Southern Health NHS
NHS Foundation Trust

SH CP 49

Admission Discharge & Transfer Policy

Version: 1

Summary:	This policy has been developed to reflect the minimum standards required in relation to the admission, discharge and transfer of patients for all inpatient services. Due to the diversity of in-patient services this is the overarching policy. Specific procedures and processes have been developed for all services.	
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Admission, Discharge & Transfer of Patients (In-Patient settings)

1. Introduction

1.1 This policy document provides overarching quality principles for the admission, transfer and discharge of patients to Southern Health NHS Foundation Trust's (the Trust) in-patient services within all services.

1.2 The admission to an in-patient unit of a patient takes place when the patient may be severely unwell and at their most vulnerable. It is important that the process for admission, transfer and discharge safeguards and promotes patient safety, is person-centred and ensures that communication between patients and their families is effective and timely. All services should put the patient at the centre of plans involving relevant care and provide information in a format the person can access and understand involving family and carers as appropriate. Permission to share and mental capacity must be referred to in all cases

1.3 An admission should be planned. Even in urgent situations a degree of planning will occur, however quickly the admission takes place. The assessment prior to admission should be based on clinical practice decisions utilising all appropriate information and include information from the patient whenever possible.

1.4 It is recognised that every patient will be admitted when there is a clearly identified need for admission in order to receive clinical in-patient assessment and treatment. Every admission will be lawful in relation to the patient's needs, wants and wishes and that the admission process takes account of all appropriate legislation e.g. Disability Discrimination Act; Mental Capacity Act; Mental Health Act.

1.5 Timely, safe and appropriate discharge is the result of good care planning from the decision to admit to providing post discharge support. Consideration should be given to alternatives to inpatient admission whenever possible e.g. Hospital at Home services which will help to reduce unnecessary and inappropriate admission; promote early discharge and support recovery.

1.6 The principle concern of the trust must be to maintain patient wellbeing via the use of a robust and effective discharge planning process commenced at, prior to or near the point of patient admission. All discharge plans will have involved as necessary, detailed assessment from inpatient and community services, Adult Social Services and the voluntary care sector. Patient's views should be taken into account as far as is reasonably possible whereas the patient's best interest should always be upheld. The views of carers, relatives and significant others should also be taken into account whenever appropriate and possible.

1.7 This document is written for all the Trust services to enable admission, transfer and discharge standards to be consistently applied.

1.8 The policy is based upon national good practice principles[1], guidance[2] and CQC[3] standards.

1.9 The terms 'patient' and 'service user' are used interchangeably to relate to anyone accessing physical and/or mental health services or learning disability in-patient setting. Whilst this policy outlines the role that Trust clinical staff have in supporting

the admission, discharge and transfer of service users, it also recognises that this is often provided in partnership with primary care, social care and third sector services. The overarching principles will apply to all services, the implementation of this policy will be in close co-operation with primary care, secondary care, Ambulance service, the Police and all SHFT services in line with established practice as per the procedures defined within this policy.

2. Scope

2.1 This policy is inclusive of all in-patient services within Southern Health NHS Foundation Trust Adult Mental Health, Older Peoples Mental Health, Learning Disability, Specialised Mental Health Services and Community Hospitals within the Trust. This Policy does not apply to the Social Care Division: TQ Twenty One, as it is expected that they will have their own policy and procedure which would be markedly different from the standards applied to clinical in-patient services.

2.2 Each service may have their own specific pathway to reflect the needs of the patients in and out of their in-patient unit. These are appended in this document.

2.3 It is expected that all relevant staff involved in the admission, transfer and discharge of patients within each service will be affected by, and will need to comply with this policy.

2.4 The Trust will expect other services that utilise and support in-patient settings, to apply the principles of this policy as a minimum standard within their services, thus ensuring the provisions of a robust patient admission, discharge and transfer process.

3. Definitions

3.1 Pre-Admission: Is the assessment process used to identify the need for admission to an in-patient setting.

3.2 Admission: Admission is the act of transferring care from community or another environment to a Trust in-patient service.

Planned:

(i) Where the admission has been negotiated with the community team, general practitioner or carer but the process started the day or days previous to the admission.

(ii) When the admission is part of a CPA contingency and/ or Crisis Plan.

(iii) Where the patient had been receiving Home Treatment or Intensive Home Support immediately prior to requiring admission.

3.3 Emergency: Where the admission process was initiated and carried through on the same day from any service (except same day referrals from other inpatient units/hospitals).

3.4 Transfer: Transfer is defined as the movement of a patient and their care and treatment needs from one in-patient unit to another (of any in-patient care setting), or a community based service for continuation of care. This may be because the needs of the patient are best met at another in-patient or care setting.

3.5 Discharge: Discharge is the act of concluding an episode of care within an in-patient setting and handing over responsibility of the care to another service or care provider

- Community team
- Hospital at Home
- Primary care
- Nursing Home
- Care Provider
- Another hospital service e.g. acute hospital care.

3.6 Delayed Transfer of care: The national definition[4] states that the delayed transfer of care occurs when a patient is ready to depart and is delayed. A patient is ready for transfer/discharge when

a. A clinical decision has been made that patient is ready for transfer/discharge AND

b. A multi-disciplinary team decision has been made that patient is ready for transfer/discharge AND

c. The patient is safe to discharge/transfer.

4. Duties / Responsibilities

4.1. The Chief executive has ultimate responsibility for ensuring that safe and effective patient discharges occur from the Trust in-patient facilities.

4.2. Senior nursing and managerial staff must ensure that all staff involved in the admission, discharge and transferring of patients are aware and adhere to this policy. They are responsible for ensuring that any deviation or errors arising are reported, dealt with in a correct manner and that risks are identified and acted upon.

4.3. All Trust clinical and non-clinical staff involved in a patient admission, discharge and transfer process, are responsible for applying the principles contained in this policy. The role of all clinicians/ team members will be clearly defined within the admission, discharge and/ or transfer process DOH (2002)

4.4 All localities and services are expected to produce an integrated care pathway for admission through to discharge pertinent to their area. Each service is expected to utilise procedures and other tools to help support the implementation of the policy and ensure that patients and carers are able to understand and engage in the pathway.

4.5 All members of the multi-disciplinary team should be aware of individual patients' needs related to admission, discharge and transfer and undertaking their responsibilities to ensure safe admission, discharge and transfer in a timely and appropriate manner according to patient need

4.6. The multi-disciplinary team should ensure that all care and planned support is scheduled and confirmed to commence with specified dates and times. This is to promote seamless care including transfer and discharge of the patient. DH (2010)

4.7. In a situation when a patient refuses discharge from an in patient setting either on or prior to the confirmed day of discharge, the Modern Matron / Area Matron or Area

Manager has the responsibility to follow their separate Procedure, Guideline, Standard Operating Procedure (SOP) to ensure discharge occurs. This could involve implementation of a discharge plan including section 117 arrangements MHA (1983). In any event the clinical team should seek appropriate advice from senior managers including Divisional Directors who will be able to access other support including legal advice if appropriate.

4.8 Clinical leads / Managers / Supervisors will:

- Ensure that sufficient priority is given to the successful implementation of the policy both in in-patient wards and the community.
- Ensure that all staff attend appropriate training
- Monitor compliance with current standards by all clinical staff
- Ensure the availability, functioning and maintenance of all appropriate materials plus equipment utilised in the assessment, discharge and transfer of patients also ensuring that staff have appropriate training to use them.
- Ensure clinical documentation and records used are in line with Trust policy including where this interfaces with other services e.g. Commissioners, Ministry of Justice.
- Ensure that any change in practice recommendations are notified to all clinical staff.
- Ensure all staff participate in audit processes to help identify good practice and identify deficits in order to support improvement and learning..

4.9 Clinicians / Staff responsibilities

- Registered staff will be accountable as per their Professional Body.
- Maintain clinical competency as per competency framework (SHFT 2011)
- Attend relevant training provided by the Trust and put it into practice
- Bring to the attention of appropriate senior staff any deficiencies in knowledge, ability or resources that may mediate against safe admission, discharge and transfer of patients.
- Participate in audit programmes related to measuring the quality and safety of admission, discharge and transfer of patients . This would include addressing any improvements required and celebration of good practice.
- Ensuring they are familiar with relevant policies and procedures in their area of practice. Specific attention should be given to ensuring staff competence in the care and discharge planning for patients with co-morbidity and that risk assessment processes are consistently applied and recorded across the care pathway.

5. Minimum requirements for all clinical staff

5.1 All new patients must have an appropriate holistic assessment of their physical and mental health needs. This assessment must be appropriately documented as per Trust record keeping guidance. Additional content and the procedure for this will vary

depending on the person's mental or physical illness, medication, age, initial findings and the involvement of primary care. Issues of sensitivity, gender, ethnicity and preference should also be considered. Clinical staff must follow the Physical Assessment & Monitoring Policy.

5.2 Relevant patient documentation will be obtained from the referring service (for example GP, Consultant or Hospital clinician, Ambulance Crew) including current problems, past medical history and medication history.

5.3 Clinical practitioners should engage the services and skills of associated staff relative to admission, discharge and transfer of patients e.g. Pathway Coordinators, MHA Administrators, Bed Managers.

6. Main policy content

6.0 Pre-Admission: Prior to admission the following best practice principles will be adhered to:

6.1 The decision for admission will be based upon a comprehensive assessment of risks and needs.

6.2 The referring clinician/team member (for example GP, Consultant or Hospital Clinician, Ambulance Crew) will have completed a comprehensive assessment of needs and risks. This assessment will be appropriate and specific to the needs of the patient.

6.3 The decision to admit will be made when all other options for assessment and treatment have been considered and deemed inappropriate. In the case of patients accessing mental health and learning disability services, the least restrictive options are deemed inappropriate due to risk e.g. Hospital at Home.

6.4 In order for the patient to maintain contact with his/her friends and family as well as the local community; the admission should be arranged at the nearest clinically appropriate in-patient unit. In the event of this not being possible an explanation must be given to the patient and relatives as to why this could not be facilitated. Clinical need and bed availability will be an important factor.

6.5 All consideration should be given to the need to repatriate patients who have not been able to be admitted to their nearest hospital. Repatriation to the nearest appropriate in-patient unit should be arranged as soon as is possible as long as this is in the best interests of the patient. The decision about repatriation is a key issue which should be informed by what is important for the patient and is clinically appropriate. When it is the best interest of the patient and clinically appropriate, repatriation should occur as soon as possible.

6.6 If the service user is admitted under a section of the Mental Health Act all the legal requirements of detaining a person under the Act will have been met so that the detention is lawful.

6.7 The admission is person centred and the decision includes consultation with carers/relatives as appropriate

6.8 The decision to admit to an in-patient unit will form part of an individualised care plan which will include the likely care outcomes of the admission and the pathway out of

hospital/in-patient care. This will be shared with the carer and nearest relative, where appropriate, prior to admission.

6.9 The reason for admission, expected outcomes and likely length of stay will be discussed with the patient and carer.

6.10 The rationale for the admission will be made clear to the patient and their carer. An explanation of the proposed care pathway will be communicated to the patient and carer including the likely length of stay, prior to admission.

6.11 The reason for admission, expected outcomes and likely length of stay will be discussed with the in-patient unit.

6.12 The information to be communicated should be delivered in a clear and concise manner wherever possible using a recognised and agreed communication tool such as SBARD. The SBARD tool is a structured method for communicating important information that requires prompt attention and action. Using a structured set of five steps it requires the communicator to clearly define the 'Situation', 'Background', 'Assessment', 'Read back' and 'Decision' to be made. Its purpose is to improve the effectiveness of verbal communication at important events such as at patient admission. It encourages prior preparation for communication and should help to reduce the likelihood of misleading or missed communication.

6.13 A full record of the assessment will be provided on electronic and/ or paper records in accordance with Trust record keeping policies. This will include RiO and any secondary records, which will be made available to the admitting in-patient unit prior to the admission.

6.14 Admission information should include all relevant clinical information pertinent to the needs of the patient e.g. Mental State, Risks, Diagnosis, Infection Risks, Physical health Needs, Mobility and Sensory Impairments, Safeguarding Concerns, Cultural and Religious needs.

6.15 The referring clinician/team member coordinating the admission will contact the ward as soon as admission is identified and ensure that there is an appropriate bed available for the patient. They will communicate to the patient which in-patient unit they are to be admitted to and the expected time of their arrival for admission.

6.16 The bed will be age and gender appropriate for the service user.

6.17 The referring clinician/team member will ensure that in relation to the risks, resources at the patient's disposal, and needs of the service user/carer, appropriate transport arrangements are made with the patient for them to arrive at the in-patient unit in a safe and timely manner.

6.18 This will be arranged as soon as possible after confirming the need for admission and availability of a suitable bed. Other relevant care agencies will be informed of the admission.

6.19 The referring clinician/ team member will ensure that the GP and other care services provided for the patient are made aware of the admission and likely length of stay. This could be deferred to the ward staff where they may be best placed to do so, however the responsibility for doing this needs to be clearly communicated by the referring clinician/team member.

6.20 The referring clinician/team member will request that the service user brings all medicines currently prescribed into hospital with them.

6.21 Infection, Prevention & Control measures: Patients with an infection can expect relevant information about it to be shared between providers when they are admitted, transferred to, or discharged from a hospital to ensure seamless care. The risk assessment undertaken on admission will include risks associated with health care acquired infections.

6.22 The IP&C procedure for documenting and sharing information about infections and their treatment will be followed. This includes evidence of information sharing to manage and support patients with an infection on an ongoing basis (including transfer and isolation arrangements for them) during admission, transfer and discharge.

7. Admission, including Emergency Admission:

7.1 Ideally, all planned admissions will be within Monday to Friday between the hours of 09:00 and 17:00. However it is accepted that urgent/emergency admissions will occur outside these hours.

7.2 Within two hours of admission the following good practice should be adhered to:

7.3 It is the admitting nurse's responsibility to ensure that the patient is met and greeted and orientated appropriately to the ward on arrival. The time and date of arrival will be recorded in the patient care record.

7.4 An initial risk assessment, risk management plan and care plan will be undertaken immediately on arrival appropriate to the patient needs by a registered nurse. This will take into account the immediate and potential risks relating to the safety of that patient within the clinical setting e.g. pain management, risk of self harm, falling, patient going missing from the ward etc. in order to establish appropriate intervention and level of observation.

7.5 Medication brought into hospital including any drugs purchased over the counter will be recorded (quantitatively); retained by the staff and kept securely in the ward for appropriate use in accordance with the patient's own drugs (PODs) procedures. Permission will be obtained from the patient/relative/carer to record details of medicines brought in. Any controlled drugs MUST be entered in the register in line with Medicines Control Administration Prescribing Policy (MCAPP).

7.6 Medicines Reconciliation: There is evidence from literature that unintentional variances of 40% can occur between the medications patients were taking before admission and their prescriptions on admission. One study reported an average of 1.3 omissions/dosing errors per patient in 3,091 patient admissions across 30 Acute Trusts; Dodds (2011)

7.7 Patients should have their medicines reconciled within 24hrs of admission. A **minimum** of two sources of information should be used to obtain a list of the medicines being taken by the patient prior to admission (single sources are rarely complete and accurate). The sources of information used should be recorded in the medicines reconciliation form (See Medicines Reconciliation Policy) and within the case notes/electronic record. The admitting nurse which may be the Named Nurse/ Key Worker, will ensure that medicines reconciliation occurs in line with trust policies.

7.8 The patient will be provided with a ward information leaflet and a Welcome Pack and their personal information/contact details checked and accurately recorded.

7.9 Alerts including drugs, allergies, foodstuff sensitivities and reactions will be recorded in line with Trust Policy on record keeping, if not previously noted. This information will also be recorded on the prescription chart and on the electronic record. The person entering this information will sign the front of the prescription chart. Important allergies and the expected response(s) e.g. anaphylaxis will also be recorded on the prescription chart.

7.10 Resuscitation status will be confirmed on the inpatient admissions record as will any advance directive or lasting power of attorney. Any subsequent change to any of these must be recorded in the patient's care records.

7.11 The patient will be asked to sign an Information Sharing consent proforma and will be provided with an appropriate information sharing leaflet. If the service user declines to grant consent, the reasons will be recorded in records and on the proforma.

7.12 With the patient's agreement, the ward will contact the next of kin to advise them of the admission if they are not already aware. Emergency contact information will be confirmed and recorded in the appropriate healthcare records.

7.13 The patient's GP will be informed of the admission and request from the GP details of the current prescription and relevant medical history. This information should be faxed back to the admitting in-patient unit.

7.14 The following will be clearly recorded on the patient record:

- The reasons for the admission
- The patient's understanding of the reasons for admission
- The goals for admission from both the professional and service user perspective.

7.15 Information about the admission will be recorded in the admission book/electronic patient administration system.

7.16 If the service user is detained under the Mental Health Act, the relevant paperwork will be completed and the Mental Health Act Administrator will be informed and the appropriate information given to the patient and the admitting nurse will undertake receipt and scrutiny procedures.

7.17 For people detained on a section of the Mental Health Act 1983, the policies relating to rights, information and Independent Mental Health Advocacy (IMHA) provision in accordance with additional policy and protocols related to admitting any patient subject to conditions of the mental Health Act (1983).

7.18 The patient must be informed about their care and the treatment they will receive. This should be documented within records and include an assessment of their capacity to consent to treatment, outcomes relating to their consent should be fully documented.

8. Within 6 hours of admission the following will be undertaken:

8.1 Generally a physical examination is expected soon after the admission. However there may be exceptions e.g. admission occurs at the weekend to meet patient/carer

need when there is no medical cover on the ward. In this case the physical examination will be undertaken prior to the admission. All physical examinations occurring outside of the expected timescale will be clearly documented and in any event the Physical Assessment & Monitoring policy should be implemented.

8.2 If the patient has been transferred from another hospital or service where a physical examination has already been carried out and is documented, it does not need be done again unless the previous examination/assessment was undertaken more than 8 weeks previously. However, if upon admission there are any medical concerns then the physical examination would be repeated.

8.3 Patients' property will be checked and recorded on arrival using the ward property form; valuables should also be recorded and, with the patient's agreement, taken into safekeeping. If patients refuse safe keeping of valuables this should be recorded in the health care records and the patient's signature obtained if possible.

8.4 An initial care plan will be recorded which details the next steps of care including any immediate assessment or tests to be undertaken as part of the admission. The initial care plan should include orientation to the clinical environment; meeting immediate care needs e.g. 'observation care plan' detailing observation level, rationale for observation level and process for review; immediate risk management.

8.5 A Named Nurse/ Key Worker will be allocated to the patient. It is the Named Nurse/ Key Worker responsibility to complete the initial assessment which should include:

8.6 Appropriate support will be provided to carers if required, e.g. help with arranging transport to get home, explanation of patient's needs and visiting times.

8.7 A clinical Management plan must be developed for every patient within 24 hours of admission. This should set out the goals for the patient and include:

- Identification of the problem(s)
- Goals for treatment activities to achieve outcomes.
- Methods for achieving these goals
- Estimated time to meet the goals

8.8 This plan should include any further assessment or investigations, plans for therapy and treatment. Ultimately this plan should be recorded as a multidisciplinary plan and in the case of Mental Health & Learning Disability Patients, recorded using the Care Programme Approach (CPA).

8.9 All previous historical clinical records of the patient will be requested and obtained from the Clinical/Medical Records Department.

9. Within 24 to 48 hours of admission the following processes will be undertaken:

9.1 If not already agreed, an estimated date of discharge will be set by the admitting/Named Nurse/ Key Worker, in collaboration with the admitting practitioner/ MDT. An estimated date of discharge is based on the expected time required for tests/ assessments and interventions to be completed, the care pathway and the time taken for the patient to be clinically stable and fit for discharge.

9.2 Within 24 hours the Named Nurse should document whether the patient has simple or complex discharge and transfer planning needs, involving the patient and their carers in this decision (as appropriate). A complex discharge involves the support

from other health and social care services outside of the immediate multidisciplinary team

9.3 The decision regarding discharge should involve the patient, relatives and carers (as appropriate) and should be made following an assessment at pre-admission or on admission. It should also take account multiple pathology/multiple needs. All those involved in the patient's care should be aware of the estimated date of discharge. Records should state clearly who has authority to change the estimated date of discharge after consultation with the senior doctor.

9.4 In the case of mental health and learning disability patients, the date for the initial CPA meeting (standard is within two weeks of admission) will be established. Where the patient already has an identified Care Co-ordinator in the community, communication will be maintained between the Care Co-ordinator and the Named Nurse/ Key Worker regarding progress and steps towards discharge, including attendance at relevant formulation or review meetings as per the CPA Policy.

9.5 The initial care plan, drawn up within the first 6 hours, will be reviewed to ensure it meets the patient's needs. It will be reviewed again after 72 hours. If the patient is detained under the Mental Health Act, they must be informed about their care and the treatment they will receive. This should be documented within the care record and include an assessment of their capacity to consent to treatment, and outcomes relating to their consent should also be fully documented.

10. Transfer

10.1 Transfer of care can occur within the same unit/ hospital or within the Division and across Divisions.

10.2 Prior and during the process of transfer of care, the following best practice principles will be adhered to. This includes transfer between wards within the same unit e.g. Intensive care ward to Acute ward or transfer between wards and hospital sites.) The following 'Transfer Principles will be applied:

10.3 A decision to transfer a patient to another ward or community service will be based on assessment of risk and need and be in the best interest of the safety and clinical management plan for patient's care.

10.4 The ward multidisciplinary team will have conducted a full and thorough assessment of risk and health which will be specific to the needs of the patient and will have identified that their clinical care needs are best meet in a different inpatient setting.

10.5 A formal transfer request will be made to the receiving in-patient unit.

10.6 The reason for the transfer, expected outcomes, likely length of stay and discharge plans will be fully discussed with the patient and their carer and recorded in the patient record.

10.7 Rationale and an explanation of the care pathway through to discharge will be made clear with the patient and if possible, an opportunity to view the environment and meet the staff will be arranged.

10.8 Transfer of care to another ward or community service will be agreed and confirmed as appropriate by the Responsible Clinicians of both the current and receiving ward.

10.9 There will be full clinical discussion within the multidisciplinary teams and between both inpatient consultants regarding the reason for transfer, the current treatment and clinical management, all significant risks, how these risks will be managed within the transfer process and most appropriate timing of the transfer of care to take place.

10.10 Coordination of the transfer of care process will be delivered through effective leadership and handover responsibilities at ward level and no transfer will take place until all transfer arrangements are fully agreed by both the discharging ward and the receiving wards or community service.

10.11 The ward staff are responsible and accountable for communicating all necessary information to the receiving transfer ward and ensuring that the care transfer process is safe, effective, timely and maintains continuity of care for the patient.

10.12 All clinical information will be fully handed over to the receiving ward and is accessible on RIO, prior to the transfer, this will include all care records, comprehensive assessment, risk history and assessment, clinical management plan, current care plan and current prescribing plan. The name and position of the receiving nurse/ clinician must be clearly documented in the patient's electronic/ paper record and on the discharge checklist. The patient record should state clearly the information which has been given to receiving clinicians/ carers. Any communication should be described and noted in the patient record including where a specific communication aid such as SBARD, has been used.

10.13 If RiO is not used then the information will be written and sent to the receiving unit using agreed transfer documentation. In addition the receiving ward must be informed prior to the transfer of;

- Any known infection risks such as Clostridium.Difficile, MRSA.
- Unexplained diarrhoea
- Significant physical health concerns.
- Any significant mobility and sensory impairment needs.
- Any significant safeguarding concerns.

This will enable the receiving ward or community service to fully plan, meet and accommodate these needs safely. Infection Prevention and Control risks should be ascertained prior to or on admission utilising a risk assessment within patient admission documentation e.g. Physical health assessment within RiO; Admissions checklist. Any risk of infection/ known infection should be clearly recorded in records (electronic and paper) and appropriate notice using stickers and alerts.

10.14 The nurse in charge of the ward at the agreed date and time of the transfer is responsible for leading the transfer process. They will ensuring that the receiving ward or community service has all necessary medicines and medical equipment that may be required to meet specific care plan needs to ensure continuity of care and safety through the transfer process. Should the patient's prescribed medication not be available immediately at the receiving ward it will be sent with the patient and their escort.

10.15 The procedure within the Medication Control and Prescribing policy (MCAPP) section 2.4 for supporting patients with medicines on transfer should be followed. Section 12 within this policy related to medicines will be undertaken.

10.16 Prior to transfer to another ward or community service a detailed risk assessment will be carried out by a designated nurse to determine the mode of transport and level of escort required (including chaperone arrangements if required).

10.17 A comprehensive transfer summary will be sent with the patient and escorting nurse to the receiving ward and hospital. Each service will utilise a transfer form as part of their own SOP, guidelines or procedure.

10.18 Transfer of a patient detained under the Mental Health Act will be legal and follow the procedures related to the transfer and admission of a patient subject to the MHA.

10.19 Patients will be admitted to a ward in their local area and if not, repatriation to their local area ward should be arranged as soon as a possible. All transfer decisions are made with the patient's best interest and continuity of care is paramount.

10.20 If a patient has been admitted to a ward outside of their local area due to unavailability of a local bed, the aim will be to transfer the patient to their local area within 7 days from admission where possible and appropriate to clinical need and speciality of clinical service required.

10.21 The patient and their carer will be kept fully informed as to when they will be able to be transferred to their area ward

10.22 The Named Nurse/ Key Worker will liaise daily with the area ward to review bed availability for transfer back and inform the patient and carer with daily updates.

10.23 The area community team who are responsible for the patient will work collaboratively with the outlying inpatient team to maintain clinical coordination of the patient's care and ensure continuity of care on transfer back to them.

10.24 The Care Coordinator from the local area community team will contact the out of area ward at the earliest opportunity to discuss the clinical management plan of patient placed out of area and will liaise with the in-patient consultant, multidisciplinary team and patient regularly.

10.25 Transfer back to the patient's area ward will be led by the outlying ward and will make arrangements for the transport based on the risk assessment. (Authorisation for payment for transport costs will be requested of the home area ward)

11. Discharge

11.1 The Department of Health (DoH) Document "Discharge from Hospital: Pathway Process & Practice 2003 confirmed that discharge is a process and not an isolated event that happens at the end of a patients stay. The following section details the underpinning principles and organisational standards that apply to clinical services to ensure that this DoH expectation is achieved. Discharge from Hospital should be a managed process with a designated person in the role of discharge coordinator; DOH (2002), DH (2010). There are 10 key steps outlined by the DH (2010):

1. Start planning for discharge or transfer before or on admission.

2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in the decision

3. Develop a clinical management plan for every patient within 24 hours of admission.

4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.

5. Discuss with the patient or carer an expected likely length of admission or date of discharge or transfer within 24–48 hours of admission.

6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.

7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.

8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.

9. Use a discharge checklist 24–48 hours prior to transfer. The discharge checklist will be contained within the local procedure or SOP.

10. Make decisions to discharge and transfer patients each day.

11.2 Planning for discharge will commence at the point of admission (or earlier where admissions are planned) DOH (2002); DOH (2003); DH (2010)

11.3 On admission the Named Nurse/ Key Worker will discuss the reasons and the goals for the admission with the patient and where appropriate with their carers. As part of this process the Named Nurse/ Key Worker will outline to the patient the anticipated length of stay.

11.4 Planning for discharge will be detailed in a discharge care plan which will be agreed with the patient and reviewed and updated on a regular basis and at a minimum at each multi-professional ward meeting including CPA within Mental Health and Learning Disability settings.

11.5 Comprehensive, ongoing assessment and review will inform the discharge process and discharge destination**.**

11.6 During multi-disciplinary meetings which could include ward rounds progress against the goals for admission will be reviewed and revised as appropriate in agreement with the patient. If not identified earlier the estimated discharge date will be agreed with the patient and clearly recorded in the patient care record.

11.7 The relevant Division discharge planning guidance should be used to ensure that all relevant issues are considered at the initial and subsequent multi disciplinary case review meetings e.g. is a continuing health care assessment indicated etc..

11.8 Ongoing review of the discharge care plans will take place weekly as a minimum. The estimated discharge date and expected destination will be reviewed and amended as required by the team together with the patient. Care plans will be signed by and copied to the patient /carer as he/she wishes.

11.9 All options for discharge will be discussed with the patient and/or their representative(s) as early in the admission process as possible

11.10 Referrals to Adult Services if a financial assessment is required will take place in a timely manner as soon as the need is indicated. This will be recorded in the care plan

11.11 Where it is expected that a move to a care home or an individualised care package will be required, and the discharge cannot be arranged until the funding source has been identified and agreed, the process to do this will begin *as soon as the need is indicated*. This can be prior to the discharge meeting. The service will liaise as required with Adult/Social Services and the relevant Primary Care Service and Commissioner.

11.12 Ward Managers or other Senior Nurses will monitor the time it takes for clinical staff to complete assessments and ensure this function receives prompt attention.

11.13 A discharge multidisciplinary case review meeting will be arranged at a time as close as possible to the point of the patient being expected to be ready to leave hospital. The date of this discharge CPA/multi disciplinary case meeting will be recorded on the patient care record.

11.14 The Named Nurse/ Key Worker will ensure outcomes are communicated to the team and the patient to ensure timely follow-up. In some instances, the initial meeting will fulfil this function e.g. short admission and the patient will be deemed to be ready for discharge at a ward round.

11.15 The patient will be identified as ready for discharge when:

1. The patient is deemed medically fit and ready for discharge by the multi-disciplinary team, and
2. Their psychiatric condition cannot be further improved by remaining in hospital, and
3. Support and resources are identified and available within an alternative setting to meet their care needs effectively.
4. A discharge checklist will be completed for every patient who is discharged in any circumstances. The discharge checklist will be included within each service guideline, protocol, SOP or procedure.

11.16 The outcomes of this discharge / multi disciplinary case review meeting will be discussed and agreed with the patient and where appropriate their carer / representative and clearly recorded in the discharge care plan of the patient care record.

11.17 The expectation that discharge to a residential placement if required will take place within 4 weeks of the ready-for-discharge date will be made clear at the discharge Multidisciplinary case review meeting.

11.18 Wherever possible, the aim will be for the patient to be enabled to return to their own home or usual care setting

11.19 Patients and/or their relative/carer/other representative (who may be an Independent Mental Capacity Advocate) will be involved with and should if possible agree with the discharge destination and future intervention decision(s).

11.20 Where patients are unable to participate in the process, decisions will be made in the best interests of the individual, as defined within the Mental Capacity Act 2005. The opinion of representatives will be sought, ensuring, where possible, their interests and wishes do not conflict with those of the patient.

11.21 All discussions with the patient and/or their representative(s) will be recorded in the patient care record in line with record keeping policy.

11.22 As soon as a decision to discharge is agreed the multi disciplinary team will ensure that adequate preparation for discharge is made.

11.23 The care arrangements following discharge will be clearly identified and recorded on the discharge care plan to ensure that all patients leaving hospital will either return home with any necessary support in place or have other appropriate care arranged.

11.24 The multi-professional team will ensure that patient /carers/representatives receive appropriate advice and education relating to all aspects of their ongoing care needs, e.g. medication, compliance aids, moving and handling, correct use of equipment, physical health needs. Assessment of concordance with medication will take place, and will be recorded in their discharge plan.

11.25 The Named Nurse/ Key Worker will liaise with other professionals involved to ensure the availability of and supervision arrangements for all necessary equipment, dietary supplements etc. where required.

11.26 The Named Nurse/ Key Worker working closely with other professionals will advise community services colleagues in writing and verbally if necessary, of the discharge and follow up care required.

11.27 All patients will have appropriate arrangements for follow up after discharge. This may be for them to arrange to see their own GP, attend a clinic or in the case of patients discharged from mental health and learning disability care settings, an appointment will be made to be seen within a maximum of 7 days following discharge and within 48 hours if the patient presented as a risk of self harm during admission.

11.28 Where discharge is delayed due to the service user being unwell, the identified professional will inform the patients' relatives and any other relevant persons/agencies involved.

11.29 If a patient chooses to self discharge ideally they will talk to the nurse in charge and medic responsible for their care. The medic in charge must be made aware and the incident recorded in records and via incident reporting. Immediate plans for medication and safe follow up must be made as soon as possible.

11.30 In the event that the patient/representative(s) decline to accept the care arrangements proposed, staff will ensure that the service user fully understands the implications of that decision and the acceptance of responsibility. Staff will document the content of conversations fully within the patient care record.

11.31 All patients will receive information about risks of infection where relevant. This will be included within the discharge checklist. The clinician discharging the patient must be assured that the patient and carers (where appropriate) understand the care process associated with any infection, including the prevention of infection, risk factors, how to gain support and steps to take to prevent the risk of spread of infection. Advice should also include how to use medicines (e.g. anti-microbial

medicines) associated with infection prevention and control and the safe use of any medical device.

11.32 All clinical information will be fully handed over to the receiving ward/ clinician and is accessible on RIO, prior to the transfer, this will include all care records, comprehensive assessment, risk history and assessment, clinical management plan, current care plan and current prescribing plan. The name and position of the receiving nurse/ clinician must be clearly documented in the patient's electronic/ paper record and on the discharge checklist. The patient record should state clearly the information which has been given to receiving clinicians/ carers. Any communication should be described and noted in the patient record including where a specific communication aid such as SBARD, has been used.

12. Medicines

Patients should have their medicines reviewed and reconciled prior to completing the immediate discharge prescription/letter. This includes any withheld during their stay.

12.1 The review and reconciliation should use the information recorded on the prescription chart and on the medicines reconciliation form completed on admission. Further information can be obtained from the case notes/electronic record. The doctor will write up the prescription for medication required on discharge on an approved Trust prescription and sign all relevant documentation.

12.2 Discharge medicines supporting treatment will be prescribed for 28 days. Short term treatment should be indicated by writing "'X' days only and then stop". Patients for whom there is a risk of self harm identified should be written up for whatever quantity of medicines is considered appropriate by the prescriber and stated "x days only". Any risk should be assessed and written in the patient care record. The Medication Control and Prescribing policy (MCAPP) section 2.4 should be followed when making arrangements for patients to be discharged.

12.3 The discharge medicine proforma will record all medicines being taken at the time of discharge with their dosage and frequency. Non-specific directions eg od (daily) or PRN must not be used. If patient's have sufficient supply of their own medicines (a minimum of 7 days) the quantity should be endorsed by writing "POD" (patient's own drugs). This is usually done by pharmacy staff e.g. medicines management technician. This proforma is then the formal record of their medicines at discharge.

12.4 The discharge address will be confirmed and all professionals involved in ongoing care informed of the planned discharge date.

12.5 Discharge medication (TTOs) will be ordered and checked. A copy of the medication summary will be faxed to the current GP. In the discharge of patients with Mental Health & Learning Disabilities, a risk assessment of suicide/self harm in relation to PODs/TTOs will be undertaken and the outcome recorded in the healthcare record.

12.6 The following will be included into the discharge plan:

- Continuing NHS care criteria assessment
- Provision of equipment, which has been identified and agreed by the Multi-Disciplinary Team
- A minimum of 14 days supply of medicines (most patients will received 28 days)
- Transfer of care documentation as required related to medicines

- An assessment for patients to self-medicate who will be responsible for managing their own medicines on discharge should be made with the patient where appropriate prior to discharge.
- An essential part of any discharge plan is ensuring that the registered nurse/ clinician has adequate time to go through all the discharge medicines with the patient and/or carer and answer any questions which may arise. The patient and/ or carer should know the purpose of the medicine, how to take it, and how long for. The registered nurse/ clinician is also responsible for checking the discharge medicines are complete and up to date. Special care must be taken to ensure any medicines which are not supplied by pharmacy but are already on the ward labelled for leave or discharge, eg. inhalers, PODs, are added to the bag of medicines.

12.7 Controlled Drugs as discharge medicines: Controlled drugs to take home must be stored in the ward/department in the Controlled Drug cupboard. These medicines should be segregated from the ward CD stock and clearly marked and remain in the bag. The Controlled Drug should be recorded in the POD section of the register or separate POD register and witnessed as outlined in 2.2.4. On discharge the Controlled Drug must then be booked out by the registered nurse and witness who both sign and date the register. The following must be checked:

- Patient Name
- Date
- Drug name + strength + form
- Quantity
- The patient/carer/driver should also sign the register for the receipt of the controlled drugs.

12.8 If a discharge has been delayed for any reason whilst waiting for care home placement, a medical assessment of the service user will be undertaken within the 24 hours prior to leaving the ward.

13. On the day of discharge:

13.1 On the planned day of discharge the patient will be assessed by the Named Nurse/ Key Worker to ensure that they remain fit for discharge and the nurse will confirm that all necessary support arrangements post discharge are in place; this will be confirmed and documented in the patient's care records.

13.2 The Named Nurse/ Key Worker will ensure completion of the appropriate service discharge pathway. All necessary written information regarding discharge advice, details of telephone help lines and contact telephone numbers of services and other professionals involved in their care etc. will be given to the patient and recorded in the patient record. Subject to agreement, the nursing summary and person centred information will be sent to care homes upon placement. Information given to patients should include how to take/ use any prescribed medicines and include over the counter remedies e.g. medicines the patient may purchase for pain relief.

13.3 Administrative staff will ensure prompt and timely completion of administrative/electronic records relating to patient discharge.

14. Out of Hour Discharge:

14.1 No discharge should be unplanned. Our policy is that there would not be an unplanned discharge with the exceptions of patients undertaking their own

discharges (see section 11). For patients who require transfer to another clinical in-patient setting, this would follow the same process as a planned discharge or transfer of care.

14.2 It is not our policy to discharge patients from hospital out of hours. Should this be the case, for example at a weekend the standard process for discharge should be adhered to out of hours according to the criteria set out in sections 11, 12 and 13.

14.3 A patient who has a planned discharge may arrange to leave the hospital out of hours e.g. during the evening when relatives have arranged to provide transport. This is not an out of hours discharge since the planning and arrangements will have been made in advance. This should be regarded as an unusual occurrence and avoided through negotiating with the patient, their carers or significant others.

15. Training Requirements

15.1 All clinical staff involved in the admission, discharge and transfer of patients should receive training through their induction processes on commencing work and through the Trust Induction process.

15.2 All clinical staff involved in the admission, discharge and transfer of patients should receive training related to the management of medicines and medicines safety which includes medicines reconciliation.

15.3 All clinical staff involved in the admission, discharge and transfer of patients should receive training related to

16. Monitoring Compliance

16.1 This policy will be reviewed through the clinical audit programme and regular monitoring by senior nurses/ matrons e.g. regular monitoring of the discharge checklist and associated standards and time lines.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Discharge requirements identified for all patients are followed	Matron/ Senior Nurse	Discharge Checklist	Monthly	Divisional Q&S meetings
Information is given to receiving healthcare professionals in accordance with policy.	Matron/ Senior Nurse	Discharge Checklist	Monthly	Divisional Q&S meetings
Information is given to patients when they are discharged in accordance with policy.	Matron/ Senior Nurse	Discharge Checklist	Monthly	Divisional Q&S meetings
Patient's medicines are managed on discharge in accordance with policy.	Matron/ Senior Nurse	Matron Walk Round Tool	Monthly	Quality dashboard. Quality and Safety Committee.
Information given to receiving healthcare professionals and patients is recorded in accordance with policy.	Matron/ Senior Nurse	Discharge Checklist	Monthly	Divisional Q&S meetings
Patient's medicines are managed on handover	Pharmacist	Medication Audit	Monthly	Quality dashboard. Quality and Safety

between care settings in accordance with policy				Committee.
Duties and responsibilities	Line Manager	Appraisal	Six Monthly / Annually	Escalated through Line Management
Audit of standards within the policy	Divisional/ Service Leads for Quality & Safety.	Audit Standards	Annual	Divisional Q&S meetings
Out of hours discharge	Matron/ Senior Nurse	Discharge Checklist	Monthly	Divisional Q&S meetings

17. Policy Review

17.1 This policy will be reviewed in 1 year or sooner if national guidance or legislation require.

18. Associated Documents

- Physical Assessment and Monitoring Policy
- Medicine Reconciliation Policy
- Medicines Control, Administration & Prescribing Policy (MCAPP)
- Risk Assessment Policy
- Management of Incidents Policy
- Ensuring the effective discharge of older patients from NHS acute hospitals. REPORT BY THE COMPTROLLER AND AUDITOR GENERAL HC 392 Session 2002-2003: 12 February 2003
- Royal Pharmaceutical Society: July 2011. Keeping patients safe when they transfer between care providers – getting the medicines right. *Good practice guidance for healthcare professions.*
- Royal Pharmaceutical Society: July 2011. Keeping patients safe when they transfer between care providers – getting the medicines right. *A guide for all providers and commissioners of NHS services*
- Standard Operating Procedures and Processes for each type of in-patient service.

19. Supporting References

- DOH (2003) Discharge from hospital: pathway, process and practice
- DOH (2004) Achieving timely 'simple' discharge from hospital: A toolkit for the multidisciplinary team
- CSIP/DH/NIMHE March (2007) Improving discharge from Inpatient mental health care – A good practice Toolkit
- DH (2010) Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care
- NPSA (2010) Rapid Response Report NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital.
- Dodds L.J. Unintended discrepancies between pre-admission and admission prescriptions: results of a collaborative service evaluation across East and SE England. IJPP 18 (Supp 2) September 2011 pp9-10.
- NICE 2011: Prevention and control of healthcare-associated infections: Quality improvement guide Issued: November 2011. NICE public health guidance 36 guidance.nice.org.uk/ph36

APPENDIX 1

LEaD (Leadership, Education & Development) Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEAD department (Louise Hartland, Strategic Education Lead or Sharon Gomez, Essential Training Lead on 02380 774091) before the policy goes through the Trust policy approval process.

Training Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
Local Induction	Once	Appropriate to each in-patient service.	Face to face training in appropriate venues within the Trust	Various	Attendance is recorded on the person's local induction checklist.	Director of Nursing & Allied Health Professionals.

Directorate	Division	Target Audience
MH/LD	Adult Mental Health	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services.
	Learning Disabilities	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	Older Persons Mental Health	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	Specialised Services	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	TQtwentyone	N/A
ICS	Adults	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	Childrens & Wellbeing	N/A
	Dental	N/A
Corporate Services	All (HR, Finance, Governance, Estates etc.)	N/A

APPENDIX 1

LEaD (Leadership, Education & Development) Training Needs Analysis

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Training Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
Medicines Management	3 Yearly	The course will take 2 days	Face to face training in appropriate venues within the Trust	Pharmacists	Staff to provide training through LEAD so that attendance is recorded on the training database	Chief Medical Officer Associate Director of Governance Chief Pharmacist

Directorate	Division	Target Audience
MH/LD	Adult Mental Health	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services.
	Learning Disabilities	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	Older Persons Mental Health	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	Specialised Services	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	TQtwentyone	N/A
ICS	Adults	Clinical Staff engaged in the Admission, Discharge and Transfer of patients to and from in-patient services
	Childrens & Wellbeing	N/A
	Dental	N/A
Corporate Services	All (HR, Finance, Governance, Estates etc.)	N/A

APPENDIX 2

Southern Health NHS Foundation Trust:
Equality Impact Assessment / Equality Analysis Screening Tool

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on different groups within the community

For guidance and support in completing this form please contact a member of the Equality and Diversity team on 01256 376358

Name of policy/service/project/plan:	**Policy for Managing Incidents**
Policy Number:	
Department:	**Quality and Governance Team**
Lead officer for assessment:	
Date Assessment Carried Out:	

1. Identify the aims of the policy and how it is implemented.	
Key questions	**Answers / Notes**
Briefly describe purpose of the policy including • How the policy is delivered and by whom • Intended outcomes	This policy sets out the requirements for the identification and management of incidents and near misses across the Southern Health NHS Foundation Trust. The policy is publically available on the Trust website. It is intended that all staff will report all incidents so that the Trust can learn from them to minimise risk and improve the health, safety and wellbeing of all who use services or enter Trust premises (including patients, service users, staff or visitors).
Provide brief details of the scope of the policy being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?	This policy is a review and amalgamation of the two policies which existed in the former Trusts – Hampshire Partnership NHS Foundation Trust and Hampshire Community Health Care. There is a national requirement for the Trust to

	have this policy to enable it to meet various statutory and legislative requirements. It is applicable to all staff within the Trust (including contractors)

2. Consideration of available data, research and information
Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations. Please consider the availability of the following as potential sources: • **Demographic** data and other statistics, including census findings • Recent **research** findings (local and national) • Results from **consultation or engagement** you have undertaken • Service user **monitoring data** • Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations • Analysis of records of enquiries about your service, or **complaints** or **compliments** about them • Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	The policy is applicable to the whole Trust including all staff (clinical and non-clinical). The Equality and Diversity team collect data in relation to the equalities profile for all Trust staff and this is available as required.
2.2	What equalities training have staff received?	All staff within the Trust receive Equality and Diversity Training at induction. There is an E-learning package for staff to complete every 2 years. If staff fail the e-learning package, support is provided to them through additional face to face contact.
2.3	What is the equalities profile of service users?	The policy is applicable to the whole Trust including all patients, service users and clients. The Equality and Diversity team collect data in relation to the equalities profile for patients, service users and clients and this is available as required.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer	The Safeguard database system which the Trust uses to record information from incidents includes the: date of birth, gender

	satisfaction surveys, consultation findings). Are there any gaps?	and ethnicity of all staff and patients or service users who have been referred to in-patient services This information can be used in the analysis of records including audit. For example, in relation to audit, patient experience surveys, PALS & Complaints reports age, gender and ethnicity in relation to various aspects are recorded and considered.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	The consultation was conducted through the relevant 'virtual team' who review policies. It is taken that comments and review was completed utilising feedback from patients in relation to their admission, transfer and discharge experience. Within MH and LD settings specific review with patient/ service user groups will be undertaken as part of an ongoing process.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	When this policy is reviewed, the consultation will target specific equality considerations and be made available to service user/ patient groups as well as carers groups.

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this.

APPENDIX 2

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this:

	Positive impact (including examples of what the policy/service has done to promote equality)	**Negative Impact**	**Action Plan to address negative impact**			
			Actions to overcome problem/barrier	**Resources required**	**Responsibility**	**Target date**
Age	The Admission, Discharge & Transfer Policy covers all age groups who will access in-patient services and gives consideration to age and needs.					
Disability	The Trust will respond positively to requests of reasonable adjustments. This includes:	There is a need to obtain more evidence of the prevalence of different disabilities. This	The Trust has adopted the Equality Delivery System (EDS) and has plans in place to improve	EDS/Workforce profile reports	Equality and Diversity Lead	January 2012-2016

	Interpreting and Translation provision, Hearing Loops and Personal Emergency Evacuation Plans (PEEP's). The policy covers all in-patient areas.	would enable the Trust to have more specific understanding of employees and identify with employees with disabilities about resources that they require to function most effectively in the workplace (HSE)	workforce profile data across all protected characteristics	Access Audits	Health and Safety	March 2013
Gender Reassignment	The policy covers all patients who need to access in-patient services and identifies that the need for admission, discharge or transfer is based on the patient's clinical needs. Social circumstances and needs on discharge are also highlighted as part of the processes involved.					

Marriage and Civil Partnership	The policy covers all patients who need to access in-patient services and identifies that the need for admission, discharge or transfer is based on the patient's clinical needs. Social circumstances and needs on discharge are also highlighted as part of the processes involved.	No adverse impacts have been identified at this stage of screening				
Pregnancy and Maternity	The policy covers all patients who need to access in-patient services and identifies that the need for admission, discharge or transfer is based on the patient's clinical needs. Social circumstances and needs on	No adverse impacts have been identified at this stage of screening				

	discharge are also highlighted as part of the processes involved.					
Race	The Trust will respond positively to reasonable adjustments. This includes providing information in alternative formats through Interpreting and Translation Equality and diversity implications are taken into account in relation to religion and belief when codes of practice and guidance notes are reviewed.	No adverse impacts have been identified at this stage of screening				
Religion or Belief	The Trust will respond positively to reasonable adjustments. This includes providing information in alternative formats	No adverse impacts have been identified at this stage of screening				

	through Interpreting and Translation Equality and diversity implications are taken into account in relation to religion and belief when codes of practice and guidance notes are reviewed.					
Sex	This policy applies to both men and women including young people and there is no discrimination either positively or negatively.	No adverse impacts have been identified at this stage of screening				
Sexual Orientation	This policy applies to both men and women including young people and there is no discrimination either positively or negatively.	No adverse impacts have been identified at this stage of screening				

APPENDIX 2

Sign Off and Publishing

Once you have completed this form, it needs to be 'approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equality and Diversity Team who will publish it on the Trust website. Keep a copy for your own records.

Name:
Designation:
Signature:
Date:

APPENDIX 3

Policy Implementation Plan

Policy Title:	Policy Author:

Action to be taken	By who	By when	Progress to date