Family Nursing & Home Care

Publications Policy

January 2024

Document Profile

Type	Policy	
Title	Publications Policy	
Author	Updated by Head of Quality and Safety	
Category Clinical / Corporate / Education / Health & Safety / Human Resources / Information Governance		Corporate
Date approved by Organisational Governance Approval Group		4.01.24
Date approved by Chief Executive Officer		8.01.24
Review date	3 years	
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.	

Version Control/Changes Made

Date	Version	Summary of changes made	Author
October 2019	2	Complete rewrite affecting all sections	Ann Morgan
2023	3	General updating for clarity and moved to new template Staff must sign to say that they have read and understood all new and updated policies using Virtual College Policy extended to include leaflets and all procedural documents produced e.g. new forms, standardised letter templates, EMIS templates Removed the requirement for Authors to monitor for legislative changes going forwards. New responsibility added to 'all staff' regarding a need to update procedural documents Removed the need for a formal 1 year review	Head of Quality and Safety

Date	Version	Summary of changes made	Author
		New document submission form – replaces the Publication Checklist, Request for Ratification form and Adoption form CEO approval no longer requires a signature – approval will be given electronically CEO approval now only required for new or fully reviewed policies New process for approving changes made out of the stated review timeline. Policy and SOP templates updated Hyperlinks to FNHC policies and procedures have been removed	

Family Nursing & Home Care

CONTENTS

1 INTRODUCTION

1.1 Rationale

This policy outlines Family Nursing & Home Care's consistent and controlled approach to the management of the organisation's procedural documents. Procedural documents include but are not limited to:

- policies and procedures
- standard operating procedures (SOPs)
- standardised letter templates
- new forms
- leaflets
- competence frameworks
- external documents to be adopted e.g clinical guidelines
- EMIS templates

It details the whole life cycle of organisational publications from the development and approval processes through to making them accessible to staff (appendix 1). The updating of publications is also covered.

1.2 Scope

This applies to all publications produced and commissioned by FNHC excluding Written Instructions to administer medicines as a different approval process is required for this type of document.

Also included are documents published by other organisations that FNHC wish to 'adopt'

1.3 Role and Responsibilities

The Chief Executive Office

The Chief Executive Officer is responsible for ensuring that:

- there are systems in place to support the policy requirements and that these are monitored
- resources are allocated for the production and implementation of procedural documents

They are also responsible for approving all new policies and those that have been fully reviewed.

Director of Governance and Care

The Director of Governance and Care is responsible for ensuring that there:

- is an up to date publications policy in place

- are systems in place to monitor the use and effectiveness of this policy

Quality and Governance Department

The Quality and Governance Department are responsible for:

- implementing and maintaining a comprehensive database for the indexing, storage, publication and retention of the organisation's documents
- chairing and managing all administrative process around the effective functioning of the Organisational Governance Approval Group
- ensuring that relevant policies approved by the Organisational Governance Approval Group are sent to the Chief Executive Officer for ratification
- communicating to the organisation, documents that have recently been approved

Author/Lead Writer

The Author/Lead Writer is responsible for:

- developing their documents in line with the requirements of this policy
- ensuring, where relevant, that documents are in line with current legislation, guidance issued by relevant professional bodies and best-practice evidence
- keeping up to date with changes to legislation affecting the organisation's procedural documents and ensuring that any required changes are made within a reasonable timeframe
- ensuring that consultation takes place with relevant staff prior to submission for approval

Line Managers

Line Managers are responsible for:

- monitoring that their staff have 'signed' (via virtual college) to say that they have read and understood this policy and where there are compliance issues, managing these appropriately
- enabling their staff to be involved in any aspects of the production of publications

All Staff

All Staff are responsible for:

- adhering to this policy and related procedures
- responding in a timely manner when they have been sent a draft publication for consultation

- ‘signing’ to say that they have read and understood relevant publications when these are allocated to them on Virtual College
- highlighting to their service lead where they are aware of changes needed to procedural documents, particularly where such changes are informed by new or updated legislation

2 POLICY

To achieve a corporate, consistent and evidence-based approach to publications, standardised templates (where available) must be used. Such templates should not be altered. Support to use the templates correctly should be sought where required. The use of agreed templates ensures documents are as easy as possible for end users to access, understand and use. Current publications will be transferred into any new templates agreed when they are next reviewed.

Documents should be written in ‘plain English.’ This is a language that is clear, concise and avoids technical jargon. Click here for tips: http://www.plainenglish.co.uk/how-to-write-in-plain-english.html

Authors should consider the specific needs of the audience when drafting publications, for example literacy, learning difficulties, language skills, age appropriateness.

Any deviation from the accepted evidence-base or legislation should be identified and the rationale given.

The Harvard convention should be used when recording reference sources.

Relevant publications should be linked by reference to other relevant publications.

Staff must ‘sign’ to say that they have read and understood all policies and any other documents that are posted for them on Virtual College.

All procedural documents must be approved prior to use (see 3.4 Approval Process).

Family Nursing & Home Care is committed to reducing and managing risk to deliver effective and safe practice. It therefore has a responsibility to ensure that policies are developed that:

- are relevant
- are written in plain English
- detail roles, responsibilities and training requirements
- are standardised in accordance with a corporate format
- avoid discrimination
- following a clear process for development, ratification and review

- have a consultation period with those to whom the document will apply, both internally and externally if applicable
- are linked by reference to other relevant procedural documents and organisational strategy where relevant
- are accessible to staff
- are monitored for effectiveness
- incorporate relevant references to the evidence base, statutory and professional standards
- are effectively archived (where required)

All policies must include the agreed equality impact statement and a completed Equality Impact Screening Tool (both already on the policy template). Should there be an identified impact on a particular group, then a full impact assessment is required ('stage 2' of the screening tool).

3 PROCEDURE

3.1 Producing Documents for Publication

When creating procedural documents, authors need to consider the following:

- justification and support for developing the document
- how it links with service priorities and if it duplicates or contradicts work, either nationally or locally
- documents used by other local, national and international organisations which can be adapted
- current best-practice evidence and any relevant legislation when updating documents to see if practice has changed
- use of a readability aid such as Hemmingway Editor, available at: http://www.hemingwayapp.com/ or Grammarly, available at: https://www.grammarly.com/
- relevant stakeholders for the consultation process
- the involvement of service users

Draft documents using the approved organisational template (see 3.2 Templates) where available.

Identify document draft versions during the production process e.g. use a watermark with 'draft 1', 'draft 2' etc. or use a date to differentiate between drafts. Avoid using 'versions' as this can get confused with the document's final version number.

Reference all quoted material using the Harvard convention https://www.ukessays.com/referencing/harvard/

Confirm, with the relevant Registered Manager/Head of Service, that implementation is achievable within the available resources.

3.2 Templates

Approved templates are available for:

- policies (this includes procedures for meeting the requirements of the policy)
- standard operating procedures (SOPs)
- leaflets

The templates/style settings should not be changed. This is to ensure that policies and standard operating procedures have a standardised look and layout. Changes also mean that time is wasted having to re-set the document back to the agreed format. Where documents do not follow the agreed format, it will be the responsibility of the author to ensure that the necessary remedial changes are undertaken.

3.2.1 Policy Template Styles

Heading 1	Heading 2	Heading 3	Normal
Bold	Bold	Bold	
Numbered	Numbering Multi-level list	Numbering Multi-level list	Bullet points •
Arial 12	Arial 12	Arial 12	Arial 11
Justified	Justified	Justified	Justified
Spacing: • before 18pt • after 6pt	Spacing: • before 12pt • after 6pt	Spacing: • before 12pt • after 6pt	Paragraph Spacing: • before 6pt • after 0pt
Indentation: • Left 0cm • Right 0cm	Indentation: • Left 0cm • Right 0cm	Indentation: • Left 0.5cm • Right 0cm	Indentation: • Left 0cm • Right 0cm
Special:	Special:	Special:	Special:

Heading 1	Heading 2	Heading 3	Normal
Hanging by 0.63cm	Hanging by 1.02cm	Hanging by 1.27cm	none
Line spacing: single	Line spacing: single	Line spacing: single	Line spacing Multi 1.3cm
Margins to be set to 'normal			
Orientation is 'portrait' but relevant pages can be changed to 'landscape' where required.			

3.2.2 Standard Operating Procedures Template Styles

Heading 1	Normal
Bold font	normal
	Bullet points • Not to be used for all entries in 'core requirements/procedures' section, only where relevant
Arial 12	Arial 11
Justified	Justified
Spacing: • before 6pt • after 6pt	Paragraph Spacing: • before 6pt • after 0pt
Indentation: • Left 0.3cm • Right 0cm	Indentation: • Left 0cm • Right 0cm
Special: none	Special: none
Line spacing: Multiple 1.3cm	Line spacing Multiple 1.3cm
Margins to be set to 'normal	
Orientation is 'portrait' but relevant pages can be changed to 'landscape' where required.	

3.2.3 Leaflet Templates

See Standard Operating Procedures for the Development and Management of Leaflets.

3.3 Consultation Process

The document author is responsible for ensuring that appropriate consultation is undertaken. In policy documents, a record will be made in the 'Consultation' section of all people that have been sent the document to review. This will include the date it was sent.

All staff involved in the development of Standard Operating Procedures will be included in the Author section i.e. name of Lead Author in consultation with …

Documents for consultation should normally be sent to recipients by email. These should be in 'Word' format.

When sent a document for consultation, key stakeholders should be given a reasonable timeframe in which to respond. This should be a minimum of two weeks wherever possible.

Consultees should be encouraged to respond using the 'comments' and 'tracked changes' functions wherever possible.

The Lead Author needs to use a process for managing all feedback to make necessary changes to documents. This will include ensuring good version control practices.

3.4 Approval Process

All publications must be formally approved before being published and formally introduced into practice.

Complete an 'Organisational Governance Approval Group Submission Form' (appendix 2). Send it by email, along with the relevant procedural document, to the Chair of the Organisational Governance Approval Group (OGAG) and the Education and Development Secretary. If approved for submission, the document will be added to the agenda for the next Operational Governance Approval Group Meeting.

3.4.1 Policies

A two-step approval process is used for Policy documents.

Once approved by OGAG, the Chair of this group will email the policy to the Chief Executive Officer (CEO) for final approval. The CEO will respond by email. If approval is given, this email will be saved as a record of this decision. A signature is no longer required.

Policies (within their stated review timeframe) updated without a full review, only need approval by OGAG.

3.4.2 All Other Procedural Documents

All other documents are approved by the Organisational Governance Approval Group (OGAG) only. In exceptional circumstances, this may be done as an 'out of meeting process', for example, where there is a need for urgency. Normally the meeting 'Chair' or a nominated deputy will be responsible for collating feedback and communicating the group's final decision.

Minor amendments can be made to such publications within its stated review timeframe, without being re-submitted to the Organisational Governance Approval Group. The relevant Registered Manager or Head of Department/Service can approve any change in consultation with the Chair of OGAG. Such decisions will be communicated at the next OGAG meeting and noted in the RAID Log/minutes.

Only new EMIS templates need to be submitted to OGAG for approval and those amended/updated where the template is used by more than one service.

3.5 Adoption of externally produced documents

Where external body documents are being adopted, such as those from the Department of Health or National Institute for Health and Care Excellence (NICE), the approval process applies. This ensures corporate ownership and reduces risk.

3.6 Commissioning of Externally Produced Documents

If an external agency is considered necessary to produce a procedural document, approval must be sought from the Senior Management Team. The approved template should be used (where available) and normal approval process followed.

3.7 Dissemination

Once the Quality and Governance Department has uploaded an approved document to the Procedural Document Library or Central Filing, the Quality and Governance Department will inform all staff of new or revised documents via email. The Line Manager of staff that do not have computer access must ensure that a hard copy is distributed where the document is relevant to their practice.

Implementation plans for major policy documents must show how phased rollouts and/or associated education programmes are to be managed. Support in such cases must be gained from a senior level as a part of the consultation process.

3.8 Version Control

The approval date is added to relevant documents by the Education and Development Secretary once ratified. These are recorded on the Procedural Document Register.

The version number of a document changes each time it is reviewed and updated. Following a full review of the document, the version number will increase, for example, 'version 1'

becomes 'version 2' and so on. This is the case even if no significant changes have been made. Minor adjustments to a document, without a full review, will be reflected in the version number as 'x.1', 'x.2' etc. for example, Version 1.1, 1.2.

All documents, with the exception of EMIS templates, are held in Microsoft Word and Portable Document Format (PDF). The PDFs are accessible through the organisation's Procedural Document Library or, where relevant, Central Filing. It is the responsibility of the Quality and Governance Department to administer and maintain the Procedural Document Library.

All previous versions and withdrawn documents are archived in the relevant system and retained for the appropriate duration as specified in the current version of the Policy and Procedure for the Destruction of Records.

3.9 Implementation

Compliance with this Publications Policy is used by FNHC to reduce risk and enhance clinical and integrated governance activities.

It is a requirement within the Staff Handbook that policies and procedures are followed.

A list of new and revised documents will be cascaded to all staff. It remains the responsibility of line managers of departments to inform staff within their area of this information and ensure that any change of working practice is implemented.

All staff are informed, during the induction process, that the organisation's policies and procedures are held on the Procedural Document Library available at: https://www.fnhc.org.je/procedural-document-library, noting that some are also held on Central Filing. New staff should also be advised where to locate other procedural documents/publications relevant to their role.

3.10 Document Review Periods

This is dependent upon the nature of the document. It is an expectation that new documents are monitored for effectiveness. Where issues are noted, timely changes should be made and the document approved as per section 3.4. Generally, most documents should have a formal and full review every 3-5 years, unless there is an identified need to do this earlier.

4 MONITORING COMPLIANCE

Compliance with this policy will be monitored as part of the process for submitting procedural documents for approval.

Procedural document users and service leads/heads should routinely monitor the effectiveness in practice of all such documents to ensure their objectives are being met.

The process of how the monitoring of policy documents will be undertaken should be specifically detailed in every policy document.

5 CONSULTATION PROCESS

Name	Title	Date
Tia Hall	Registered Manager – Adult Nursing	3/11/23
Michelle Cumming	Registered Manager – Child & Family Services	
Clare Stewart	Registered Manager – Rapid Response and Reablement	
Teri O' Connor	Registered Manager – Home Care	
Claire Whelan	Head of Information Governance and Systems	
Justine Bell	Head of Education and Development	
Rachel Foster	Quality and Governance Development Nurse	
Amanda de Freitas	Head of Human Resources	
Michael Gardiner	Head of Finance	
Kalina Syvret	Head of Fundraising	

6 IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Policy to be placed on organisation's Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Via 'Virtual College', staff to 'sign' that they have read and understood this policy	All staff	Within 1 month following ratification

7 EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race,

disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- Putting patients first
- Keeping people safe
- Have courage and commitment to do the right thing
- Be accountable, take responsibility and own your actions
- Listen actively
- Check for understanding when you communicate
- Be respectful and treat people with dignity
- Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See overleaf for the Equality Impact Assessment for this policy.

7.1 EQUALITY IMPACT SCREENING TOOL

Stage 1 - Screening			
Title of Procedural Document: Publications Policy			
Date of Assessment	5.01.24	Responsible Department	Quality and Governance
Completed by	Elspeth Snowie	Job Title	Head of Quality and Safety

Does the policy/function affect one group less or more favourably than another on the basis of:

	Yes/No	**Comments**
Age	no	
Disability *(Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia)*	no	
Ethnic Origin *(including hard to reach groups)*	no	
Gender reassignment	no	
Pregnancy or Maternity	no	
Race	no	
Sex	no	
Religion and Belief	no	
Sexual Orientation	no	

If the answer to all of the above questions is NO, the Equality Impact Assessment is complete. If YES, a full impact assessment is required: go on to stage 2.

Stage 2 – Full Impact Assessment

What is the impact	**Level of Impact**	**Mitigating Actions** (what needs to be done to minimise / remove the impact)	**Responsible Officer**

Monitoring of Actions

The monitoring of actions to mitigate any impact will be undertaken at the appropriate level

8 IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Policy to be uploaded to the Procedural Document Library	Education and Development Administrator	Within 2 weeks following ratification
Email to all staff	Education and Development Administrator	Within 2 weeks following ratification
Upload policy (+/- assessment tool) to Virtual College and allocate to relevant staff	Education and Development Department	Within 2 weeks following ratification
Relevant staff to sign (via Virtual College) that they have read and understood policy.	All staff notified via Virtual College.	Within 2 months of notification

9 GLOSSARY OF TERMS

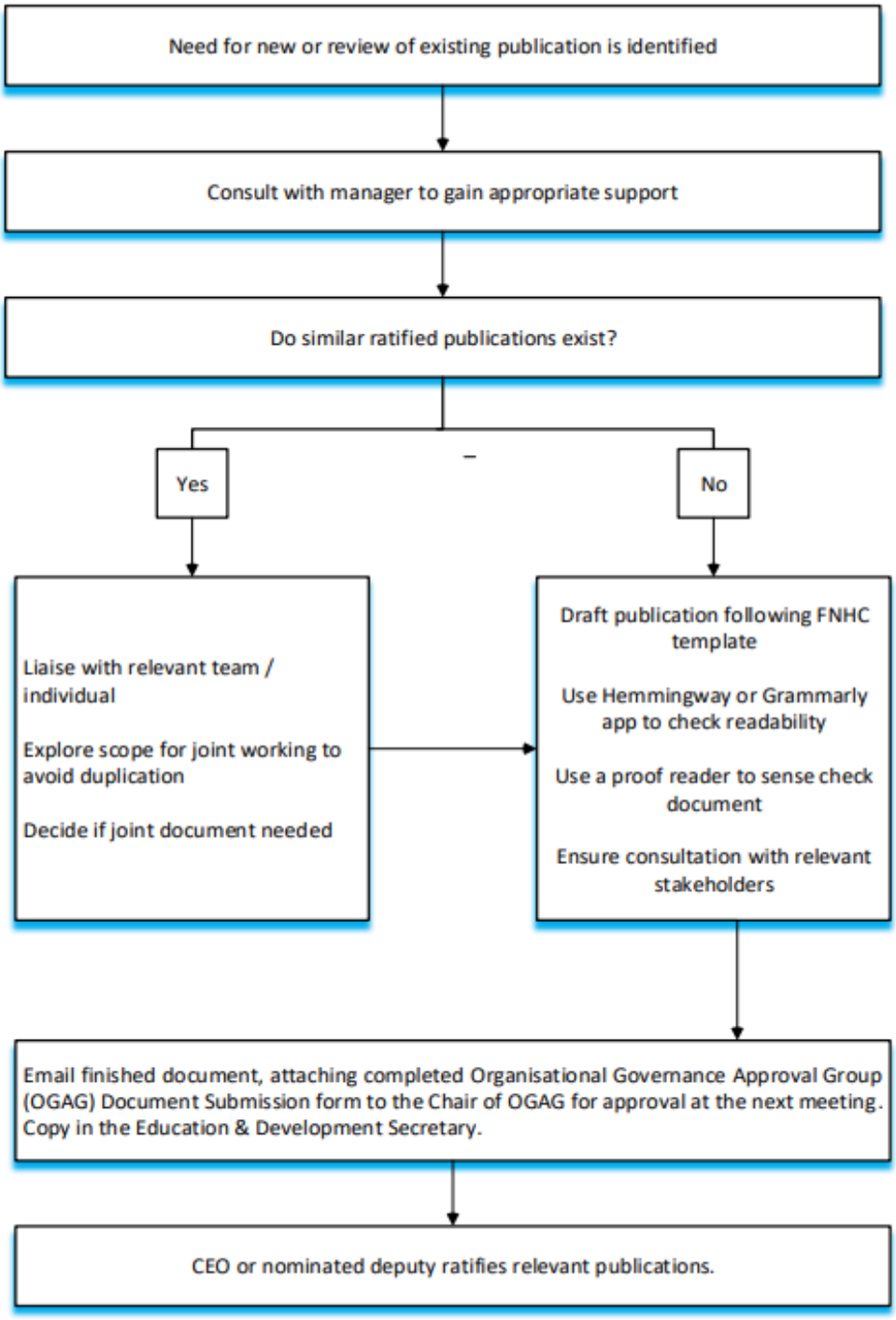
Approval	In the context of this policy, the approval process ensures that all publications are appropriate, meet expected standards and are fit for purpose. Some publications may be approved by the Organisational Governance Group only whilst others also require approval by the Chief Executive Officer or nominated deputy.
Author/Lead	The person responsible for ensuring the publication is written or being reviewed; whilst ensuring contribution by others.
Guidelines	A guideline is a systematically developed statement to assist practice. Evidence based research provides the basis for sound clinical guidelines. Guidelines allow for flexibility to allow for professional judgement, in relation to changing patient needs.
Policy	A formal statement of intent about how the organisation will comply with legislation or directives. Its purpose is to demonstrate the organisation's position on a specific subject within a corporate framework which reflects the organisation's values and beliefs.

	Policies do not allow for variation of practice and it is a contractual requirement for staff to comply with them. A policy may be supported by a range of procedures.
Procedure	These provide the information to "carry out the intent" and are day-to-day working instructions on how to perform tasks and will consist of a series of steps to be followed in a regular order. Procedures are mandatory documents, and must be followed. They often support a policy.
Standard Operating Procedures (SOPs)	These provide clarity about what staff are required to do in relation to local day to day working. The SOP template can be used for procedures that are not necessarily evidence based. They tend to be specific to department/work areas.
Protocol	These are specific agreements on practice, required by an employer and approved by a qualified body. Protocols are targeted at relevant staff groups enabling safe autonomous practice, including enhanced practice, at local level. They have a specific use and are non-transferable. Deviation is not permissible.
Publications/procedural documents	In the context of this policy, these terms are used for any documents/templates listed in section 1.1. The terms may be used interchangeably.
Standard	An explicit statement, which defines specific measureable actions and responsibilities.

10 REFERENCES

11 APPENDICES

11.1 Appendix 1 Flowchart



11.2 Appendix 2 Organisational Governance Approval Group Submission Form

See central filing:

L:\FNHC\Central Filing\Policies & Procedures\Documents to help Develop Procedural Documents