Patient Transfer Policy
Version4.0

Policy Statement:
This policy supports the safe transfer of adults and children across HEFT

Key Points:

- Transfer of patients between wards, specialist units and other hospitals.
- The purpose of this policy is to provide clear guidance and instruction to staff with regard to the permanent transfer of adult and paediatric patients into, out of, and within the Trust sites.
- Each type of patient transfer is now outlined with a specific SOP
- All patients being transferred must have an up to date assessment of any physical or mental capacity risks
- All Patients being transferred must have a current MEWS/PEWS score and a treatment management plan.
- Verbal Handover of patients must be backed up with the appropriate Trust SBAR transfer form.

Key Changes:

- The introduction of the new Trust SBAR transfer sheet.
- The use of standard operating procedure for each type of transfer

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Ratified Date1st October 2013
Ratified By: Sam Foster– Chief Nurse
Review Date: 30th June 2014
Accountable Directorate: Nursing Directorate
Corresponding Authors: Ruth Spedding, Jo Richmond, Tara Hughes, Sarah Quinton

Quick Reference guide
Requirements for Patient Transfer between wards and hospital sites

Severity of illness	Appropriate mode of transfer	Minimum escort requirement	Documentation required	Risk	Skills required
Level O Internal transfer (SOP Appendix 1)	Bed Trolley or Chair	HCA or Pre-Reg Nurse +/- Porter	SBAR transfer sheet All notes and Charts	Low	• Aware of patients current needs. • Understands Transfer process.
Level 1 Internal transfer (SOP Appendix 1)	Bed Trolley or Chair	RGN + Porter	SBAR transfer sheet All notes and Charts	Med	• Aware of patients current needs. • Understands Transfer process. • BLS
Level 2 Internal Transfer (SOP Appendix 2)	Bed or Ambulance Stretcher	Clinician/Practitioner +/or RGN with appropriate skills	SBAR transfer sheet All notes and Charts	Med	• Appropriate Critical care skills • Aware of patients needs. • Understands Transfer process • BLS
Level 3 Internal Transfer (SOP Appendix 3)	Bed or Ambulance Stretcher	Critcal Care Clinician / Practitioner and Critical Care outreach Nurse	SBAR transfer sheet All notes and Charts	High	• Appropriate Critical care skills • Aware of patients current needs. • Understands Transfer process • ALS
Level 0 External transfer (SOP Appendix 4)	Stretcher or wheelchair	Paramedic Crew alone or Technical Crew +/- RGN, HCA or Pre- Reg Nurse	Any medical /nursing notes required for the purpose of the transfer	Low	• Aware of patients current needs. • Understands Transfer process. • BLS
Level 1 External transfer (SOP Appendix 4)	Stretcher	Paramedic Crew or Technical Crew + RGN	Any medical /nursing notes required for the purpose of the transfer	Med	• Aware of patients current needs. • Understands Transfer process • BLS

Meta Data

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Status	Approved
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Related documents	• Transfer procedures: in-utero, Neonatal and post-natal. • Safeguarding Adults Policy • Safeguarding Children's Policy • Bed Management Procedures • Single Sex Accommodation Policy • Pressure Ulcer Policy • Adult MEWS Policy • Paediatric Observation and Monitoring Policy • Discharge Policy • Health and Safety Policy • Patient Property • Medicines Policy • Medical Devices • MRSA Policy • Isolation Policy • Diarrhoea and Vomiting Policy • TB Policy • Viral Haemorrhagic Fever Policy • Electronic Patient Handover (EPH) Policy • Birmingham & Black Country Critical Care Network Policy for Transfer of Level 3 Patients • Birmingham & Black Country Critical Care network Policy for Repatriation of Level 2 Patients • Resuscitation Policy Appendix I (DNACPR during transfer) • Transfer Procedure Maternal and Neonatal before or during labour and following delivery (http://intranet_1/guidelines/)
Superseded documents	Transfer Policy v1.0
Relevant External Standards/ Legislation	NHSLA Standards (Standard 4 Clinical Care) Intensive Care Society Guidelines (2002) Transfer of the Critically Ill Patient West Midlands Strategic Commissioning Group: Standards for Care of the Critically Ill and Critically Injured Child (2004)
Key Words	Transfer

Revision History

Version	Status	Date	Consultee	Comments	Action from Comment
0.1	Draft	May 2008	First Draft & Consultation	Considered	Revised
1.0	Approved	June 2008			
1.1	Draft	August 2009	Ian Donnelly – Head of Capacity, Sarah Quinton – Critical Care Outreach Lead,		
1.2	Draft	March 2010	Ian Donnelly – Head of Capacity, Sarah Quinton – Critical Care Outreach Lead, Peter Moon/ Rachael Blackburn – Governance, Yvonne Higgins - Patient Safety team, Karen Barber and Julie Rowland – Lead Paediatric Nurses, Liz Lees – Consultant Nurse Matrons PGNF Corporate Nursing	Comments noted and considered	Added standard operating procedures to policy to show transfer procedure for all levels of patients Updated SBAR transfer sheets
2.0	Approved	Jan 2011	Matrons Business meeting		Forward for Ratification
3.0	Revised and Approved	June 2013	Corporate Nursing Chief Nurse	Minor amendments made relating to the checking of Patient bedside medication lockers. Updated SBAR transfer sheet re bedside lockers Title of Matrons updated to Lead Nurses Definition of external transfer amended	Approved and Ratified by Chief Nurse
4.0	Revised and Approved	October 2013	Head Nurse for Children's Services Lead Nurses for Children's and Childrens HDU Service	An amended flowchart to incorporate the process for all children transfers from Good Hope to Heartlands	Flowchart attached Policy accepted by Chief Nurse

Table of Contents

Executive Summary

All patients within Heart of England Foundation Trust that require transfer from one area to another either internally or externally must have the appropriate documentation completed to ensure that patient care is not compromised as a result of the transfer.
This policy and its supportive appendices aim to ensure safe and appropriate transfer of the patient with minimal risk.
The NHS Risk Management Standards issued by the NHS Litigation Authority (NHSLA) requires participating Trusts to develop a policy on patient transfer and procedural documents.

1. Circulation

This policy applies to all Healthcare Practitioners employed on a substantive or temporary contract by the Heart of England NHS Foundation Trust (HEFT), including Bank & Agency staff, which are required to undertake patient transfer both internally and externally to the Trust.

All staff required to undertake patient transfers are expected to comply with this policy

2. Scope

2.1 Includes

- This Policy applies to adults and children, according to their definitions included in this policy, who are transferred both internally and externally to or from (HEFT)
- All staff required to undertake patient transfers are expected to comply with this policy

2.2 Excludes

Transfer of Maternity Patients:

This policy does not cover the transfer of maternity patients. Please refer to: Transfer procedures: In–utero and post natal, to cover this patient group

Transfer of Neonatal Patients:

This policy does not cover the transfer of neonatal patients. A separate policy and guidelines are available to cover this patient group

External Transfer of Level 2 and 3 Critical Care Patients:

This policy does not cover the external transfer of Level 2 and 3 Critical Care patients
Please refer to the Birmingham & Black Country Critical Care Network Transfer Guidelines for the transfer of all Level 2 and 3 Critical Care Patients externally

Temporary Transfer of patients:

This policy does not cover the temporary transfer of patients to and from departments within and from HEFT. Examples of a temporary transfer are: to and from x-ray, theatre, physiotherapy, occupational therapy, dialysis unit and outpatient departments.

3. Definitions

3.1 SBAR

S- Situation
B- Background
A- Assessment
R- Recommendation

3.2 Adults

An adult is classed as any person who is nursed on an adult in- patient ward. This may include a patient under the age of 18 years who is deemed more suitable to be nursed on an adult ward than a children's ward due to the nature of their condition.

3.3 Children

A child is classed as any person who is nursed on a children's ward.

3.4 Internal Transfer (Permanent)

This refers to any patient being transferred across HEFT, irrespective of site, to another clinical area **along with** responsibility of care (i.e. from one ward area to another ward area or from an emergency department to ward / assessment area)
These Patients remain inpatients and will require transferring on the Trust Patient management (HISS) systems.

3.5 External Transfers

This refers to Patients who are transferred out of HEFT to another health care provider for planned treatments and then return to the trust immediately following this treatment.
These patients remain on the HEFT HISS system as inpatients.

Patients permanently transferred out of HEFT to another healthcare provider are classed as a discharge and are discharged off the Trust Patient Management (HISS) system please refer to discharge policy for guidance relating to this.

3.6 Clinical Transfer

This refers to the permanent transfer of patients from one hospital to another or between wards within HEFT when a clinical need has been identified. For example:

- The patient needs to move due to a change in clinical management
- Clinical need to increase level of care requiring move to ICU/HDU/CCU/PHDU
- Clinical need to decrease level of care requiring transfer from ICU/HDU/CCU/PHDU following assessment prior to placement on a dedicated speciality or Consultant based area.
- When a 5 day ward closes at the weekend
- When a single bed side room is required due to the patient's condition
- For admission after a day case or routine procedure
- As a result of a diagnosis which identifies the need for a change of consultant responsibility i.e. a medical patient requiring surgical intervention

(This is not an exhaustive list)

3.7 Non- Clinical Transfer

This refers to the permanent transfer of patients from one hospital to another or between wards within HEFT for a non- clinical reason. For example:

- Movement to a cohort ward due to hospital pressures
- External transfer due to repatriation
- Movement of a patient to achieve single sex occupancy

(This is not an exhaustive list)

3.8 Escort

An escort is a member of staff considered appropriate to be able to safely transfer a patient and meet their needs. Any person involved in the transfer of a patient should have the necessary knowledge, skills and experience to be able to achieve a safe transfer. An appropriate escort for the patient should be identified by the nurse in charge of the transferring ward.

3.9 Levels of Care for adult and paediatric patients

The following levels of care have been taken from the Intensive Care Society Standards (ICS) published in 2002 and Paediatric Intensive Care Standards (2001):

- Level 0 Patients whose needs can be met through normal ward care in an acute hospital.

- Level 1 Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team.

- Level 2 Patients who require more detailed observation or intervention. This may include support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.

- Level 3 Patients who require advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi – organ failure.

4. Reason for Development

Heart of England NHS Foundation Trust (HEFT) is committed to providing high quality care to all patients. The Trust has a duty of care to ensure it provides secure safe transfer of patients between wards, specialist units and other hospitals without compromising their care.

5. Aims and Objectives

5.1 Aims

The aim of this policy is to:

Ensure the safe transfer of patients between wards, specialist units and other hospitals and to maintain the quality of patient care.

5.2 Objectives

The objectives of this policy are:

- To provide effective and accurate communication of all patient transfers to patients, relatives and carers
- To Provide effective and accurate communication of all patient transfers between clinicians
- To ensure an appropriate assessment of risks is conducted prior to transfer
- To provide clarity on the use of an appropriate escort as clinical need dictates
- To Ensure a HEFT SBAR Transfer Form is completed by a Registered Nurse or Midwife for all patient transfers
- To Ensure the appropriate SOP is followed for the level of patient
- To Ensure the safety of patient's property is maintained throughout the transfer process.

6. Standards for Policy

6.1 General Principles

- Wherever possible the patient and their relatives/carers will be involved in the discussion and decision regarding transfer. When this is not possible e.g. in an emergency situation, the patient's relatives /carers must be informed by the nurse responsible for the patients care as soon as a decision to transfer has been made by the multidisciplinary team.

- For clinical transfer it is the responsibility of the referring clinician to ensure that the receiving clinician has the necessary information prior to transfer to enable appropriate and timely management of the patient.

- For all types of transfer referred to in this policy, a clear and accurate verbal handover using the **SBAR** approach must be given by a registered nurse from the transferring area to a registered nurse in the receiving area so that the receiving area has the information to enable them to give appropriate and timely management of the patient when they arrive. This should include an up to date assessment of any physical or mental risks, a current MEWS/PEWS score and a treatment management plan.

- For all permanent transfers a registered nurse from the transferring ward/department **must** complete the appropriate HEFT SBAR transfer form, prior to movement of the patient.

- It is the responsibility of the receiving ward to ensure that the patient's details are entered into the HISS system and ward transfer completed. This will enable all electronic handover information to be transferred and be accessible by the receiving ward.

- **For all permanent transfers face to face handover will be given at receiving end backed up by the use of the SBAR transfer sheet. The transfer sheet must be filed in the patient's medical notes.**

6.2 Transfer of Patients out of Hours

- In line with HEFTs bed management policy and procedures (section 16.2) the transfer of any patient, should be completed by **20.00 hours** on the day in question, therefore the transferring ward has the responsibility to ensure arrangements are made for a timely transfer, liaising with the receiving ward to ensure effective continuity of care.

- Clinical or non-clinical needs of patients may require transfers to occur outside of this parameter; these should be assessed on an individual basis and includes patients needing transfer from an emergency area to a base ward area.

- In situations where a patient needs to be transferred out of hours then the appropriate SOP must still be followed and the general principles outlined in this policy still apply. In these circumstances if it is considered unacceptable to contact relatives/carers at that hour then they must be informed at the earliest opportunity unless the patient or relative/carer has expressed a wish otherwise.

6.3 Transfer of Deteriorating Patients

When transferring a patient who has a clinical condition causing concern or deteriorating physiological parameters discussion must take place between the referring clinician and the receiving clinician and a fit for transfer decision must be agreed.

If the patient currently has a MEWS score of 4 or above (PEWS > 5 for paediatrics) then the MEWS/PEWS policy and escalation pathways **must** be followed prior to transfer and any communication between clinicians agreeing to proceed with transfer must be documented in the medical notes.

For patients transferred into the Trust from another Trust or Healthcare Provider the receiving clinician must ascertain if an early warning scoring system is in use, establish the equivalent level and whether appropriate referral to critical care outreach has taken place. This must be recorded in the patient's medical records.

6.4 Transferring Patients to the Trust Cohort Ward for Infection Control Purposes

For patients who need clinical transfer, for infection control purposes (E.g. C Difficile), to the Trust cohort ward at the BHH site, the referring clinical team must agree the transfer in advance with a member of the receiving Consultant team and record the name of the receiving consultant in the case notes.

For patients transferred from the GHH and SH sites to the Trust cohort ward the receiving consultant will normally be the Consultant on call for Infectious Diseases at the time of the planned transfer.

For patients transferred to the Trust cohort ward from the BHH site the referring consultant stays responsible for the patients care.

6.5 Transferring Patients Who Are Approaching End of Life

For patients approaching end of life requiring transfer (discharge) to a hospice or other care setting the ambulance control must be informed that a direct transfer is required.

(See Policy and Procedure for Discharge Practices Section 7.10)

HEFT staff should take (and document) the following steps when arranging for the transfer/ discharge of a patient with a DNAR order.

- Ensure that the DNAR order is valid

- Contact ambulance control and state that a DNAR is in place and that resuscitation should not be attempted by the ambulance crew in the event of a cardiac arrest.

- Advice the patient (and relatives) (if appropriate) that the DNAR will remain in place during the transfer

- Show the ambulance crew the valid DNAR order

In the rare event that the clinician responsible for the patients care wishes for resuscitation to be provided during transfer then the DNAR decision should be cancelled and nursing and ambulance staff informed accordingly. The reasons for this decision should be clearly documented in the medical records.

6.6 Adequate Assessment of Risks Prior to Transfer

An initial assessment will take place by the clinician to ascertain if it is necessary and safe for the patient to be transferred. This will include an assessment of the level of care required and what equipment/medications are required to maintain or improve condition of the patient before, during and after transfer.

An appropriate assessment will be undertaken by the registered nurse of the transferring area to establish the most suitable form of transport required to safely transfer the patient. It is the responsibility of the transferring ward to arrange the transport for the transfer to take place as outlined in the relevant SOP.
It is the responsibility of the transferring ward, to inform all involved in the transfer, of any infection control risks.

6.7 Escorting Patients on Transfer

An escort will be provided by the transferring ward. Clinical condition will dictate who is a suitable escort for the patient as outlined in the relevant SOP.

All Level 2 /3 patients must be accompanied by the appropriately skilled Clinician and/or Registered Nurse as outlined in the relevant SOP.

At no time must a relative, carer or friend be used as an alternative to staff escorts and asked to assist in the movement of patients. This however does not preclude relatives/ carers accompanying the transfer if appropriate.

If a relative /carer are to accompany a transferring patient in an ambulance the ambulance control MUST be informed of this at time of booking.

6.8 Safety of Patients' Property

In line with the patients' property policy (sections 6.6-6.8+) when patients are transferred from one ward area to another it is the responsibility of the transferring ward to notify the patients property office of the patients new location and the receiving ward that the patient has valuables stored there. The transferring ward must ensure all patients clothing and belongings accompanies them to their new location.

6.9 Patient Medications

When the patient has been deemed appropriate for transfer any required medication will be administered and any named patient medication transferred with the patient. Patient bedside medication lockers must be emptied of any patient medication prior to transfer. It is the responsibility of the transferring member of staff to handover medications to the registered nurse on the receiving ward for safe custody.

6.10 Medical case notes

Medical case notes must accompany patients on transfer unless otherwise indicated. This includes patients that require external transfer from the trust for treatment / appointments and who are returning to the trust on the same day and are remaining HEFT inpatients.

Medical case notes or any part of them **MUST NOT** be sent with a patient if the patient is being discharged to another hospital / hospice. A photocopy of the notes can be taken if required by the receiving hospital / hospice. .

7. Responsibilities

7.1 Individual Responsibilities

7.1.1 Chief Executive

The Chief Executive has overall accountability for ensuring the Trust meets all its responsibilities with regard to the standards outlined in this policy. The responsibility for Implementation, monitoring and renewal of this policy is delegated to the Chief Nurse.

7.1.2 Chief Nurse

The Chief Nurse has overall responsibility for the development, review and monitoring of this Policy. This can be delegated to the Corporate Nursing team. The Corporate Nursing Team will oversee the implementation of this policy and supporting procedure and provide reports, as required, to the Trust Board in this regard.

7.1.3 Lead Nurses

Lead Nurses are responsible for ensuring that nursing staff within their remit comply with the Patient Transfer Policy.
Lead Nurses are responsible for ensuring that nursing staff within their remit are encouraged to access the nursing intranet regularly to ensure that that are familiar with current practices.

7.1.4 Ward / Unit Manager

The Ward / Unit Manager are responsible for:

- Raising awareness of this policy and content, including its SOPs, with all staff members in their remit who may be involved in patient transfer, at local induction.
- Ensuring any permanent members of staff conducting patient transfer on their ward or dept have accepted responsibility for reading this policy and understand how to achieve a safe transfer.
- Ensuring that nursing staff within their remit are encouraged to access the nursing Intranet regularly to ensure that that are familiar with current practices.
- Any temporary nursing staff (bank and agency) working in their area are identified as suitable escorts, based on the patients level of care, and are given the information to be able to effectively care for the patient during the transfer. This responsibility can be delegated on a day to day basis to the nurse in charge of the ward.

Health Care Assistants and Support Workers should only undertake patient transfer when it has been deemed appropriate to their duties by their Ward/unit manager. This can be delegated to the nurse in charge on a day to day basis

7.1.5 All Staff Conducting Patient Transfers

All staff conducting patient transfers are responsible for:

- Providing effective care for the patient during transfer by being aware of the patients' condition and current needs.
- Maintaining the patient's dignity and respect throughout.
- Familiarising themselves with this policy, its contents including its SOP's locally or via the nursing intranet.
- Familiarising themselves with emergency telephone numbers and location of receiving area.

- Ensuring that prior to undertaking patient transfer they have been given adequate information regarding the patient to be able to care sufficiently for them during the transfer process.
- Registered nurses are personally accountable for their own safe practice, actions and omissions as outlined in the NMC Code.
- Clinical staff are personally responsible for their own safe practice, actions and omissions as outlined in GMC duties of a doctor/ good medical practice.

7.2 Board and Committee Responsibilities

7.2.1 Approval / Ratification Committee

The Nursing Midwifery Board will be responsible for the approval and ratification of this policy.

8. Training Requirements

The Ward / Unit Manager are responsible for:

- Ensure all staff read new policy
- Incorporate the Transfer Policy and SOPs as part of local induction for any new staff

9. Documentation

Appendix 1 to 6 of this policy details the transfer arrangements for each of the patient groups. For clarification the following table details the documentation required to accompany each patient when being transferred.

Internal Transfer Level 0-1 Patients (Appendix 1) • In patient SBAR transfer sheet, signed by the transferring nurse. • Medical/Clerking notes • Nursing notes • Observation charts
Internal Transfer Level 2 Patients (Appendix 2) • In patient SBAR transfer sheet, signed by the transferring nurse. • Medical Notes • Nursing notes • Observation charts
Internal Transfer Level 3 Patients (Appendix 3) • In patient SBAR transfer sheet, signed by the transferring nurse. • Medical Notes • Nursing notes • Observation charts
External Transfer from HEFT Level 0-1 Patients (Appendix 4) Any medical /nursing notes required for the purpose of the transfer
External Transfer into HEFT Level 0-1 Patients (Appendix 5) No special requirements for documentation

10. Monitoring and Compliance

Minimum Criteria	Monitoring Method	Responsible	Frequency	Responsible Committee
A. Duties	Corporate Nursing Audit Including staff knowledge questions	Corporate Nursing Team	Annually	ED's Committee Group quality and safety committees Governance and risk committee
B. Definition of all patient groups	Corporate Nursing Audit	Corporate Nursing Team	Annually	
C. Transfer requirements which are specific to each patient group				
D. Documentation to accompany the patient when being transferred				
E. Process for Transfer out of hours	Corporate Nursing Audit accessing electronic patient handover to identify out of hours transfer	Corporate Nursing Team	Annually	

All staff to declare non-compliance with this policy through IR1

Compliance in relation to staff duties, the transfer process and the completion of the SBAR transfer sheet will be audited by The Corporate Nursing team annually and reported back, via the quality and safety committees, to the chief nurse.
Safety and Governance will provide quarterly reports to the Corporate Nursing Team detailing all reported incidents of non-compliance. This will be reported back, via the quality and safety committees, to the chief nurse.

10.1 Non-Compliance

Identified non–compliance should be reported to the Ward/unit line manager and matron for the area concerned via IR1. Safety and Governance will provide reports to the individual group structures quality and safety committees. Non- compliance of this policy shall be dealt with by the ward /unit manager and Matron.

In situations where a transfer has resulted in a serious untoward incident, an investigation must be conducted to assess if compliance with the policy had been achieved.

11. References

Intensive Care Society (2002) Guidelines for the transport of the adult critically ill patient

NHSLA Standards (Standard 4 Clinical Care)

Paediatric Intensive Care Standards (2001)

West Midlands Strategic Commissioning Group: Standards for Care of the Critically ill and Critically Injured Chid in the West Midlands (2004)

12. Appendices

Appendix 1: Standard Operating Procedure – Internal Transfer Level 0-1 Patients
Appendix 2: Standard Operating Procedure – Internal Transfer Level 2 Patients
Appendix 3: Standard Operating Procedure – Internal Transfer Level 3 Patients
Appendix 4: Standard Operating Procedure – External Transfer from HEFT Level 0-1 Patients
Appendix 5: Standard Operating Procedure – External Transfer into HEFT Level 0-1 Patients
Appendix 6: Standard Operating Procedure – Paediatric Internal and External Transfer Protocol
Appendix 7: Standard Operating Procedure – Paediatric Transfer Pathway from Good Hope Site to Heartlands Site
Appendix 8: Standard Operating Procedure – Critically Ill / Injured Child Requiring Stabilisation and Transfer to PICU
Appendix 9: Management of Children Requiring 'Time Critical' Transfers
Appendix 10: Adult SBAR Transfer Sheet
Appendix 11 Paediatric SBAR Transfer Sheet
Appendix 12: AMU SBAR Transfer Sheet

13. Attachments

Attachment 1: Equality & Diversity – Policy Screening Checklist
Attachment 2: Equality Action Plan / Report
Attachment 3: Approval / Ratification Checklist
Attachment 4: Launch and Implementation Plan

Appendix 1: Standard Operating Procedure – Internal Transfer Level 0-1 Patients

Level 0 = Patients needs can be met through normal ward care in an acute hospital.
Level 1 = Patients at risk of their condition deteriorating whose needs can be met on an acute ward and includes those stepping down from higher levels of care.

Aim: To ensure the safe transfer of patients between wards, specialist units and other HEFT hospital sites and to maintain the quality of patient care.

SECTIONS A-G MUST BE FOLLOWED ACCORDING TO CLINICAL NEED

USE SBAR:
S- What is the Situation?
B- What is the Background?
A- What was the last Assessment?
R- What are the Recommendations?

Referral method: Registered Nurse to Registered Nurse following direction from Bed manager, Bed co-ordinator or Site/ Night Practitioners
(A) Assessment: **All patients must be assessed by a registered nurse prior to transfer to ensure a safe transfer is achieved** **Any physical or mental capacity risks must be identified prior to transfer and documented on the SBAR transfer form**
(B) Communication: • Discuss the transfer with the Patient, their next of kin, or carer and document on transfer form. Any exceptions to this should also be documented in the patient's notes and on SBAR transfer form. • Inform transport if required • Complete the SBAR transfer form and use this to Inform the receiving ward of the patient's condition including infection control status and current Mews score
(C) Identify and request appropriate mode of transport • Bed – This will require a minimum of two people • Trolley- This will require a minimum of two people • Wheelchair- This can be undertaken by one person • Ambulance (Patients requiring transfer from one building to another on the same site will require an internal ambulance unless clinical condition dictates otherwise)
(D) Monitoring and Equipment • Following an assessment made by a registered nurse consider all equipment that may be required for safe transfer this may include: oxygen, 02 saturation monitor, 3 lead ECG monitor, infusion pumps, iv stand • If patient is receiving oxygen therapy, then provision must be made using portable cylinder with enough oxygen for the journey and extra capacity in case of delay the Registered nurse must ensure appropriate oxygen therapy is established before leaving the ward / dept
(E) Escort - Must be an appropriate healthcare professional • **Registered Nurse**–for patients who may be acutely ill with a MEWS score of 4 or above or requires ongoing clinical intervention whilst in transfer e.g. Blood transfusion / IV infusions • **Health care assistants** or support workers can only transfer patients who are clinically stable, following the assessment made by the registered nurse and it has been deemed appropriate for their role by their line manager
(F) Documentation that Must accompany patient • In patient SBAR transfer sheet, signed by transferring nurse • Medical/Clerking notes • Nursing notes • Observation charts
(G)Anything else to accompany patient • Patients property – The property office must be informed of the transfer if the patient has valuables stored there **(see patients property policy section 6.6-6.8)** • Named Patients medications should be transferred with the patient. See medicines policy section 1.2

Appendix 2: Standard Operating Procedure – Internal Transfer Level 2 Patients

Level 2= Patients who require more detailed observation. This may include support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.

Aim: To ensure the safe transfer of patients between wards, specialist units and other HEFT hospital sites and to maintain the quality of patient care.

SECTIONS A-G MUST BE FOLLOWED ACCORDING TO CLINICAL NEED

USE SBAR:
S- What is the Situation?
B- What is the Background?
A- What was the last Assessment?
R- What are the Recommendations?

Referral Method:
The decision to transfer a level 2 patient should be made by the Critical Care Consultant or ICU Specialist registrar in discussion with Critical Care Consultant to ensure a safe transfer is achieved and requires the involvement of the Bed Manager, Bed Co-ordinator or Site / Night Practitioners.

(A) Assessment:
All Level 2 patients must be assessed by Critical Care team prior to transfer and assess suitability for transfer.
No critically ill patient will be transferred without first being adequately resuscitated and stabilised.
Any physical or mental capacity risks must be identified prior to transfer and documented on the SBAR transfer form

(B)Communication:
- Discuss the transfer with the Patient, their next of kin or carer and document on transfer form. Any exceptions to this should also be documented in the patients' notes and on the transfer form.
- Inform transport if required
- Complete the SBAR transfer form and use this to Inform the receiving ward of the patient's condition including infection control status and current Mews score

(C)Identify and request appropriate mode of transport
- Bed - This will require a minimum of two people
- Trolley - This will require a minimum of two people
- Ambulance - (paramedic or tech crew)

(Patients requiring transfer from one building to another on the same site will require an internal ambulance unless clinical condition dictates otherwise)

(D)Monitoring and Equipment
- Following an assessment made by a registered nurse consider all equipment that may be required for safe transfer. This will include the minimum standards for monitoring:
  - -3 lead ECG
  - -oxygen saturations
  - -non invasive blood pressure
- If patient is receiving oxygen therapy, then provision must be made using portable cylinder with enough oxygen for the journey and extra capacity in case of delay the Registered nurse must ensure appropriate oxygen therapy is established before leaving the ward / dept
- Staff should be prepared with appropriate equipment in case of rapid deterioration and be able to act accordingly

(E)Escort
All level 2 patients must be escorted by a Clinician/Practitioner and/or Registered Nurse with appropriate critical care skills

(F)Documentation that MUST accompany patient
- In patient SBAR transfer sheet, signed by transferring nurse.
- Medical Notes
- Nursing notes
- Observation charts
- Doctor's letter or summary if needed

(G)Anything else
- Patients property- The property office must be informed of the transfer if the patient has valuables stored there **(see patients property policy section 6.6-6.8)**
- Named Patients medications should be transferred with the patient. See medicines policy section 1.2

Appendix 3: Standard Operating Procedure – Internal Transfer Level 3 Patients

Level 3= Patients who require advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi – organ failure.

Aim: To ensure the safe transfer of patients between wards, specialist units and other HEFT hospital sites and to maintain the quality of patient care.

SECTIONS A-G MUST BE FOLLOWED ACCORDING TO CLINICAL NEED

USE SBAR:
S- What is the Situation?
B- What is the Background?
A- What was the last Assessment?
R- What are the Recommendations?

Referral Method: The decision to transfer a level 3 patient should be made by the Critical Care Consultant or ICU Specialist Registrar in discussion with Critical Care Consultant and requires the involvement of the Bed Manager, Bed Co-ordinator or Site / Night Practitioners.
(A) Assessment: **All Level 3 patients must be assessed by Critical Care team prior to transfer and assess suitability for transfer.** **No critically ill patient will be transferred without first being adequately resuscitated and stabilised.** **Any physical or mental capacity risks must be identified prior to transfer and documented on the SBAR transfer form**
(B) Communication: • Discuss the transfer with the Patient, their next of kin or carer and document on transfer form. Any exceptions to this should also be documented in the patients' notes and on the transfer form. • Inform transport if required • Complete the SBAR transfer form and use this to inform the receiving ward of the patient's condition, including infection control status.
(C) Identify and request appropriate mode of transport • Bed - This will require a minimum of two people • Trolley - This will require a minimum of two people • Ambulance (paramedic or tech crew) (Patients requiring transfer from one building to another on the same site will require an internal ambulance unless clinical condition dictates otherwise)
(D) Monitoring and Equipment • Following an assessment made by a registered nurse consider all equipment that may be required for safe transfer. This will include the minimum standards for monitoring: - 3 Lead ECG - oxygen saturations - non invasive blood pressure / invasive blood pressure monitoring - If patient ventilated use end tidal CO2 monitoring • If patient is ventilated, then oxygen provision must be made using portable cylinder with enough oxygen for the journey and extra capacity in case of delay the Registered nurse must ensure appropriate oxygen therapy is established before leaving the ward / dept • Staff should be prepared with appropriate equipment in case of rapid deterioration and be able to act accordingly.
(E) Escort **All level 3 patients must be accompanied by a Critical care clinician/ practitioner and Critical Care / Outreach nurse**
(F) Documentation that MUST accompany patient • In patient SBAR transfer sheet, signed by transferring nurse. • Medical Notes • Nursing notes • Observation charts • Doctor's letter or summary if needed
(G)Anything else • Patients property- The property office must be informed of the transfer if the patient has valuables stored there **(see patients property policy section 6.6-6.8)** • Named Patients medications should be transferred with the patient. See medicines policy section 1.2

Appendix 4: Standard Operating Procedure – External Transfer from HEFT Level 0-1 Patients

Level 0 = Patients needs can be met through normal ward care in an acute hospital.
Level 1 = Patients at risk of their condition deteriorating whose needs can be met on an acute ward and includes those stepping down from higher levels of care.

Aim: To ensure the safe transfer of patients from HEFT to another organisation and to maintain the quality of patient care.

SECTIONS A-F MUST BE FOLLOWED ACCORDING TO CLINICAL NEED

USE SBAR:
S- What is the Situation?
B- What is the Background?
A- What was the last Assessment?
R- What are the Recommendations?

Referral method: This transfer has to be agreed between the host wards/departments and receiving wards/department with involvement from the medical team responsible for the patients care.
(A) Assessment: **All patients must be assessed by a registered nurse prior to transfer to ensure a safe transfer is achieved** **Any physical or mental capacity risks must be identified prior to transfer and documented.**
(B) Communication: • Discuss the transfer with the Patient, their next of kin, or carer and document on transfer form. • Arrange appropriate transport
(C) Identify and request appropriate mode of transport • Paramedic or Tech Crew ambulance • Ambulance Stretcher • Ambulance Wheelchair • Patients own Wheelchair
(D) Monitoring and Equipment • Following an assessment made by a registered nurse consider all equipment that may be required for safe transfer this may include: oxygen, 02 saturation monitor, 3 lead ECG monitor, infusion pumps, IV stand. • This information needs to be communicated to the transferring ambulance company so they arrive prepared on the transferring ward with the appropriate equipment to avoid any delays.
(E**) Escort- Must be an appropriate healthcare professional** • **Registered Nurse with ambulance crew** –for patients who may be acutely ill, with high MEWS score or requires ongoing clinical intervention whilst in transfer e.g. Blood transfusion / IV infusions • **Paramedic crew** without nurse escort if patient is clinically stable. • **Health care assistants or support workers** can only transfer patients who are clinically stable, following the assessment made by the registered nurse and it has been deemed appropriate for their role by their line manager.
(F) Documentation Any medical /nursing notes required for the purpose of the transfer

Appendix 5: Standard Operating Procedure – External Transfer into HEFT Level 0-1 Patients

Level 0 = Patients needs can be met through normal ward care in an acute hospital.
Level 1 = Patients at risk of their condition deteriorating whose needs can be met on an acute ward and includes those stepping down from higher levels of care.

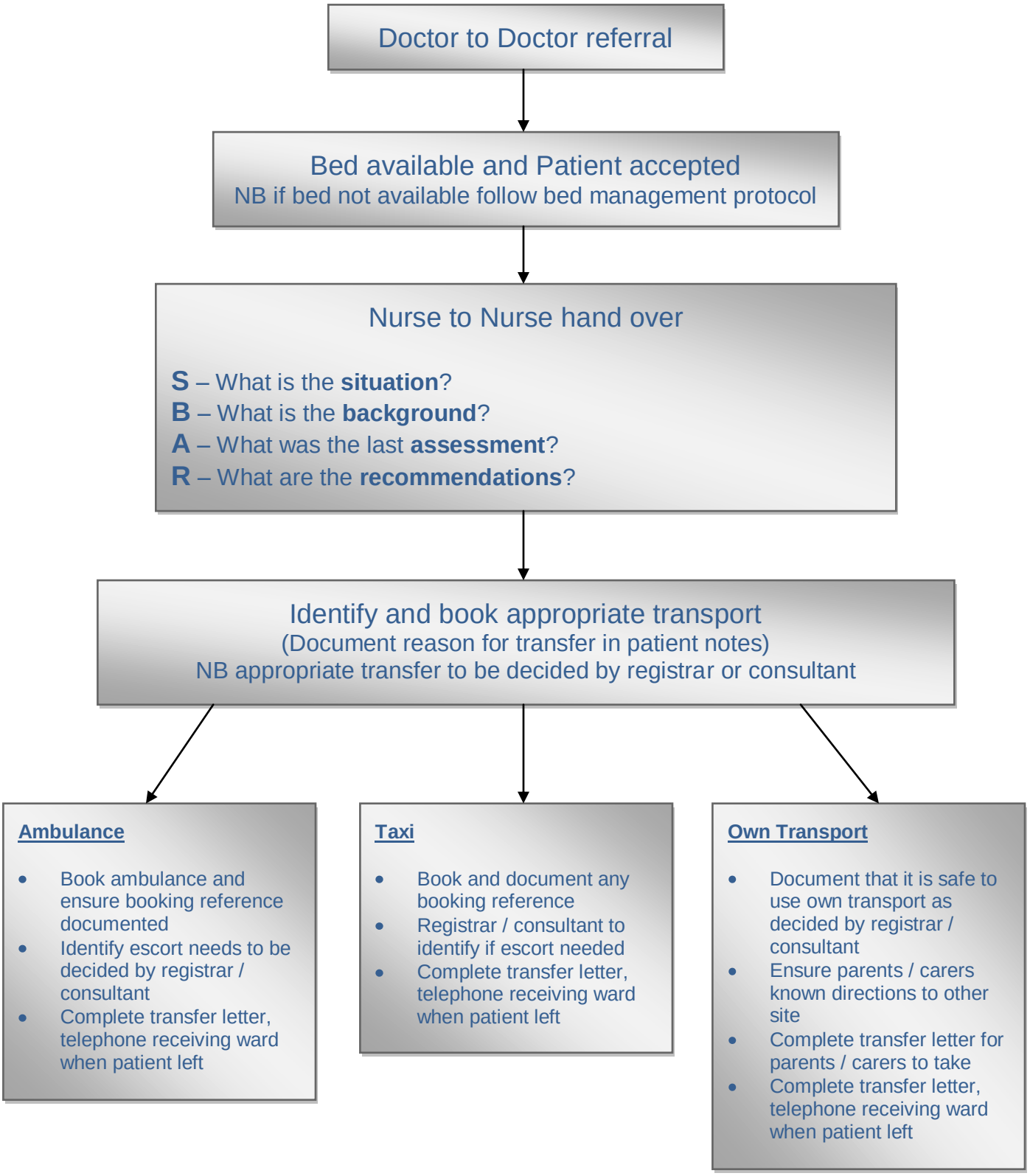
Aim: To ensure the safe transfer of patients from another organisation to HEFT and to maintain the quality of patient care.

SECTIONS A-D MUST BE FOLLOWED ACCORDING TO CLINICAL NEED

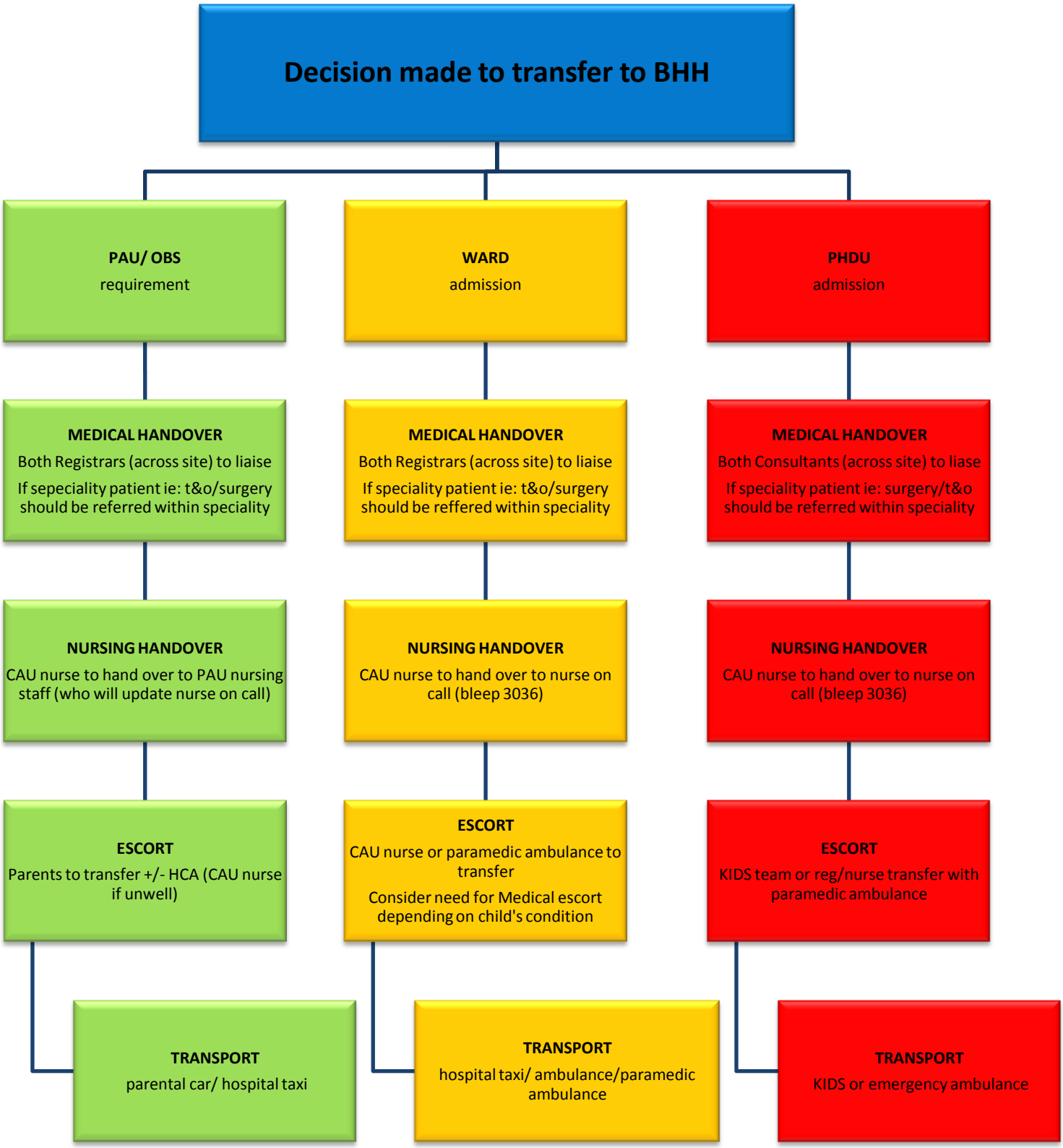
USE SBAR:
S- What is the Situation?
B- What is the Background?
A- What was the last Assessment?
R- What are the Recommendations?

Referral method: This transfer has to be agreed between the host wards and receiving wards consultants with involvement from Bed manager, Bed co-ordinator or Site/ Night practitioner on both sites.
(A) Assessment: **All patients should be assessed by the host ward prior to transfer to HEFT to decide if the transfer is both necessary and safe** **Any physical or mental capacity risks should be identified prior to transfer**
(B) Communication: The receiving ward must be aware of the following prior to transfer: • The host ward is to arrange transport • The patient and their NOK/ Carer have been informed • How the patient shall be transferred and if any escort shall be provided. • Expected time of transfer • Information about the patient's condition, equivalent MEWS score, DNAR status, isolation requirements, any equipment they will require to safely receive the patient and any other nursing requirements
(C) Monitoring and Equipment Following the Handover of the transferring patient the registered nurse must: • Consider any equipment that may be required to be able to safely receive the patient this may include: oxygen, 02 saturation monitor, 3 lead ECG monitor, infusion pumps, IV stand. • Arrange any specialist mattress or high /low bed if required. • Identify an appropriate location on the ward depending on the patient's clinical condition and nursing requirements.
(D) Anything else • Patients property and any valuables should be processed as a new admission to the ward **(See patient property policy section 6.2-6.8)**

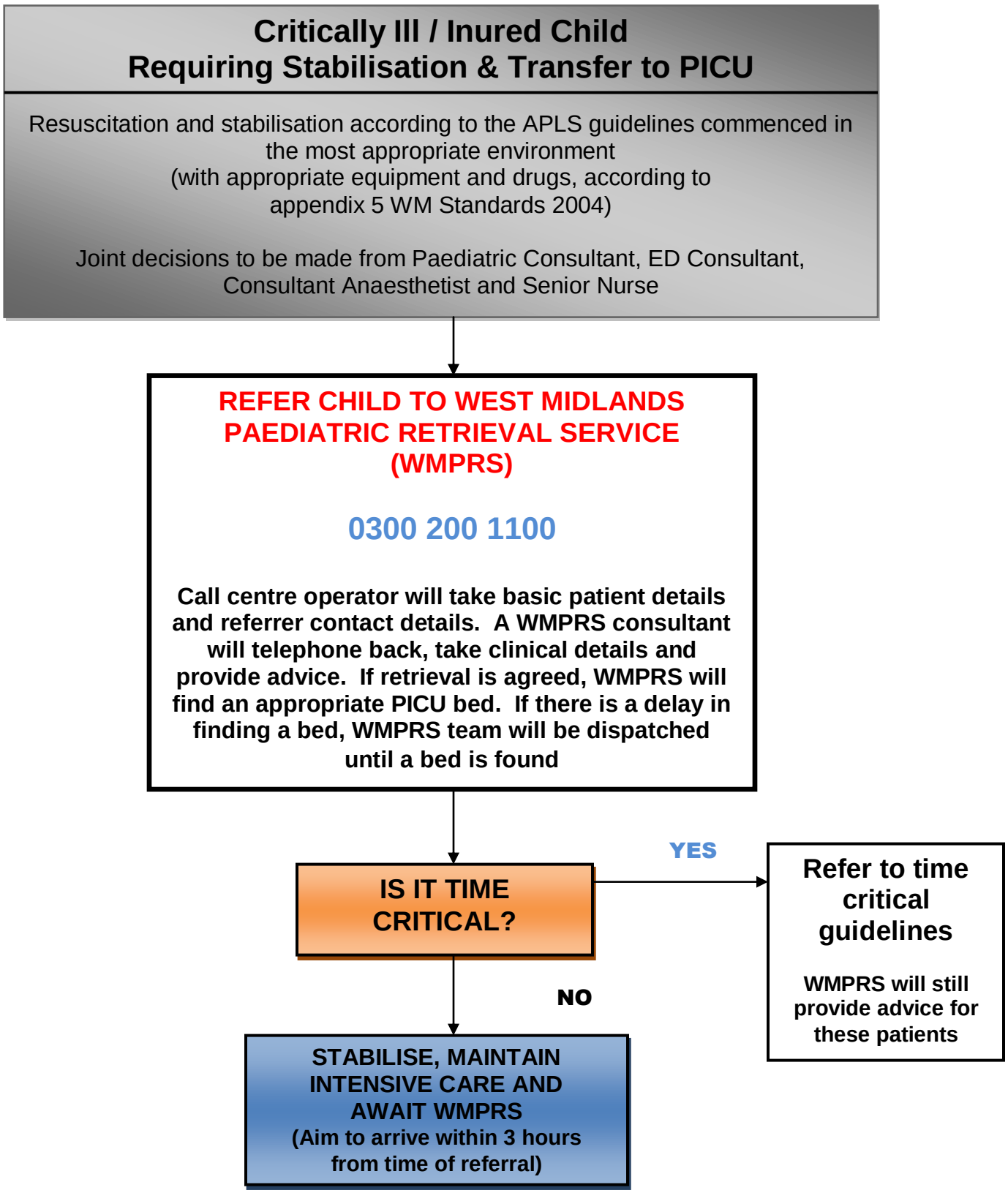
Appendix 6: Standard Operating Procedure – Paediatric Internal and External Transfer Protocol



Appendix 7: Standard Operating Procedure – Paediatric Transfer Pathway from Good Hope Site to Heartlands Site



Appendix 8: Standard Operating Procedure – Critically Ill / Injured Child Requiring Stabilisation and Transfer to PICU



Appendix 9: Management of Children Requiring 'Time Critical' Transfers

Time critical transfers:

- Neuro-Surgical Emergencies
- Expanding extra-dural haematoma
- Other severe head injury requiring neuro-surgical intervention
- Spontaneous intra-cranial bleed
- Ventriculo-peritoneal shunt malfunction
- Other severe trauma requiring 'specialist' surgical intervention (liver trauma, chest trauma, micro-vascular surgery)

Decision to Transfer

Should be taken jointly by the ED, Paediatric and Anaesthetic consultant (if the child is in ED) and jointly by the Paediatric and Anaesthetic consultant (if the child is in Harvey ward).

Find a bed :

- Contact West Midlands Paediatric Retrieval Service (WMPRS) 0300 200 1100 for advice and assistance in finding an appropriate bed.
- In case of trauma requiring specialist surgical intervention, the surgical consultant at referring centre should discuss with the appropriate surgeon at the accepting centre.

Seek advice about pre-transfer and intra transfer management

- Referring Consultant should discuss optimum management plan with the accepting team (both PICU and the appropriate surgeon).
- Consultant Anesthetist should discuss the management and transfer plan with the PICU consultant prior to departure.

Transfer team

- Transfer should be lead by the consultant anaesthetist on call.
- Referring consultant and the nurse in-charge to judge the appropriateness of the accompanying nurse, who should at minimum have PLS and preferably APLS training.
- Contact the adult Critical Care Outreach Team for assistance, as an adult ITU nurse may be more appropriate in some situations.

Transfer

- Book an emergency ambulance with paramedic crew.
- Refer to transfer checklist for equipment and paperwork
- Get photocopy of notes, X-rays and scans on CD, copy of blood results and a courtesy referral letter
- Keep in regular touch with receiving team (get direct dial no)
- Make sure you have parent's telephone number.
- Arrange journey back to base.
- Keep parents informed about receiving unit (post code, GPS, telephone number)
- Transferor to take a charged mobile phone with the PICU's number at hand

Appendix 10: Adult SBAR Transfer Sheet

S	**From Ward/Hospital:**	**To Ward/Hospital:**			**Date:**	
	Telephone handover given to:				**Time:**	
	Patient Name	Form completed by - Name				
	PID	Form completed by- Signature				
	Age	Date of admission:	Length of stay on current Ward/HDU/ITU…… days			
	Consultant					
	Resuscitation status DNAR decision made on……	**Allergies:**	**Valuables** With patient In property office	**Relatives informed and documented** **YES/NO**		
	Type of accommodation required	General Ward	Side Room	High Visibility Area	Isolation Room	
	Type of equipment required	Hi Lo Bed	Bed Rails	Specialist Mattress	Oxygen	
B	**Presenting Condition:**	Diabetic Yes / No State Frequency CBG's Hrly		**EDD**		
A	**Infection Control**	MRSA	ESBL	C.Diff	None	Other (*state)*
	Current MEWs = *(If 4 or more agreement from medical team is required)* ***Patient Level = 0 1 2 3***	BP	Pulse	Temp	Pain Score	Oxygen Yes/ NO % = Litres/min =
		RR	O2 Sats	GCS = /15		nasal Cannula / mask / humidified
	Cannula Y/N	CVP Y/N		IV Fluids Y/N		IV Drugs / Infusions (specify)
	Communication	Visually impaired		Hearing impaired	Speech impaired	First Language (state)
	Mobility	Independent		Bed Bound	Stick / Zimmer / Wheelchair	
		Help of 1		Help of 2	Hoist	Profile bed
	Mental Status	Alert & orientated		Cognitively impaired	Confused	Likely to wander
R	**Risk of falls**	Low / Med / High		Needs High visibility area	Fall on ward: Yes / No	Bed rails Yes / No / Hi-low bed
	Pressure areas	Pressure ulcer YES / NO		Grade:	State Preventative measures:	
	Wound	YES / NO	Site:	Dressings type:	Sutures due out:	
	Elimination	Continent / Incontinent	Constipated / Diarrhoea	Catheter: Short term / long term. Conveen.	Stoma (specify)	
	Nutrition	Food chart	Fluid chart	Red tray	Encourage fluids	Thickened fluids (specify)
		Diet (specify type & texture)		NBM		Fluid restriction _____ml / 24h
	Medication	All due medications given YES / NO / NA		Named Patient medications transferred with patient YES / NO/ NA		Patient Medication locker emptied YES / NO/ NA
	Outstanding Actions	E.g. Medications/ blood tests/ specimens/ scan /OPD (Continue overleaf if necessary)				

Appendix 11: Paediatric SBAR Transfer Sheet

S	**From** **To Ward/Hospital:**						**Date:**	
	Telephone handover given to:						**Time:**	
	Patient name			Transferring nurse name:				
	PID			Transferring nurse signature:				
	Date of birth		Age	Date of admission:		Length of stay …….DAYS		
	Consultant							
	Valuables - with patient / in property office			**Relatives informed of move and documented: YES/NO**		**Allergies:**		
	Glasses	Hearing aid	Dentures					
B	**Presenting condition and summary of events.**					**Length of stay in HDU …….DAYS or N/A**		
A	Previous HDU /ITU admissions **YES / NO** CPAP / BIPAP required **YES / NO** Bolus fluids given **YES / NO ……mls per kg**					Specimens and Investigations:		
	Last set of observations: PEWS SCORE..... TEmperature …… Pulse ……. Respirations …… O2 Saturations …… Blood pressure ……/……. BG …… Pain Score (0-3).....					Investigations still outstanding :		
R	**Infection Control**	General ward	Cubicle	MRSA	ROTAVIRUS	RSV+VE	Other (state)	
	Communication	Visually impaired	Hearing impaired	Speech impaired	First language			
	Mobility	Independent	Bed bound/profile bed	Crutches	Wheelchair	Baby		
	Mental Status	Alert & orientated	Confused	Likely to wander	**GCS……../15**			
	Risk of falls	Low / Med / High	High visibility area	Hi-low bed	Bed rails	Fall on ward Y/N		
	Pressure areas	Broken or sore areas Yes / No	Special mattress (specify type)					
	Wound site	YES / NO Including Drains and packs (specify)						
	Elimination	Continent / Incontinent	Constipated / Diarrhoea	Catheter Long term / Short term	Nappy	Stoma (specify)		
	Nutrition	Encourage fluids	Fluid balance	NG feeds	Special feeds (specify)	Thickened fluids (specify)		
		Diet (specify type & texture)	NBM	fluid restriction _____ml / 24h				
	Cannula	YES / NO	**IV Regime / IV Drugs** (specify)					
	Medications	All due medications given YES / NO/ NA	Named Patient medications transferred with patient YES / NO / NA					
	Outstanding Actions	E.g. Medications/ blood tests/ specimens/ scan /OPD (Continue overleaf if necessary)						

Appendix 12: AMU SBAR Transfer Sheet

S

B

A

R

Situation

PATIENT NAME: …….. PID ……Time ……

DATE: _____ CONSULTANT: _____ **DNAR** order Yes ☐ or NO ☐

MRSA screen: Yes ☐ No ☐ if yes:- Rapid ☐ Culture ☐ Positive ☐ Negative ☐

Background

From: **A&E** ☐ **GP** ☐ **Self ref** ☐ **Ward 19** ☐ Other internal transfer ☐ _____

Diagnosis:……....PMH .....

Diarrhoea within 48hrs ☐ Vomiting within 48hrs ☐ **Does the patient require isolation** ☐

Assessment

Airway problems YES NO ……..

Breathing: problems YES NO……...

Circulation: problems YES NO……...

A V P U (circle): problems YES NO……..

MEWS score:…… If MEWS >4, note which parameters have triggered the score

Airway ☐ Sys BP ☐ HR ☐ Urine output ☐ RR ☐ 0_2 Sats ☐ Temp ☐ AVPU ☐

Actions

Critical Care Outreach contacted: **YES/NO*** Time contacted…….
Stat or IV antibiotics prescribed: **YES/NO*** Time given……
Stat or IV fluids given: **YES/NO*** Time given……
Stat analgesia given: **YES/NO*** Time given……
Oxygen in progress/prescribed: **YES/NO*** Time given…… % or Litres……

Other stat treatment: **YES/NO*** State:…….....Time given……..

Cannulae		Bloods taken		SAD score		Relatives aware	
Sliding scale		ECG		X Rays		Phone numbers	
Catheterised		Notes & MEWS chart scanned		Waterlow score		Wristband	
NBM		Falls assessment		Property yes/no		Valuables yes/no	

Recommendation

Transfer to: Ward _____ Placement: Bay ____ Bed ____ High Visibility ☐ Side ward ☐

Equipment required: Yes ☐ No ☐ If Yes state ……..…

Patients Own Drugs: *Yes ☐ No ☐ **Drugs trolley checked** by ……..

Transfer by: Registered Nurse (if MEWs > 4) ☐ Health Care Assistant ☐ Porter ☐

Signature of transferring nurse……..... Time of hand over.....

Signature of accepting nurse……..... Time……

Attachment 1: Equality & Diversity – Policy Screening Checklist

Policy/Service Title: Patient Transfer Policy (permanent) v2.0	**Directorate:** Nursing Directorate
Name of person/s auditing/developing/authoring a policy/service:	
Aims/Objectives of policy/service:	

Policy Content:

- **For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?**
- **The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.**

1. Check for DIRECT discrimination against any group of SERVICE USERS:							
Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
1.1	Age?	✓			✓		
1.2	Gender (Male, Female and Transsexual)?		✓				
1.3	Disability?		✓				
1.4	Race or Ethnicity?		✓				
1.5	Religious, Spiritual belief (including other belief)?		✓				
1.6	Sexual Orientation?		✓				
1.7	Human Rights: Freedom of Information/Data Protection		✓				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
2. Check for INDIRECT discrimination against any group of SERVICE USERS:							
Question: Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
2.1	Age?		✓				
2.2	Gender (Male, Female and Transsexual)?		✓				
2.3	Disability?		✓				
2.4	Race or Ethnicity?		✓				
2.5	Religious, Spiritual belief (including other belief)?		✓				
2.6	Sexual Orientation?		✓				
2.7	Human Rights: Freedom of Information/Data Protection		✓				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires							

review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION =							
3. Check for DIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
3.1	Age?		✓				
3.2	Gender (Male, Female and Transsexual)?		✓				
3.3	Disability?		✓				
3.4	Race or Ethnicity?		✓				
3.5	Religious, Spiritual belief (including other belief)?		✓				
3.6	Sexual Orientation?		✓				
3.7	Human Rights: Freedom of Information/Data Protection		✓				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any statements which may exclude employees from operating the under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
4.1	Age?		✓				
4.2	Gender (Male, Female and Transsexual)?		✓				
4.3	Disability?		✓				
4.4	Race or Ethnicity?		✓				
4.5	Religious, Spiritual belief (including other belief)?		✓				
4.6	Sexual Orientation?		✓				
4.7	Human Rights: Freedom of Information/Data Protection		✓				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION =							

Attachment 2: Equality Action Plan / Report

Directorate:

Service/Policy:

Responsible Manager:

Name of Person Developing the Action Plan:

Consultation Group(s):

Review Date:

The above service/policy has been reviewed and the following actions identified and prioritised.
All identified actions must be completed by: _____

Action:	**Lead:**	**Timescale:**
Rewriting policies or procedures		
Stopping or introducing a new policy or service		
Improve /increased consultation		
A different approach to how that service is managed or delivered		
Increase in partnership working		
Monitoring		
Training/Awareness Raising/Learning		
Positive action		
Reviewing supplier profiles/procurement arrangements		
A rethink as to how things are publicised		
Review date of policy/service and EIA: this information will form part of the Governance Performance Reviews		
If risk identified, add to risk register. Complete an Incident Form where appropriate.		

When completed please return this action plan to the Trust Equality and Diversity Lead; Pamela Chandler or Jane Turvey. The plan will form part of the quarterly Governance Performance Reviews.

Attachment 3: Approval / Ratification Checklist

Title	Patient Transfer Policy v2.0	
	Ratification checklist	**Details**
1	This is a Combined Policy & Procedure	
2	This is a Revised	
3*	Format matches Policies and Procedures Template (Organisation-wide)	Yes
4*	Consultation with range of internal /external groups/ individuals	Ian Donnelly – Head of Capacity, Sarah Quinton – Critical Care Outreach Lead, Peter Moon/ Rachael Blackburn – Governance, Yvonne Higgins - Patient Safety team, Karen Barber and Julie Rowland – Lead Paediatric Nurses, Liz Lees – Consultant Nurse Matrons PGNF Corporate Nursing
5*	Equality Impact Assessment completed	YES
6	Are there any governance or risk implications? (e.g. patient safety, clinical effectiveness, compliance with or deviation from National guidance or legislation etc)	NO
7	Are there any operational implications?	NO
8	Are there any educational or training implications?	NO
9	Are there any clinical implications?	NO
10	Are there any nursing implications?	NO
11	Does the document have financial implications?	NO
12	Does the document have HR implications?	NO
13*	Is there a launch/communication/implementation plan within the document?	YES – Corporate Nursing
14*	Is there a monitoring plan within the document?	YES
15*	Does the document have a review date in line with the Policies and Procedures Framework?	YES- March 2013

16*	Is there a named Director responsible for review of the document?	YES – Corporate Nursing
17*	Is there a named committee with clearly stated responsibility for approval monitoring and review of the document?	YES – Matrons Business meeting

Document Author / Sponsor

Signed …… ……..……

Title……

Date……..……..……

Approved by (Chair of Trust Committee or Executive Lead)

Signed …… ……..……

Title……

Date……..……..……

Ratified by (Chair of Trust Committee or Executive Lead)

Signed …… ……..……

Title……

Date……..……..……

Attachment 4: Launch and Implementation Plan

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Action	Who	When	How
Identify key users / policy writers	Corporate Nursing		See consultation
Present Policy to key user groups	Corporate Nursing	Jan 2011-Feb 2011	Present to Matrons business meeting/ward managers meeting/ senior sisters forums Communications strategy
Add to Policies and Procedures intranet page / document management system.	Corporate Nursing	March 2011	Add to HEFT policies site Add to HEFT nursing intranet site
Offer awareness training / incorporate within existing training programmes	Corporate Nursing	ongoing	Incorporate into Band 5 development programme
Circulation of document(paper)	Corporate nursing	Jan 2011	See consultation
Circulation of document(electronic)	Corporate Nursing	March 2011	Circulate policy electronically to all key user groups

Dissemination Record - to be used once document is approved
(This dissemination record is not mandatory)

Date put on register / library of procedural documents		**Date due to be reviewed**	

Disseminated to: (either directly or via meetings, etc)	Format (i.e. paper or electronic)	Date Disseminated	No. of Copies Sent	Contact Details / Comments

Acknowledgement: University Hospitals of Leicester NHS Trust.