# Visual Communication Alert Symbols Guidelines for Staff

## Version 4.0

<table>
<thead>
<tr>
<th>Purpose:</th>
<th>To inform hospital staff of the process for ensuring that patients are treated with dignity and respect through providing ‘visual communication alerts’ which enable all staff to be aware of individual patient’s needs in respect of communication and safety.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For use by:</td>
<td>All Hospital Staff</td>
</tr>
<tr>
<td>This document is compliant with /supports compliance with:</td>
<td>Care Quality Commission’s ‘fundamental standards’</td>
</tr>
<tr>
<td>This document supersedes:</td>
<td>Visual Communication Alert Symbols Guidelines for Staff Version 3.0</td>
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<tr>
<td>Approved by:</td>
<td>Patient &amp; Carer Experience Group</td>
</tr>
<tr>
<td>Approval date:</td>
<td>28 August 2015</td>
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<tr>
<td>Ratified by</td>
<td>Healthcare Governance Committee</td>
</tr>
<tr>
<td>Date Ratified</td>
<td>02 September 2015</td>
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<tr>
<td>Implementation date:</td>
<td>28 August 2015</td>
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<td>Review date</td>
<td>28 August 2018</td>
</tr>
<tr>
<td>In case of queries contact: Responsible Officer</td>
<td>Sarah Higson, Patient Experience Lead X1101</td>
</tr>
<tr>
<td>Directorate and Department</td>
<td>Clinical Directorate, Patient Experience Team</td>
</tr>
<tr>
<td>Archive Date ie date document no longer in force</td>
<td>To be inserted by Information Governance Department when this document is superseded. This will be the same date as the implementation date of the new document.</td>
</tr>
<tr>
<td>Date document to be destroyed: ie 10 years after archive date</td>
<td>To be inserted Information Governance Department when this document superseded</td>
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Version and document control:

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date of Issue</th>
<th>Change Description*</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>07 May 2008</td>
<td>New document</td>
<td>S. Higson, L. Parrish</td>
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<tr>
<td>1.1</td>
<td>March 2011</td>
<td>Review and update of original document</td>
<td>S. Higson</td>
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<td>August 2012</td>
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<tr>
<td>3.1</td>
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<td>Review by PCEG and update</td>
<td>S. Higson</td>
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This is a Controlled Document

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Hospital documents may be disclosed as required by the Freedom of Information Act 2000.

Sharing this document with third parties

You need to decide if this document can be shared. If yes – apply and insert the following:

As part of the hospital’s networking arrangements and sharing best practice, the hospital supports the practice of sharing documents with other organisations. However, where the hospital holds copyright to a document, the document or part thereof so shared must not be used by any third party for its own commercial gain unless this hospital has given its express permission and is entitled to charge a fee.

Release of any strategy, policy, procedure, guideline or other such material must be agreed with the Lead Director or Deputy/Associate Director (for hospital-wide issues) or Directorate/Departmental Management Team (for Directorate or Departmental specific issues). Any requests to share this document must be directed in the first instance to Sarah Higson, Patient Experience Lead.
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SECTION 1 - INTRODUCTION

1.1 Policy Statement and Rationale

The Ipswich Hospital NHS Trust is committed to ensuring that all staff at The Ipswich Hospital NHS Trust recognise, respect and respond to the right for all patients, their families and carers, visitors and members of the public to be treated with privacy and dignity.

The Trust is committed to meeting the needs of patients who require additional support and there are a number of ways in which the Trust does this eg; through providing British Sign Language Interpreters, Hearing Loops, equipment.

1.2 Key Principles

- To provide ‘visual communication alerts’ which enable staff to be aware of individual patients needs in respect of communication and safety.

- To ensure effective communication with all patients, their relatives/carers.

- The Trust is committed to providing services that are non-discriminatory and ensure equitable provision for all regardless of age, race, gender, gender reassignment, ethnicity, disability, religion and sexual orientation (this list is not exhaustive).

1.3 Definitions

DH - Department of Health
IHNHST - Ipswich Hospital NHS Trust
PCEG – Patient & Carer Experience Group
IHUG - Ipswich Hospital User Group
KSF - Knowledge and Skills Framework
EMSA - Eliminating Mixed Sex Accommodation

SECTION 2 – DUTIES AND RESPONSIBILITIES

2.1 Chief Executive

The Chief Executive is the Accountable Officer of the Trust for all matters relating to the service provided by the hospital and as such has overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health.

2.2 Director of Nursing and Quality

The Director of Nursing and Quality is accountable to the Chief Executive and has delegated responsibility for Quality and Patient Experience.

2.3 Patient Experience Lead/Responsible Officer

The Patient Experience Lead has delegated responsibility from the Director of Nursing & Quality for measuring and reporting on the patient experience and compliance with this guideline. The Patient Experience Lead will ensure this is monitored by the Patient and Carer Experience Group.
2.4 Divisional Leads
All Divisional Leads are jointly responsible for ensuring that all staff within their areas of practice work within the scope of hospital policies and guidelines and have a responsibility to ensure their staff are aware of and understand this guideline and their responsibility for applying it into their practice. Staff should have access to any specific training in regard to communication skills and using the visual alerts.

2.5 Matrons, Sisters and Consultants
Matrons, Sisters and Consultants have a responsibility to ensure that all their staff are aware of and comply with the guideline and that any failures to comply with the policy are managed and appropriate action is taken as to ensure future compliance. The Ward Sisters, Matrons and Consultants are responsible for leadership and must lead by example in all matters relating to this guideline.

2.6 All Employees and Volunteers
All members of staff have an individual responsibility and accountability in the provision of a service that ensures patients are treated in such a way to maintain their Privacy & Dignity. All members of staff must adhere to this guideline and all relating documents. If failures to comply with this guideline are identified, they must be managed appropriately.

2.7 Students on Placement in the Trust
Students who are on placement in the IHNHST work either directly or indirectly supervised. The students' trainer, mentor/associate mentor will assess the student's competency in applying this guideline to their practice.

2.8 Bank/Locum Staff
All staff working for the Trust are expected to work within the Trust policies and guidelines and are accountable and responsible for their practice.

2.9 Patient and Carer Experience Group
To approve the document in accordance with hospital policy.

2.10 Healthcare Governance Group
To note the document in accordance with hospital policy.

SECTION 3

3.1 Key related Trust documents that support this document.

- Dignity & Respect Charter
- Confidentiality Policy
- Equality Policies and Schemes
- Professional Behaviour and Etiquette Guide
- Guidelines Following Death
- Interpreters Policy
- Chaperone Policy
- Consent to Examination and Treatment Policy
- Eliminating Mixed Sex Accommodation Policy
3.2 Guideline

3.2.1 Above each bed within the hospital there should be a Patient’s Needs at a Glance Board (a laminated sheet including the Visual Alert symbols) and an EWhite Board on the ward.

3.2.2 Consideration to the need for a Visual Communication Alert Symbol should be given during the admission process and the ongoing assessment of patient needs.

3.2.3 If it is considered that the use of a Visual Communication Alert Symbol would be appropriate this should be discussed, in full, with the patient. If necessary, an interpreter or carer may assist in this process.

3.2.4 A leaflet outlining the benefits of the use of the symbols is available and should be provided to the patient/carer to aid the consent process.

3.2.5 The patient should be shown an illustration of the symbols so they know what they are agreeing to.

3.2.6 Family members and carers should, where possible/appropriate be involved in the decision making process, however, it is the patient’s decision that counts.

3.2.7 The outcome of the discussion (consent to use a Visual Communication Alert Symbol or not) must be recorded in the patient’s nursing records.

3.2.8 If the patient is unable to give consent, staff will act in the patient’s ‘best interest’. The patient’s family may be involved in the ‘best interests’ discussion. When acting in the best interests of the patient the discussion and decision must be recorded in the patient’s notes.

3.2.9 The appropriate symbol/s should be circled/ticked on the Patient’s Needs at a Glance Board/E White Boards. More than one of the symbols may be chosen.

3.2.10 If the patient who is utilising a symbol is transferred to another ward the use of a symbol should form part of the hand-over process.

3.2.11 If a patient declines the use of a symbol their decision and reasons for it must be recorded in their nursing notes.

3.2.12 The patient can change their mind and withdraw or give consent at any time.

3.2.13 Visual Alert Stickers are available from the Copy Shop and can be affixed to a patient’s notes without need for gaining consent - these reflect the symbols used on the laminated/magnetic signs and are for the same purpose.
3.2.14 Flowchart

Assess patient - discuss use of symbols
Provide patient information leaflet & record discussion in nursing records

Patient gives consent for use of symbol(s)/'best interests' applies - recorded in nursing records

Patient does not give consent for use of symbol(s)
‘No Consent’ recorded in nursing records

Mark up the Patient’s Needs at a Glance Board/ E White Boards

Visual Alert Stickers - can be affixed to the patient’s notes (all notes including drug charts)

3.2.17 Symbols available:

This list is not exhaustive

- Eye = sight impairment
- Ear = hearing impairment - may need British Sign Language (BSL) interpreter
- Falling person = at risk of falling
- ‘Forget-me-not’ flower = has dementia/may be confused
- Interpreter = English not understood - interpreter required - may also mean BSL interpreter needed
- Two Ticks = non-specified disability
- Caring for Carers = family carer involvement
- Purple dot = Learning Disability
- Blue butterfly = End of Life

SECTION 4 – TRAINING AND EDUCATION

4.1 The Trust will provide further support and guidance to staff in the use of these symbols via the Patient Experience Office.

4.2 A leaflet has been produced, written in conjunction with the Disability Forum and Hearing Services User Group, outlining what resources the Trust has available, the benefits of utilising the symbols and a brief description and illustration of each symbol.

SECTION 5 – DEVELOPMENT AND IMPLEMENTATION INCLUDING DISSEMINATION

The following have been involved in the development of this guideline:-
5.2 This guideline will be made available on the hospital intranet. Staff will be informed via key staff meetings and intranet page - ‘New Policies & Guidelines’

SECTION 6 – MONITORING COMPLIANCE AND EFFECTIVENESS

Audits of the use of the symbols will be carried out as part of the Quality Management System.

SECTION 7 – CONTROL OF DOCUMENTS INCLUDING ARCHIVING ARRANGEMENTS

7.1 Once ratified by The Healthcare Governance Committee the Responsible Officer will forward this guideline to the Information Governance Department for a document index registration number to be assigned and for the guideline to be recorded onto the central hospital master index and central document library of current documentation.

7.2 In order that this document adheres to the hospital’s Records Management Policy, the Responsible Officer will arrange for staff to be advised when this document is superseded and for arranging for this version to be removed from the hospital’s intranet. The Responsible Officer will also advise the Information Governance Department who will ensure that this document is removed from the current index and library, archived and retained for 10 years from the archive date.

SECTION 8 - SUPPORTING COMPLIANCE AND REFERENCES

8.1 State how this document will support the hospital’s compliance with

- Its legal obligations as set out in the (insert title of legislation eg NHS Act 2006)
- The requirements of (Standards for Better Health + standard reference and/or NHS Litigation Authority standard + standard reference and/or Auditors Local Evaluation and/or national guidance etc)

- The requirements of the Care Quality Commission’s ‘fundamental standards’. 