# Hart First Response

## Volunteer Training and Development Policy

Registered Charity 1092333

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**1. Summary**

1.1. The aim of this policy is to ensure that statutory and mandatory training is embedded in a culture of development that is based on needs that link to the Aims and mission of HFR.

1.1. The purpose of training & development is to ensure that all volunteers have the necessary skills and knowledge to do their job effectively, now and in the future, and that they have the ability to meet the changing needs of both patients and the organisation.

1.2. Statutory Training is defined as training that ensures compliance with relevant statutory provision. Mandatory Training is defined as training identified by HFR as an essential requirement for the safe conduct of the HFR's activities.

1.3. This document sets out the policy of Hart First Response to provide training and development for its volunteers.

2. **Related Policies, Procedures and Acts**

2.1. Health and Safety at Work etc Act 1974

2.2. NHS Litigation Authority Risk Management Standards 2013

3. **Related HFR Policies and Procedures**

3.1. Personal Training Record and competences

3.2. Trustee Induction procedure

3.3. First Aid Training Quality Assurance Procedures

3.4. New volunteers process pack

3.5. Volunteer Handbook

**4. Responsibilities**

4.1. The Executive Committee is responsible for the effectiveness of this policy. They will therefore monitor performance of HFR in respect of its response to all issues regarding the provision of safe and suitable premises, including ambulances.

4.2. The Honorary Secretary is the lead responsible for training and development.

4.3. All volunteers have a responsibility to read and understand this policy.

**5. Commitment**

5.1. Hart First Response will provide weekly training sessions to:

- maintain current skills in first aid and ambulance aid
- update skills in first aid and ambulance aid
- provide training in other related fields e.g. anatomy and physiology, driver training etc.

5.2. Hart First Response will also provide the opportunity and funding for volunteers to update and enhance their skills external to the organisation e.g. training and ambulance skills.
5.3. Hart First Response will also ensure that new members are assigned a mentor.
5.4. Each volunteer is expected to commit to attend at least half of the training sessions run each year, to maintain the skill levels required for active first aid delivery. At the discretion of the Exec. Com. alternative training pathways may be accepted.

## 6. Aims

6.1. To provide training in first aid to the equivalent standard of HSE FAW certificate, enhanced by further training in paediatric life support skills and administration of medication. The long-term aim of Hart First Response is to provide a means of assessment as well as training.
6.2. To provide training in ambulance skills to at least the equivalent level of Emergency Medical Technician certificate such as FPOSI (First Person on Scene Intermediate), or equivalent.

## 7. Training sessions and qualifications

7.1. Hart First Response training sessions will be structured to include regular practical and knowledge-based training and assessment in relevant skill areas. Hart First Response assessments will be undertaken via a competency-based system. This will use checklists incorporating performance criteria and the collection of knowledge evidence.
7.2. Teaching will be undertaken by those with qualifications in the relevant subject area and a C23 (or equivalent), or by those under their supervision. Assessments will be undertaken by those with qualifications in the relevant subject area and a D32 (or equivalent), or by those under their supervision. Ideally, trainers will hold the C7407, City & Guilds Level 4 Certificate in Further Education Teaching (CFET) or equivalent.

## 8. Health and Safety

Everyone who teaches or assesses any subject for Hart First Response must be aware of the relevant health and safety issues. These include:

8.1. Use of face shields and gloves
8.2. Implementation of appropriate hygiene, in relation to the use of resusci-annies
8.3. Use of casualty actors (safety codes, public reactions)
8.4. Reporting any accidents during sessions, as incidents via the usual HFR process.
8.5. Keeping of fire lists and knowing the evacuation procedure for the building
8.6. Manual and minimal handling options

## 9. Induction Training for new volunteers

9.1. The induction training module (available online) will be undertaken by all new HFR members before attending any event and will include the following:

- Introduction to HFR
- Child and vulnerable adult protection
- Data protection and patient confidentiality
- Consent

- Health and safety, incident reporting and COSHH
- Manual and minimal handling
- Infection control and waste disposal
- Equal opportunity and diversity
- Volunteer policies and procedures
- Training and development

9.2. Failure to complete the full Induction Training will result in the volunteer not being able to attend HFR events and may result in the volunteer being asked to leave by the Executive Committee.

## 10. Personal Training Records and Competency self-assessment

10.1. At induction (and regularly thereafter), each volunteer will provided with a personal training record pack.

10.2. The personal training record pack will allow the volunteer to agree their individual development plan along with their first aid competency self-assessment. The Self-Assessment Questionnaire (SAQ) has been devised for both training levels (FA and AA), which includes the most significant skills needed. The aim of the SAQ is to produce an initial baseline assessment, which can be used by the Lead Trainer as part of the volunteer's personal development plan. This process has been devised to support the education, training and development programme undertaken by the volunteers. The programmes for volunteers in training have two clearly defined structures, which identify the objectives for each training level i.e. first aider and ambulance aider.

10.3. HFR supports the view that "*There should be no learning curve as far as patient safety is concerned*" (Senate of Surgery).

10.4. This process has been devised to support the education, training and development programme undertaken by the volunteers. It will also remind individuals of the appraisal systems.

10.5. All volunteers in training will undertake the self-assessment when taking up a new role or position and will be responsible for continuing to update their individual personal training record packs.

10.6. The personal training record packs contain details of the regularity of the HFR mandatory training requirements for updates in first aid skills, which include:

- Drugs
- Treatment techniques (includes resuscitation etc)
- Medical devices

10.7. The Lead Trainer will use regular updates from the personal training record packs to enter this information into the HFR training database.

## 11. Probationary Training Decisions

11.1. <u>First Aiders</u>

Must have undertaken the HFR induction training module
Qualifications needed:

- FAW or equivalent

- Child and infant resuscitation and administration of relevant medication competencies

To be promoted from probationer status the first aider needs to:

- Have patient contact on a minimum of ten HFR patient report forms.
- Show professional conduct
- Have attended a minimum of half of all weekly HFR training sessions

Competence to move from probationer to full first aider status will be agreed by the Executive Committee.

11.2. Ambulance Aiders

Must already have full first aider status

Qualifications needed:

- "Emergency Medical Technician" Certificate, or equivalent
- Manual handling training records

To be promoted from probationer status the ambulance aider needs to:

- Administer medical gases twice (documented on PRF)
- Perform spinal immobilisation (documented on PRF)
- Show professional conduct
- Have attended a minimum of half of all weekly HFR training sessions

Competence to move from probationer status will be agreed by the Executive Committee. All ambulance aider crews must contain at least one member who has a minimum of four years AA experience.

## 12. Mandatory and Statutory training requirements

12.1. All new starters will fully complete their statutory and mandatory training requirements via Induction.

12.2. A Training and Development matrix which details the required statutory and mandatory training requirements for different volunteer roles can be found in the Appendix.

12.3. It is vital that all statutory and mandatory training is completed prior to any other training being undertaken.

12.4. HFR volunteers and their mentors will be informed of non-attendance/compliance with statutory and mandatory training.

12.5. It is the Mentor's responsibility to ensure compliance with this policy.

12.6. If a volunteer continues not to undertake their statutory and mandatory training after discussions with their mentor, this will be reviewed by the HFR Exec. Com. and a risk-based decision will be made as to what areas of activity the volunteer may continue to undertake, or whether they should be asked to resign.

12.7. Training attendance will be monitored by the Hon. Sec. and recorded in the HFR database as relevant.

## 13. Policy Consultation

13.1. This policy has been circulated to the HFR Executive and Medical Advisor for consultation.

13.2. The policy will be approved by the HFR Executive with future reviews and updates tabled for approval at Exec meetings.

14. **Dissemination**
    14.1. Once the policy has been approved a summary of relevant changes (and a link) will be disseminated via email to the HFR volunteers, and a pdf copy of the policy placed by a member of the Exec on the member's section of the website: www.hartresponse.org.uk

15. **Monitoring of Compliance and Effectiveness**
    15.1. Monitoring of the policy will be the responsibility of the HFR Executive. This will be through incidents reported on the HFR database, and annual audits. Actions and lessons learned from incident investigations will be monitored through the HFR Executive. Where any omissions or deficits have been noted results and action plans will be monitored through the HFR Executive.
    15.2. Lessons learned will be disseminated to the HFR volunteers through email briefings or via weekly training sessions.

16. **Implementation**
    16.1. The HFR Executive are responsible for communicating this information to HFR volunteers and ensuring that the procedures are followed.

17. **Archive Statement**
    17.1. The Honorary Secretary is responsible for archiving all previous versions and supporting evidence of approval for this policy.

**Appendix 1 Training and Development matrix**
A HFR Supporter is defined as a volunteer who does not administer first aid at an event.

| **Mandatory and Statutory Training** | **Supporter** | **FA/AA** | **Paramedic/Dr** |
|---|---|---|---|
| Induction | Once | Once | Once |
| Data protection / information governance | Annual | Annual | Annual |
| Equality and Diversity | 3 yearly | 3 yearly | 3 yearly |
| Fire | Annual | Annual | Annual |
| Infection Prevention and control (includes waste management and inoculation injuries) | 3 yearly | Annual | Annual |
| Manual Handling | 3 yearly | 3 yearly | 3 yearly |
| Risk & Incident management | 3 yearly | 3 yearly | 3 yearly |
| Safeguarding | 3 yearly | Annual | Annual |
| Violence and Aggression | 3 yearly | 3 yearly | 3 yearly |
| Personal training record competency assessments | None | As detailed in the pack | As appropriate |

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## Appendix 2 Equality Impact Assessment

| Impact | Age | Disability | Race | Gender | Religion or Belief | Sexual Orientation |
|---|---|---|---|---|---|---|
| Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy? | N | N | N | N | N | N |
| Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups? | N | N | N | N | N | N |
| Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)? | N | Y | N | N | N | N |
| Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups? | N | N | N | N | N | N |

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| Do different groups (age, disability, race, sexual orientation, gender, religion or belief) have different needs, experiences, issues and priorities in relation to the proposed policy? | We have no statistical or anecdotal evidence, at this stage, to show that this policy will affect the groups mentioned differently. |
| Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups (age, disability, race, sexual orientation, gender, religion or belief)? | We have no statistical or anecdotal evidence, at this stage, to show that this policy will not promote equality of opportunity or good relations between different groups. |
| Is there potential for or evidence that the proposed policy will affect different population groups (age, disability, race, sexual orientation, gender, religion or belief) differently (including possibly discriminating against certain groups)? | Given the nature and type of vehicles that HFR use, access by a person using a wheelchair will not be possible. In this event it is likely that assistance will be sought from the NHS ambulance service if required. |
| Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups (age, disability, race, sexual orientation, gender, religion or belief)? | We have no statistical or anecdotal evidence, at this stage, to show that this policy will not promote equality of opportunity or good relations between different groups. |

Based on the information set out above the HFR Executive has decided that a full equality impact assessment is not necessary.