Trust Policy

Ward Clinical Handover of Care and Internal Transfer and Escorting of Adult Patients (Excluding Maternity)

Issue Date	Review Date	Version
June 2018	June 2021	3.3

Purpose

This policy sets out for staff across the Trust what is required to ensure a safe and effective transfer and handover process for any adult patient who requires moving to another ward or department within Plymouth Hospitals NHS Trust or transfer to another care provider.

It includes an outline of the roles and responsibilities of trust staff, key principles fundamental to transfer and handover and the range of factors that need to be considered with patients and their carers before and during transfer.

The standards in this policy should be adhered to by all trust staff regardless of the type of transfer or the time of day in which the transfer is taking place.

The fundamental aim of any handover is to achieve the efficient transfer of timely, high quality clinical information when the responsibility for a patient is transferred from one clinician to another and when patients are moved between wards and departments.

Who should read this document?

Trust Directors
On call Managers
All Medical and Nursing Staff
The Operations Team
All clinical and support staff who are involved in the transfer of a patient

Key Messages

The transfer and clinical handover of patient care is a core task for all members of the healthcare team, but will particularly apply to those with a direct role in patient care where they need to hand over to another team in an effective and efficient manner.

This policy specifically applies to the transfer and handover of clinical information between wards in relation to the immediate care of patients. It applies to all situations where clinical care is transferred from one healthcare professional to another when the patient moves from one ward to another.

This policy applies to all staff providing care and who are involved in the transfer of patients

Core accountabilities

TRW.OPS.POL.629.3.3 Clinical Handover of Care and Internal Transfer of Adults SOP

Owner	Deputy Chief Nurse
Review	Clinical Effectiveness Group
Ratification	Medical Director and Chief Nurse
Dissemination	Senior Matron for Clinical Standards
Compliance	Senior Matron for Clinical Standards

Links to other policies and procedures

Nursing Safer Staffing Escalation Standard Operating Procedure
Transfer of Patients with Mental Health Needs
Postnatal Transfer of Mother and Baby
Antenatal Transfer and Handover of Care
Operational Policy for the Intensive Care Unit
Management of Patients Property
Maternity Standard Operating Procedure
In utero transfer (out of area) and Handover of Care
Guidelines for the Admission, Transfer & Discharge of the Infected Patient

Version History

V1	July 2012	Operational Policy for the Discharge and transfer of Patients from Hospital split into separate SOPs
V2	November 2015	Approved by Clinical Effectiveness Group andratified by Head of Nursing for Surgery
V2.1	August 2016	Review Date extended to Feb 2017
V2.2	April 2017	Review Date extended to May 2017
V3	November 2017	Merging of 2 polices; Clinical Handover of Care and Internal Transfer of Adults (excluding Maternity) and Standard Operating Procedure and Handover Standard Operating Procedure
V3.1	February 2018	Feedback received and changes made to the risk grading of the patients Escort duties added to policy
V3.2	April 2018	Further discussions and feedback received. Amendments made to the escort duties and RAG rating of patients
V3.3	June 2018	Additional line re medical devices and IV medication

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Introduction

This policy aims to support the safe and appropriate transfer and handover of patients and to achieve the efficient transfer of timely high quality clinical information when the responsibility for a patient is transferred from one clinician to another and when patients are moved between wards and departments.

All patients within PHNT who require transfer from one area to another internally must have the appropriate documentation completed to ensure that patient care is not compromised as the result of the transfer.

This policy will ensure there is a clear and consistent process in place for managing a safe clinical transfer and handover of care within Plymouth Hospitals NHS Trust. This will ensure continuity of care for the patient with no detrimental effects attributable to the transfer.

1.1 The key principles that underpin this policy and should be adhered to by individual members of staff and multiagency teams during patient transfer:

1. The potential benefits of transfer must be balanced against the risk: It must be established that the transfer is in the best interests of the patient and that the investigation is actually required for on-going treatment.
2. The safety of the existing patients must be taken into consideration**:** transfer should only take place when the capacity of the admitting area is sufficient to do so safely in the context of the handover information.
3. The use of bay and bed numbers must be avoided to prevent misidentification.
4. Transfer must be timely: Wherever possible, transfers after 22:00 hrs should be avoided. However due to changes in patients' conditions and increased patient throughput, some transfers will have to take place outside of these hours.
5. Effective communication (between staff, patient and carer) and accurate documentation regarding patient condition and their care needs is of paramount importance to patient safety. Poor handover can lead to fragmentation and inconsistency of care
6. The type of staff support required during transfer (escort) will be proportionate to the "level of care" needs.
7. **All in-patient areas are expected, where practical, to observe a protected mealtime protocol.** Wherever possible, transfers during mealtimes should be avoided. It is the nurse on the receiving ward's responsibility to ensure that the patient is given a choice of a meal on arrival if a meal was missed during transfer.
8. Whenever possible the patient and their relatives/carers will be involved in the discussion and the decision regarding the transfer. When this is not possible the patient's relatives/carers must be informed by the nurse responsible for the patients care as soon as the decision to transfer has been made.
9. For all types of transfer referred to in this policy, a clear and accurate handover using the **SBAR** form must be written by the registered nurse and the ward doctor from the transferring area to the registered nurse in the receiving area. This will so ensure 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 current problem under investigation and likely diagnosis, any

physical or mental health risks, last recorded observations and a treatment management plan. Continuity of information is vital to the safety of our patients

10. For all patients undergoing transfer it is essential that their administrative data is updated as soon as possible after transfer. If location and responsible consultant are not accurately recorded and readily accessible this exposes the patients and the hospital to considerable risks.

This policy will have the most relevance to areas which transfer patients on a regular basis, such as the Medical Assessment Unit, Acute Assessment Unit and Surgical Assessment Unit, however this policy is of equal importance when patients are transferred for diagnostic procedures.

The principle in this policy should be followed at all times, including those of exceptional operation pressure (such as OPEL-4). Deviation from this policy may have patient safety implications and therefore should only occur with the consent of the Consultant responsible for the patient and the On-Call Manager.

2 Definitions

2.1 Clinical Transfer is the permanent movement of a patient from one area of the hospital to another as dictated by clinical need.

For example

- The patient needs to move due to a change in clinical management
- Clinical need to increase level of care requiring a move to ITU/HDU/High Observation bay
- Clinical requirement to decrease level of care requiring transfer from ITU/HDU/High Observation bay to a dedicated ward
- As a result of a clinical condition which identifies the need for a change in consultant responsibility

2.2 Non clinical transfer is the permanent transfer of patients from one ward to another for a non-clinical reason and this should only be undertaken in exceptional circumstances.

For example

- Movement to a cohort ward due to operational pressures – this would normally be during the recovery phase of a patient who is likely to be fit for discharge in the near future, the management of that patient should not be compromised by the transfer
- To enable another patient to receive care that can only be provided in a particular area and where the patient being transferred out may have their own needs met equally elsewhere
- Movement of a patient to achieve single sex occupancy

2.3 Handover is a vital communication method which is usually employed to transfer knowledge between staff that is vital in the provision of continuous safe care to

patients. Handovers are to include a combination of written, electronic and verbal information.

2.4 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 using the scoring system below to support the professional decision making.

2.4.1 Prior to the transfer of patients within Derriford Hospital an assessment of potential risk, using clinical judgement and this policy guide must be undertaken to ensure the patient is escorted and transferred safely without harm. This policy and its supportive appendices aim to ensure safe and appropriate transfer and escort of a patient and reduce risks by:

- Providing guidance on the key aspects of patient assessment prior to transfer
- Provide guidance for enabling best decisions regarding appropriate escort and mode of transfer
- Guiding the allocation of appropriate escort to maintain patient safety during transfer.

2.4.2 The registered nurse and doctor must use their clinical judgement to make an appropriate assessment of the patient's clinical condition to determine if an escort is required and to ensure the escort is able to care for the patient during transfer

2.4.3 The reference guide may be used to assist with decision making if required.

2.4.4 A registered nurse escort however MUST be provided is any of the following apply

- The patient's condition is causing clinical concern that the transfer may carry risk or where nurse to nurse handover is considered essential
- The patient has had a recent NEWS trigger
- The patient has a potential risk to airway (E.g. post op / post procedure / post sedation / recent seizures or vomiting)
- The Patient has acute respiratory problems
- The Patient is dependent on continuous oxygen greater then 4L/min
- The Patient is receiving continuous high risk medication Infusions or treatments (E.g. Blood / Opiates/ PCA / Epidural / Antibiotics / Insulin /Heparin / Potassium based infusions) – these medications infusions should not be removed from the medical devices for the purpose of transferring the patient or retaining the medical device on the ward
- The patient requires continuous cardiac monitoring

2.4.5 Appropriate monitoring continues during patient transfer in accordance with the patient's condition and plan of care. When this is not possible transfer should not take place except in exceptional circumstances where any delay in transfer would be considered life threatening. The Senior Nurse should be contacted for support in this instance.

2.4.6 Health care assistants are responsible for patients during transfer if they have accepted the delegated task from a registered nurse providing the conditions in this guidance are met.

2.4.7 A registered nurse should provide health care assistants undertaking transfer with the same full handover of any relevant patient needs/ issues prior to the transfer

3 Regulatory Background

Improvement and standardisation of handover are vital keys to improvement in efficiency, patient safety, and patient experience. There is a need to define common core principles for handover which can be adapted locally. For example, a standardised proforma for written handover is essential, preferably in conjunction with face-to-face verbal handover. Furthermore, in the current technological climate, where possible, electronic handover processes should be encouraged.

Evidence suggests that communication improves when all transfers and handovers involves the patient and is carried out using a structured reporting format

The World Health Organisation goes as far as to recommend the use of SBAR (Situation, Background, Assessment, and Recommendation) as a tool to standardise handover communications. It is recognised in the literature that one system does not fit all settings and that local adaptations may be needed.

The Care Quality Commission Key lines of enquiry (2017) expect organisations to demonstrate how arrangements for handovers and shift changes ensure that people are safe. (S2.4)

4 Key Duties

The SBAR handover sheet is an integrated document that requires engagement with both medical and nursing teams and should be completed by both the doctor and nurse prior to transfer.

Patients are streamed into three categories based on the flowchart included with the SOP. Depending on the patient's clinical parameters, they will allocated a 'green', 'amber' or 'red' status which will be used to determine the most appropriate approach to handover. The nurse and doctor caring for the patient will decide which category the patient falls under.

Green Patients – The nurse and doctor responsible for the patient must be informed that the patient is to be moved. The nurse responsible for the patient completes the SBAR sheet. No written handover is required from the doctor. The patient is moved once the nursing handover is completed. No phone call to the receiving ward is needed however SALUS must be checked for an available empty bed. A GSA/health care assistant can escort these patients but the decision is to be made by the nurse in charge of the patients care.

Amber Patients – The nurse and doctor responsible for the patient must be informed that the patient is to be moved. The doctor responsible for the patient must complete their sections of the SBAR sheet first, before information is completed by the registered nurse. The patient can be moved once the medical and nursing sections of the handover are completed. No phone call to the receiving ward is necessary. The nurse in charge of the patient must decide on the level of escort needed but a porter and HCA/Registered Nurse should be considered. This category of patient must have the SBAR signed by a doctor.

Red Patients – The nurse and doctor responsible for the patient must be informed that the patient is to be moved. The doctor responsible for the patients must complete the SBAR sheet first, before information is completed by the registered nurse. The doctor responsible for the patient must also ring the receiving doctor to handover the patient. The ward nurse must ring the receiving ward to inform them of the imminent transfer. Patients who are being escalated to Level 1 care must be accompanied by a member of registered staff on transfer. Patients being escalated to Level 2 or 3 care must be accompanied by a member of the acute care team. If this is the case, continuous monitoring must be maintained during transfer and this must include BP monitoring, ECG, pulse oximetry as a minimum. Intubated patients also require an anaesthetist and monitoring with capnography. These patients must be escorted from the ward environment or ED to Intensive Care by a member of the Acute Care Team / a doctor with advanced airway skills. This category of patient must have the SBAR signed by a doctor.

5 Procedure to Follow

The document below is a copy of the handover form

<table>
<tr><td colspan="5">Inpatient Ward to Ward Transfer Form</td></tr>
<tr><td colspan="2">Name:

DOB: Pt
Sticker

Unit Number:</td><td>Acuity
Stream:

Red ☐
Amber ☐
Green ☐</td><td colspan="2">NHS University Hospitals Plymouth NHS Trust

In Patient Transfer Form
Completed by ward doctor and registered nurse before transfer occurs.</td></tr>
<tr><td colspan="2">Transfer Date:</td><td colspan="3">Transfer Time: From: To:</td></tr>
<tr><td colspan="3">Next of Kin informed:
Yes ☐ No ☐</td><td colspan="2">Consultant:</td></tr>
<tr><td rowspan="6">S
B</td><td rowspan="6">Situation and Background – the following must accompany the patient: Medical and Nursing Notes, Drug Chart, Property, own medications, walking aids.</td><td>Working diagnosis:</td><td colspan="2">Relevant medical history:</td></tr>
<tr><td>Completed TEP form: Yes No
Completed drug chart: ☐</td><td colspan="2">Allergies:</td></tr>
<tr><td colspan="3">Any Infection control issues: Yes/No:</td></tr>
<tr><td colspan="3">All assessments completed and updated: ☐
Details high risk assessment:</td></tr>
<tr><td colspan="3">Requires cubicle: ☐</td></tr>
<tr><td colspan="3">Diabetes Mellitus ☐
Insulin administration: IV ☐ SC ☐
Frequency of blood glucose monitoring required:
Most recent CBG:</td></tr>
<tr><td rowspan="4">A</td><td rowspan="4">Assessment – what is happening clinically in preparation for discharge</td><td colspan="3">Observations: Time:</td></tr>
<tr><td colspan="3">Temperature: | Saturations: | Resp Rate: | Pulse: | AVPU: | Blood Pressure:</td></tr>
<tr><td colspan="3">Cannula ☐ Intravenous Drugs ☐ Intravenous Fluids ☐
Oxygen ☐ Analgesia ☐ Urinary Catheter ☐</td></tr>
<tr><td colspan="3">Violence / aggression / capacity concerns/ Learning Disability/ DOLS.: Please circle</td></tr>
<tr><td rowspan="5">R</td><td rowspan="5">Recommendations – what do you want done</td><td colspan="3">Treatment Plan/Critical actions to be taken: (e.g. 1 hourly observation)

Investigations requested that need to be chased:</td></tr>
<tr><td colspan="2">Further investigations required to be requested:</td><td>Estimated Date of Discharge:</td></tr>
<tr><td colspan="3">Anticipated Discharge Issues
(e.g. Ambulance required / lives alone /
social services required):</td></tr>
<tr><td colspan="3">Medications and property transferred with patient, property list completed ☐</td></tr>
<tr><td colspan="3">Other Information:</td></tr>
<tr><td></td><td colspan="4">Nurse providing transfer information
Print: Sign:
Doctor providing transfer information
Print: Sign: Bleep:
Name of doctor handed over to:</td></tr>
<tr><td></td><td colspan="4">Person receiving the patient
Print: Sign:
Doctor to sign on receiving patient on ward (amber / red)
Print: Sign:</td></tr>
</table>

Clear instructions must be given when booking a porter regarding infection precautions, additional equipment e.g. portable oxygen and escort status. The following guidance should be used in conjunction with other patient related information at the time. Vital signs should be recorded thirty minutes prior to transfer and recorded on the SBAR. If the recorded vital signs trigger early warnings, do not transfer and request medical review prior to transfer.

If an adequate handover through SBAR is not completed the patient will not be transferred to another ward – this may result in some unnecessary delays and therefore the nurse in charge of the patient must escalate concerns early to the Matron/Senior Nurse and liaise with the Site Team to ensure patient safety is paramount.

The SBAR form should be started as part of the admission process and remain on the front of the medical notes for ease when arranging the transfer. The form will be provided in yellow to ensure it is easily recognisable on transfer. The SBAR will ultimately form part of the patient records and as so must be filed accordingly in the patient's notes.

5.1 Safety of Patients' Property

In line with the patients' property policy 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 if the patient has valuables stored there. The transferring ward must ensure all patients clothing and belongings accompanies them to their new location and recorded in the property book.

5.2 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 storage.

5.3 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 PHNT 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.

6 Responsibilities

6.1 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

6.2 Medical Director

The Medical Director will be responsible for implementing this policy across the medical workforce and ensuring that patient safety is paramount.

6.3 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 policy and provide reports, as required, to the Trust Board in this regard.

6.4 Heads of Nursing / Matrons

Heads of Nursing/Matrons are responsible for ensuring that nursing staff within their remit comply with this policy.

Heads of Nursing/matrons are responsible for ensuring that nursing staff within their remit are encouraged to access the intranet regularly to ensure that that are familiar with current practices

6.5 Ward/Unit Managers

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 department have accepted responsibility for reading this policy and understand how to achieve a safe transfer.
- 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 assessed as competent in this skill and 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

6.6 Acute Care Team

- The Acute Care Team are available to support patients with high level needs during transfer, and in particular:
- To provide advice on the safe transfer of level 2 and 3 patients within the Trust and provide escort when deemed necessary.
- To help identify and advise ward staff when patients are requiring uplift/downgrade of their care level categorisation.
- To advise on the level of monitoring required during transfer.
- The Acute Care Team will provide transport monitoring equipment as required.
- To support and communicate transfer of emergency and elective patients including inter ward transfers.

- To identify appropriate patients for internal transfer as outlying patients during out of hours periods. At other times, this is the responsibility of the Bed Managers

6.7 **Porters**

- To ensure that the request from a Ward is completed in a timely manner and the mode of transport is in good working order.
- To maintain safety, privacy and dignity at all times

6.8 **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 locally or via the 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, and the delegation of tasks to no registered staff and any 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 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the policy described.

This document will be reviewed by the Nursing and Midwifery Committee and ratified by the Director of Nursing or Deputy.

Non-significant amendments to this document may be made, under delegated authority from the Director of Nursing or Deputy, by the nominated author. These must be ratified by the Director of Nursing or Deputy and should be reported, retrospectively, to the Nursing & Midwifery Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director of Nursing or Deputy and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring and Assurance

Any delays in the transfer of patients or in appropriate transfers are to be reported via the Datix system and this will be monitored by the Operational Site Team.

10 Reference Material

- Department of Health (1996) Guidelines on admission to and discharge from intensive care and high dependency units. DoH, London.
- Department of Health (2000) Comprehensive Critical Care: A review of critical care services, DoH, London
- Doring B L and Kerr M. E., Lovasick D A Thayer T, (1999) Factors that contribute to complications during intra-hospital transport of the critically ill. Journal of Neuroscience Nursing 31, (2) 80-86.
- Intensive Care Society (1997) Guidelines for transport of the critically ill adult. British Medical Association. London
- Lawler P.G. (2000) Transfer of critically ill patients: part 1 Physiological concepts, Care of the Critically ill. 16, (2) 61-65
- Lawler P. G. (2000) Transfer of Critically ill patients: Part 2 Preparation for Transfer, Care of Critically Ill 16, (3) 64-97
- Mackenzie P., Smith E. Wallace P (1997) Transfer of adult patients between intensive care units in the United Kingdom. BMJ
- Resuscitation Council (UK) (2000) Advanced Life Support Course Provider Manual. Fourth Edition. Resuscitation Council (UK), London
- Swarbrick K. (2004) Lancashire Teaching Hospitals NHS Trust: Transfer of patient guidelines
- CQC Regulation 12: Safe Care and Treatment

Assessment of Patients	SBAR	Risk	Minimum Escort Required	Mode of transfer	Minimum skills required
• Maintaining own airway • No Oxygen support required during transit • Stable observations no NEWS triggers in last 4 hours • No medical devices in progress during transfer • Alert and orientated	Nurse only	Low	Porter HCA or Pre registered student Nurse (delegated by the Registered Nurse	• Walk • Wheelchair • Bed/Cot • Trolley	• Familiar with trust transfer policy • Understands Transfer process. • Clinical staff BLS/PLS
• Maintaining own airway • Stable on Continuous Oxygen less than 4L/Min • Stable observations no NEWS triggers in last 4 hours • No medical devices that may require intervention during transfer • Confused /disorientated/Learning disability • High risk of falls / likely to wander	Nurse and Doctor	Med	HCA, Pre-registered student Nurse or Therapist & Porter (delegated by the Registered Nurse)	• Wheelchair • Bed/Cot • Trolley	• Awareness of patient's current clinical condition and needs. • Familiar with trust transfer policy • Understands Transfer process. • BLS / PLS
• Requires continuous cardiac monitoring • Risk to airway (e.g. post op / post procedure / post sedation / recent seizures or vomiting) • Acute respiratory problems/potential risk to airway • Requires continuous oxygen greater then 4L/min • Recent NEWS trigger within the last 4 hours • Continuous Infusions or treatments in situ E.g. Blood /PCA/Epidural/Antibiotics/Insulin/potassium based infusions • Patient causing clinical concern / increasing NEWS score • Clinical challenging behaviour	Nurse and Doctor	High	Registered Nurse +/- Medic if indicated For manifestations of aggression consider security escort	• Bed/Cot • Trolley	• Aware of patient's current clinical condition and needs. • Familiar with trust transfer policy • Understands Transfer process • BLS / PLS

Requires Invasive / Non Invasive Ventilator Support Acute respiratory problems • Unstable Circulatory System • Complex Patients requiring support for multi organ failure	Nurse and Doctor	Critical	Critical Care Clinician / Practitioner and Critical Care Nurse/ACT Nurse +/- porter	Bed/Cot Trolley	• Aware of patients current clinical condition and needs • Appropriate Critical care skills • Familiar with trust transfer policy • Understands Transfer process • ALS / PLS

This aims to guide staff with appropriate escort requirements and does not replace the clinical judgement and ultimate decision of the Registered Nurse

Disssemination Plan | Appendix 1

Core Information	
Document Title	
Date Finalised	April 2018
Dissemination Lead	Senior Matron for Clinical Standards
Previous Documents	
Previous document in use?	Yes, electronic version on the Trust Document Network Share Folder
Action to retrieve old copies.	To be managed by the Information Governance Team.

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff	November 17	Email / Vital Signs	Document Control	
Nursing and Midwifery Committee	November 17	Email	Senior Matron for Clinical Standards	5th December 2017
All Service Line Teams	November 17	Email	Senior Matron for Clinical Standards	
All staff	April 18	Email	Senior Matron for Clinical Standards	

Review		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Y
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y
Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Equalities and Human Rights Impact Assessment | Appendix 3

Core Information	
Manager	Nicola McMinn Senior Matron for Clinical Standards
Directorate	Quality Governance Team
Date	November 2017
Title	Clinical Handover of Care and Internal Transfer of Adult Patients (Excluding Maternity)
What are the aims, objectives & projected outcomes?	This policy sets out for staff across the Trust what is required to ensure a safe and effective transfer and handover process for any adult patient who requires moving to another ward or department within Plymouth Hospitals NHS Trust or transfer to another care provider.

Scope of the assessment
This assessment covers the impact the project will have on the workforce (patients, clinicians, admin staff and others) and patients

Collecting data	
Race	This is mitigated as the policy can be made available in alternative languages and formats.
Religion	There is no evidence to suggest that there is a negative impact on religion or belief and non-belief regarding this policy.
Disability	This is mitigated as the policy can be made available in alternative languages and formats.
Sex	There is no evidence to suggest that there is a negative impact on gender regarding this policy.
Gender Identity	There is no evidence to suggest that there is a negative impact on gender identity regarding this policy. Currently data is not collected for this area due to the current provision on the data collection systems. However, this is an area that is under development.
Sexual Orientation	There is no evidence to suggest that there is a negative impact on sexual orientation regarding this policy. Currently data for this area is not collected due to the current provision on the data collection systems. However this is an areas that is under development.
Age	There is no evidence to suggest that there is a negative impact on age regarding this policy.
Socio-Economic	There is no evidence to suggest that there is a negative impact on socio-economic regarding this policy.
Human Rights	Data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans.
What are the overall trends/patterns in the above data?	There are currently no trends or patterns in the data that is produced.

Specific issues and data gaps that may need to be addressed through consultation or further research	This is mitigated as the policy can be made available in alternative languages and formats. Any concerns will be presented to the Quality Improvement Committee.
Involving and consulting stakeholders	
Internal involvement and consultation	The policy has been reviewed and compiled by the Senior Matron for Clinical Standards. The policy has been circulated to the MAU Consultants/Ward /Department Leads and Matrons, for consultation.
External involvement and consultation	The policy has been developed following a programme of quality improvement work. Medical engagement has been very positive with this policy.
Impact Assessment	
Overall assessment and analysis of the evidence	No impact.

Action Plan

Action	Owner	Risks	Completion Date	Progress update