their local induction.
- Including the issuing of the procedure in the Team Brief.

In addition compliance with the required standards in relation to the role and responsibilities of a Named Nurse will be discussed in supervision with individual staff members.

4.14 Details of how staff compliance with the standards set out in this document will be monitored.
As the Named Nurse plays a vital role in the delivery of safe and effective care to patients it is important that the minimum standards set out in the document are adhered to. In view of this the compliance of individual staff will be monitored in the following ways:

- Through discussion of the roles, responsibilities and required competencies of the named nurse during the annual PDR. (see appendix1)

- Through the Named Nurse audit which will be undertaken by the relevant ward Sister/ Charge Nurse on each Named Nurse annually. (This will equate to 1 or 2 per month). The results will then be feedback and discussed with the Named Nurse.(see appendix 2 &3 )

5. References


6. Appendices

Appendix 1 - Named Nurse Competencies
Appendix 2 – Named Nurse Patient Satisfaction Audit
Appendix 3 - Named Nurse Audi Data collection Proforma
## Appendix 1

### Named Nurse Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>Measurement Criteria</th>
<th>Achieved</th>
<th>Not Achieved</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to recognise the importance of their role as a named nurse</td>
<td>Through both discussion and observation of their general interaction with the patients on a day to day basis does the staff member demonstrate a good understanding of their role and responsibilities in line with the minimum requirements of the Adult Mental Health Standard Operating Procedure for the role of the Named Nurse within Adult Mental Health Inpatient Services and guidance in the Adult Mental Health services Named Nurse roles and responsibilities booklet. Named Nurse audit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to deliver safe and effective care to patients.</td>
<td>That the staff member is able to discuss the requirements within the following policy documents. Adult Mental Health Standard operating procedure for the admission of a patient to one of the adult mental health inpatient wards. Trust discharge procedure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td>Measurement Criteria</td>
<td>Achieved</td>
<td>Not Achieved</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>Adult Mental Health Services Standard Operating Procedure for the Granting of Leave to Patients.</td>
<td>Standard operating procedure for the discharge or transfer of a patient from an adult mental health inpatient ward. Trust CPA procedure. Adult Mental Health Services Standard Operating Procedure for the Granting of Leave to Patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust policy for the provision of an age appropriate environment and guidelines to inpatient staff on the care and treatment of patients under the age of 18.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Record Keeping - Adult Mental Health Services Standard Operating Procedure.</td>
<td>Care of Inpatients who are identified as posing a significant risk to themselves or others. Clinical risk assessment and management. That the staff member is able to demonstrate a good understanding of how to recognise and manage environmental risks as appropriate to the clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td>Measurement Criteria</td>
<td>Achieved</td>
<td>Not Achieved</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>--------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| To demonstrate an understanding of the importance of working with relatives and carers. | Review of the patient clinical records to check for documented evidence of the following:  
- Is the carer contact sheet completed?  
- Did the named nurse offer the relatives/carers a face meeting within 72 hours of the patients’ admission?  
- That the relatives/carers have been provided with a copy of the carers information pack.  
- That the relatives/carers have been invited to the multi-disciplinary reviews.  
- That there has been regular engagement with the patient’s relatives/carers.  
- That for patients being considered for or having periods of leave their relatives/carers have been involved in discussions around the planning of this.  
- That where periods of leave have been taken feedback has been sought from the patients’ relatives/carers.  
- That where plans are in place to discharge the patients the relatives/carers attended a pre discharge |          |              |          |
<table>
<thead>
<tr>
<th>Competency</th>
<th>Measurement Criteria</th>
<th>Achieved</th>
<th>Not Achieved</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>To demonstrate an understanding of clinical information sharing and confidentiality.</td>
<td>That the staff member is up to date with their information governance training.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To demonstrate an up to date knowledge of current National policy and impact on clinical practice. (Including relevant NICE guidelines)</td>
<td>Discussion in relation to relevant policy and application to practice.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>That the Named Nurse is meeting the required clinical record keeping standards.</td>
<td>Clinical records audit.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2.

Adult Mental Health Inpatient Services
Named Nurse Patient Satisfaction Audit

Ward ........................................

Date .........................................

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How long have you been on the ward?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Do you know who your named nurse is</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Do you feel you have been given enough information about what to expect</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>from your Named Nurse</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>How long had you been on the ward before your named nurse introduced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>themselves to you</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Does your Named Nurse involve you in the planning of your care and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment whilst on the ward?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>On average how many times a week do you meet with your Named Nurse?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do feel this is often enough.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>If no how often would you like to see your Named Nurse each week?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>What sort of things do you discuss with your Named Nurse</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>If your Named Nurse is going to be off duty for a few days do they let</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>you know</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Does your named nurse make arrangements for another staff member to see</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>you whilst they are off duty?</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>Do you feel your named nurse listens to you</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>No</td>
<td>Questions</td>
<td>Response</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>13</td>
<td>If not why do you feel like this.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Is there anything that could be done by your named nurse to improve your experience of being an inpatient?</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Are there any additional comments you wish to make.</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 3

## Named Nurse Clinical Records Audit

<table>
<thead>
<tr>
<th>No</th>
<th>Standard</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Did the allocated Named Nurse admit the patient</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>If no did the allocated Named Nurse introduce themselves to the patient within 24 of the admission having taken place?</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Is there a record of the Named Nurses first meeting with the patient in the clinical records?</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Has the carers contact sheet been completed?</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Is there evidence that the Named Nurse made contact with the patient’s relatives/carers within the first 72 hours of admission and offered a face to face meeting?</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Is there evidence that the Named nurse has maintained regular contact with the patients Community Care Coordinator?</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Is there evidence that the patients care plans been reviewed with them at the agreed intervals.</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>Is there evidence that the Named Nurse has seen the patient for a 1-1 on each shift that they have been on duty?</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>On the Acute wards has the patients risk assessment been reviewed weekly as a minimum .during the patients first month of admission, or monthly thereafter.</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>On the rehabilitation and recovery wards have the risk assessments been reviewed with the patient on a monthly basis as a minimum.</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>For patients undertaking periods of leave is there a leave care plan in place.</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>For patients undertaking periods of leave, has the risk assessment been reviewed to take account of any potential risk</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>Standard</td>
<td>Achieved</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>factors which may arise from the patient not being on the ward.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>For patients who have had periods of leave, is there evidence of consultation with their relatives/carers before leave took place.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>For patients who have had periods of leave, is there evidence that feedback was sought from their relatives/carers following the period of leave.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>For patients being prepared for discharge is there a discharge care plan in place.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>For patients being prepared for discharge is there evidence of consultation with their relatives/carers.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>For patients being prepared for discharge, has the risk assessment been reviewed to take account of any potential risk factors which may arise from the patient not being on the ward</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Is there evidence that the named nurse has been regularly attending the patients MDT reviews.</td>
<td>Yes</td>
</tr>
<tr>
<td>19</td>
<td>Is there evidence that the named nurse has been undertaking side effects monitoring part of their review with the patient?</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>For patients who are subject to detention under the Mental Health Act is there evidence that the Named Nurse has been providing the patients with an explanation of their legal rights in line with the required minimum time frames.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>If the named nurse has undertaken a period of leave from the ward is there evidence that they handed over to one of their colleagues prior to leave commencing.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>If the named nurse has undertaken a period of leave from the ward is there evidence that they received a handover from their colleague when they returned to duty.</td>
<td></td>
</tr>
</tbody>
</table>