Version 12

Vitality
HEALTHCARE SERVICES
... Healthcare Par Excellence!

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REGISTRATION PACK FOR ALL CANDIDATES TEMP AND PERM

DOCUMENTS TO BE RETAINED BY VITALITY HEALTHCARE SERVICES PERSONNEL CONSULTANT AND EMAILED TO ADMIN@VITALITYHCS.CO.UK	Checklist to be ticked by VHC representative
Candidate Application Form together with Occupational Health Assessment (and any relevant certificates re: education, qualifications, Ltd Companies etc)	☐
Copy of 48 hour opt out agreement **PAYE workers only**	☐
Back up Identification as per Immigration Code ___ (Consultant please enter code by referring to Immigration Policy in this pack)	☐
I wish to avail of the training, fitness to work certificate, and PPE (Personal Protective Equipment) provided at a weekly charge of six pounds and ninety five pence. Full insurance is provided at no cost (see details attached).	YES ☐ NO ☐

I confirm that the Candidate Application Form together with the Occupational Health Assessment is completed correctly and I have read and understand the Coyle Introductory Letter, Staff Handbook, Health and Safety Policy, Immigration Policy, 48 Hour Opt Out Agreement and Terms of Engagement *2 and that a copy of all these documents as outlined below have been given to me.

Name of Candidate: (Block Capitals) ___________________________________

Signature ____ Date: _____________________
(will always be on or before the date a temp assignment or perm job commences)

*2not applicable to perm candidate

DOCUMENTS TO BE GIVEN TO CANDIDATE

Document		Checklist
Introductory letter (gaps to be filled in and items to be deleted by Coyle representative)		☐
Copy of Health and Safety Policy		☐
Copy of Immigration Policy		☐
Copy of Terms of Engagement of PAYE workers	Coyle representative to give candidate whichever one is applicable (Not required for perm candidates)	☐
Copy of Terms of Engagement of Ltd Company workers		☐
Copy of Insurance documentation		☐

FOR INTERNAL PURPOSES ONLY

Note to Coyle representative: Under no circumstances can we legally set up a new employee until the above boxes are ticked and all the back up documentation attached.

DECLARATION BY COYLE REPRESENTATIVE

I hereby confirm that all the above boxes are ticked, the candidate has signed above and the relevant documents outlined above have been handed to the candidate. I also confirm that all documents retained by Coyle Personnel outlined above together with a copy of the original form of ID required for immigration purposes have been attached and sent to payroll by electronic means for registration and verification. I also confirm that where relevant any photographic ID bears a true resemblance to the person I have engaged.

Name of Coyle Representative: (Block Capitals)____

Division: (Block Capitals)______________________________ Branch (Block Capitals) _____________________________

Signature:____ Date: ________________________
(will always be on or before the date a temp assignment or perm job commences)

CONDUCT REGULATIONS OPT OUT NOTICE (Limited Company Contractors Only)

NOTE TO LIMITED COMPANY CONTRACTOR: Limited company contractors can opt out of the Conduct of Employment Agencies and Employment Businesses Regulations 2003. If, you, the Contractor, and the Individual to be supplied to do the work wish to opt out of the Conduct Regulations, please read this form carefully. It is recommended that you take independent legal advice so that you know what the opt-out means for you.

1. This Opt Out Notification is supplemental to the agreement ("the **Agreement**") between Coyle Personnel plc and the Contractor. The terms used in this notification shall have the same meaning as those defined in the Agreement.
2. The Contractor and the Individual acknowledge that it is their intention that the provisions of the Conduct of Employment Agencies and Employment Businesses Regulations 2003 (the "**Conduct Regulations 2003**") do not apply to any assignment agreed between the Parties.
3. The Parties have freely entered into this Opt Out notification.
4. Further that the Contractor and the Individual are free to withdraw from this Opt Out notification at any time by giving not less than one month's written notice to Coyle Personnel plc. However, where notice is given during an Assignment it will not take effect until the Individual stops working in that Assignment and commences a new assignment.

I the undersigned have read, understand and agree to be bound by the terms of this Opt Out notification. In particular, I understand that by signing this Opt Out notification I am agreeing that the provisions of the Conduct Regulations 2003 shall not apply to any assignment agreed between the Parties.

Signed

____
The Individual

Name______________________________

Dated ______________________________

Confirmation of Bank Details

Candidate Name:

Bank/Building Society:

Name on Account:

Sort Code:

Account Number:

Roll Number (if applicable):

I authorise Coyle Medical to pay my weekly earnings directly into the bank or building society who details I have given above.

I confirm I will notify Coyle Medical in writing of any changes to these details.

Signed:

Print Name :

Payroll Number (If Known):

Date:

Agency Worker Handbook Declaration

I have read a copy of the Agency Worker Handbook which outlines the goals, policies, benefits and expectations of Coyle Medical and its Clients, as well as my responsibilities as an Agency Worker. I have familiarised myself with the contents of this Handbook. By my signature below, I acknowledge, understand, accept and agree to comply with the information contained in the NMC's "Standards for Medicines Management", 2008 (Cover 2010) and the Agency Worker Handbook provided to me by Coyle Medical. I further confirm that I am aware that I must notify Coyle Medical about any changes regarding my Fitness to Practice and/or to Professional Registration immediately.

I understand this handbook is not intended to cover every situation which may arise whilst on assignment, but is simply a general guide to the goals, policies, practices, benefits and expectations of Coyle Medical.

Updates to this Handbook will happen from time to time. Whenever this happens Coyle Medical will notify me. I agree to familiarise myself with these changes before undertaking any further shifts through Coyle Medical.

I understand that the Agency Worker Handbook is not a contract of employment and should not be deemed as such.

Print Name ....

Profession ....

Registration No ....

Signature ....

Date ....

I hereby give permission for Coyle Medical to allow access, as a minimum, to my personnel files as part of any official audit, or Client compliance purposes, carried out by, but not limited to, NHS Buying Solutions and/or any person authorised by the NHS Authority. These personnel files will be viewed in accordance with the requirements of the Data Protection Act 1998.

Signature: ....Date: ....

5 year address history

ADAPT/INVU:

FULL NAME (including middle names)	
DATE OF BIRTH	
GENDER	
NATIONAL INSURANCE NUMBER	
BIRTH PLACE (TOWN AND COUNTRY)	
NATIONALITY	
BIRTH SURNAME?	
POSITION (e.g. RGN)	
UNSPENT CONVICTIONS?	

CANDIDATE PHONE CALL:

CURRENT ADDRESS	
DATE FROM WHICH LIVING AT CURRENT	
PREVIOUS ADDRESS 1 (IF APPLICABLE)	
DATE FROM WHICH LIVING AT ADDRESS	
PREVIOUS ADDRESS 2 (IF APPLICABLE)	
DATE FROM WHICH LIVING AT ADDRESS	
PREVIOUS ADDRESS 3 (IF APPLICABLE)	
DATE FROM WHICH LIVING AT ADDRESS	
BIRTH SURNAME?	
DATE OF NAME CHANGE	

NEW EMPLOYEE MEDICAL QUESTIONNAIRE

CONFIDENTIAL

The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician. Your record will be held on file for a short period of time and may be subject to audit. Your file may also be used to cross reference and ascertain your fitness should you register with other clients of Healthier Business UK Ltd.

Personal Information			
Title	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:	GP Address:		

Medical History		
All staff groups complete this section	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	☐	☐
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	☐	☐
Are you having, or waiting for treatment (including medication) or investigations at present? If your answer is yes, please provide further details of the condition, treatment and dates	☐	☐
Do you think you may need any adjustments or assistance to help you to do the job?	☐	☐

- If you have indicated yes to any of the above questions you must provide further details, failure to do so will result in the form being **returned/rejected**.

Additional Information (If you have answered yes to any questions above please provide additional information below)

Tuberculosis			
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)		Yes	No
Have you lived continuously in the UK for the last 5 years?		☐	☐
If you answered NO to the above, please list all of the countries that you have lived in/visited over the last 5 years, including duration of stay and dates i.e. United Kingdom July 2012 to November 2012.			
Have you had a BCG vaccination in relation to Tuberculosis?		☐	☐
If you answered yes please state when	Date		

Tuberculosis Continued		
Do you have any of the following	Yes	No
A cough which has lasted for more than 3 weeks	☐	☐
Unexplained weight loss	☐	☐
Unexplained fever	☐	☐
Have you had tuberculosis (TB) or been in recent contact with open TB	☐	☐

Additional Information (If you have answered yes to any questions above please provide additional information below)

Chicken Pox or Shingles		
Have you ever had chicken pox or shingles		
Yes	**No**	**Date**

Immunisation History			
Have you had any of the following immunisations	**Yes**	**No**	**Date**
Triple vaccination as a child (Diptheria / Tetanus / Whooping cough)			
Polio			
Tetanus			
Hepatitis B (If Yes is ticked please give dates below)			

Course:	1		2		3	
Boosters:	1		2		3	

Proof of Immunity (Please send the following)	
Varicella	You must provide a written statement to confirm that you have had chicken pox or shingles however we **strongly advise** that you provide serology test result showing varicella immunity
Tuberculosis	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result **(Do not Self Declare)**
Rubella, Measles & Mumps	Certificate of **"two"** MMR vaccinations or proof of a positive antibody for Rubella and Measles
Hepatitis B	You must provide a copy of the most recent pathology report showing titre levels of 100Iu/l or above
Proof of Immunity (Please send the following) EPP Candidates Only	
Hepatitis B Surface Antigen	Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS)
Hepatitis C	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)
HIV	Evidence of a negative antibody test Report must be an identified validated sample. (IVS)

Exposure Prone Procedures		
Will your role involve Exposure Prone Procedures	Yes	No

Declaration		
I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for the Healthier Business UK Ltd to make recommendations to my employer.		
Name	**Signature**	**Date**

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Trained Staff: Pre Registration Assessment (Version 10)

Candidate Name: ____

Position applied for:_________________________Date:_____________

Signature:____

Interview questions

1. It is your first day on a new unit. What would you familiarise yourself with before you start?

____

____

____

2. If you were asked to check a drug but didn't agree with the dose, what would you do?

____

____

____

3. If you found a visitor collapsed at the entrance to the ward/unit, what would you do?

____

____

____

4. A medication due on the previous shift has not been administrated, what would you do?

____

____

____

5. The charge nurse has approached you about a complaint against you, what are you actions?

____

____

____

Medication Management (Version 10)

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Candidate Name: ____

Signature:__________________________________Date:______________

Complete the drug calculations below. Show all working and calculations.

DOSE ORDERED	STOCK
1. Metformin 850mg **Amount to be given:**	500mg/5ml (LIQUID)
2. Warfarin 6mg **Amount to be given:**	1mg, 2 mg, 5mg tablets
3. Omeprazole 40mg **Amount to be given:**	20mg tablets

IV (DRUG) - DOSE ORDERED	STOCK
4. Butenamide 1.5mg **Amount to be given:**	500mcg/ml

5. What do you need to monitor in patients who are on diuretics?
   Answer:

6. Erythromycin 12.5mg/kg (Patients weight is 80kg) **Amount to be given:**	1g in 2ml
7. Diclofenac Sodium 75mg **Amount to be given:**	25mg/ml
8. Dexamethasone 16mg **Amount to be given:**	4mg/ml

IV (FLUID) - DOSE ORDERED	DURATION
9. Normal Saline 1000ml **Rate in ml/hour:**	250ml STAT, then remainder over 10hours
10. Hartmann's 250ml **Rate in ml/hour:**	4hours
11. Tazocin 4.5mg in 100ml **Rate in ml/hour:**	2hours & 30minutes

Mark:________/10 (must be 100%)   PASS / FAIL

Interviewed by (Print Name):________________________________

Signature (Interviewer):________________________________

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RGN Scenario – Medical (Version 10)

Patient: 87 year old female
History: Breast cancer, diabetes type 2, C-diff infection x2, hypertension.
Medications: Metformin 500mg OD and Bumetanide 1mg OD.

Admission: Admitted with abdominal pain and a high temperature of 39°C.

Scenario: Patient arrives on the ward and has an episode of very watery stool and starts vomiting.

What are your actions?
Please describe all the steps you would follow for the complete care of this patient.

Name of Candidate:____

Candidate Signature:___________________________Date:__________

Interviewed by:____

Interviewers Signature:_________________________Mark:_____/ 5

RGN Scenario – Surgical (Version 10)

Patient: 23 year old female
History: Nil significant

Admission: Abdominal pain – started centre of the stomach travelled to lower right-hand side, nausea and vomiting.

Scenario: Diagnosed with acute appendicitis for emergency laparoscopic appendectomy. The patient has just arrived post operatively to your ward. The patient has one vac-drain insitu and intravenous fluids running at 80ml/h.

Her vital signs are as follows:
BP: 87/50 **Pulse:** 107 **RR:** 23 **Saturations:** 95% on RA **Temperature:** 36.9°C

What are your actions?
Please describe all the steps you would follow for the complete care of this patient.

Name of Candidate: ____________________

Candidate Signature: ____________________ Date: __________

Interviewed by: ____________________

Interviewers Signature: ____________________ Mark: ____ / 5