Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

COMMUNITY (THERAPY) VISIT POLICY

POLICY

Reference	CPG-TW-CVP		
Approving Body	Therapy Clinical Governance Group		
Date Approved	20th October 2023		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	6th November 2023		
Version	4.0		
Summary of Changes from Previous Version	Title change from 'Community Visit Policy (for adult patients)'. Minor amendments to update some names of related procedural documents, change CPR to ReSPECT and confirm requirements for Appendix A.		
Supersedes	Community Visit Policy (for adult patients), Version 3.0, Issued 7th December 2020 to Review Date November 2023		
Document Category	• Clinical		
Consultation Undertaken	Circulated for comment at Clinical governance and to matrons on 9th October 2023		
Date of Completion of Equality Impact Assessment	27/10/2023		
Date of Completion of Equality Impact Assessment	27/10/2023		
Legal and/or Accreditation Implications	Not Applicable		
Target Audience	All Trust staff working with patients in a community setting within their role and / or who may be involved in planning inpatient discharges		
Review Date	October 2026		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	• Kate Lyons – Therapy Team Leader Newark / Senior Occupational Therapist Neurological Outpatients • Sally Kennedy – Therapy Team Leader / Specialist Physiotherapist		
Lead Division/ Directorate	Clinical Support, Therapies and Out-patients		
Lead Specialty/ Service/ Department	Therapy Services		
Position of Person able to provide Further Guidance/Information	Named authors above		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	*Not Applicable*
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

1.1 This document sets out the Sherwood Forest Hospitals NHS Foundation Trusts (the Trust) Policy and Procedures for Occupational Therapy (OT) and Physiotherapy (PT) home visits and access visits with hospital patients to facilitate discharge from hospital and with community patients where intervention is being provided in the home of the patient or other community venue.

2.0 POLICY STATEMENT

2.1 This policy and the supporting procedures aim to ensure that community visits are agreed, organised and carried out effectively and that all necessary measures are taken to ensure the health and safety of both patients and staff.

Staff groups

2.2 This policy applies to all therapy staff, including temporary or locum staff, and therapy support workers with due consideration to their level of experience and ability who undertake home/access/community visits.

2.3 Therapy Students may carry out community visits with or without a member of the therapy team if consideration has been given to their level of experience and ability.

2.4 The out-patient Therapy team may carry out home visits to provide therapy intervention in the patient's home. The principles in this policy apply to these services.

2.5 Hospital medics need to be aware of the policy and their role in ensuring that inpatients are medically fit for a home visit to be carried out.

2.6 Inpatient nurses need to be aware of the policy and their role in ensuring that the necessary checks are done and that the patients are ready in time for the visit.

Clinical areas

2.7 This policy is to be used in all Trust adult and paediatric patient clinical areas within all hospital sites and in community settings where therapy intervention is being provided to Trust patients.

Patient group

2.8 This document applies to all patients treated by Therapy Services.

3.0 DEFINITIONS/ ABBREVIATIONS

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
ED	Emergency Department
OT	Occupational Therapist
PT	Physiotherapist
MDT	Multi-disciplinary Team
ReSPECT	ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy This policy details the standards, considerations and procedures within Sherwood Forest Hospitals, relating to a broad range of treatment and care decisions but with a particular focus on those decisions relating to life sustaining treatment.
Home visit	The patient and therapist(s) visit the patient's home residence with or without accompaniment from family or other carer(s)

Access visit	The therapist(s) visits the patients home with the consent of the patient and / or the patients family or other carer(s)
Community visit	The therapist(s) visits the patient in their home or other community venue for the purpose of a therapeutic intervention or other liaison with the patient, family, other carer or health professional

4.0 ROLES AND RESPONSIBILITIES

4.1 Inpatient Medical team

The Medical team will be responsible for determining if their inpatient is medically fit enough to undertake the visit and confirming that their patient can undertake a home visit if there is a ReSPECT form. The responsibility for inpatient discharge remains ultimately with the Consultant/Medical Team.

4.2 Inpatient Named Nurse / Nurse in Charge

The Named Nurse or Nurse in Charge will be responsible for identifying any medication and/or oxygen needs that the patient may have during the visit, making arrangements for these to be administered, if required, and documenting this information.
If there is an infection risk regarding the patient, the Infection Prevention and Control Team must be contacted for advice.

4.3 Named Qualified Therapist or Support Worker

The Occupational Therapist, Physiotherapist or Support Worker is responsible for:

- the decision to carry out a home assessment or community intervention in liaison with the multi-disciplinary team
- arranging the home assessment or community intervention or co-ordinating the arrangements if delegated
- carrying out the home assessment or community intervention
- providing feedback to the multi-disciplinary team
- completing the Inpatient Home Visit Checklist and keeping this within the patients hospital therapy record

4.4 Therapy Staff

4.4.1 The member of staff carrying out the home visit will make arrangements with a colleague to act as a ‘buddy’ to ensure their safe return following the home assessment or intervention, in accordance with the Lone Working Guidelines and Procedures.

4.4.2 A registered Therapist must be present on all inpatient visits. All visits with a patient require the attendance of a second member of staff. This could be a registered /unregistered/student member of therapy or MDT staff dependent upon the patient’s needs.

4.4.3 An outpatient community visit or inpatient access visit may be carried out by a single staff member, including appropriately trained band 4 or 3 therapy staff or student.

4.5 Therapy Team Leaders

The Therapy Team Leaders are responsible for:

- ensuring new staff are aware of policy via local induction procedures
- ensuring any incidents are reported via DATIX
- providing advice / support / de-brief to staff during and following any incidents

5.0 APPROVAL

Following appropriate circulation/ consultation, this updated policy (v3.0) was agreed via the Therapy Clinical Governance Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1 Inpatient Home Visits

6.1.1 Home visits, access visits and community visits are completed for a variety of reasons based on the clinical reasoning of the qualified staff member completing the assessment, the individual needs of the patient and on consultation with the MDT. Not all patients referred to Therapy will require a home visit.
The following areas are taken into consideration when reaching a decision as to whether an inpatient home visit or access visit is necessary:

- If, following therapy assessment in the hospital, concerns are identified about the patient's functional ability to return home safely.
- If there is a significant decrease in the individuals' function which would result in them having difficulty functioning at home
- If completion of an assessment in the hospital would provide unrealistic results e.g. the patient is visually impaired, or there are issues regarding suitability of home environment for equipment.
- Whether it is feasible for the patient to return home on discharge from any Sherwood Forest Hospital.
- Community intervention may provide a more appropriate or effective environment for therapy.

6.1.2 In rare circumstances the Therapist, following liaison with the MDT may decide that a Home Visit discharge is in the patient's best interests. This should never be used as a method for avoiding a self-discharge. Good communication between all staff, the patient and the patient's family/carers is essential.

The patient should be informed that there will be 2 possible outcomes of the visit, one being to return to their inpatient bed and the other to remain at home having been discharged from that bed.

The Therapist must make a clinical judgement that the patient demonstrates the potential to remain safely at home if all assessments during the visit prove successful before agreeing to carry out a discharge home visit. **The MDT must give an assurance therefore that the inpatient bed will be kept until the Therapist returns having made a clinical judgement that the patient could safely remain at home. If this assurance cannot be made than a discharge home visit should not be carried out.**

The patient must only be medically discharged once the home visit has proven successful**.** Any follow up after a discharge home visit should be within the normal parameters of any discharge i.e. no planned extra intervention should be created/made necessary by a discharge home visit.

6.1.3 If the patient lives outside of the area normally covered by SFHT, staff should ascertain if it is appropriate and possible for the patient to be transferred to a local hospital, or for local agencies to carry out an assessment without the patient. If an out-of-area assessment needs to be carried out, the therapist will discuss with a senior therapy clinician or manager.

6.2 Organisation of Inpatient Home Visit/Access Visit

6.2.1 The decision and reason to carry out or not carry out a home assessment must be recorded, and guidance document followed (See Appendix A)

6.2.2 The patient's verbal consent must be obtained and then documented in the Therapy record prior to planning and carrying out a home assessment.

6.2.3 Patient's family/carers, as identified by the patient, should be invited to attend the home assessment. Consideration should be given to the number of people invited.

6.2.4 The Therapist should arrange for relevant professionals to attend the home assessment e.g. Physiotherapist, Community Nurse, Social Worker, and Social Services Occupational Therapist where their input is essential for decisions to be made on the assessment. The number of professional representatives should be kept to a minimum.

6.2.5 Transport arrangements must be appropriate to the patient's needs. Across the Trust the following transport can be used:

- OT service vehicle
- Ambulance Service
- Contracted Taxi service
- Therapists own car - ONLY providing they have appropriate insurance and authorisation.

6.3 On the day of, and during the Inpatient Home Visit

6.3.1 The Therapy staff undertaking the home visit must ensure

- that the patient is fit enough to undertake the visit , establish if they have a ReSPECT form in place and if so take the documentation on the visit
- that the patient is appropriately dressed for the home assessment
- In inclement, cold or hot weather the therapy staff will determine whether the home assessment should be postponed
- They take their identification badges

6.3.2 If mobile phones or lone worker devices are available they must be taken on the home visit in case of emergency and to increase safety.

6.3.3 The therapist must behave professionally at all time, respecting that they are a visitor to the patient's home.

6.3.4 The Home Visit kit bag (see Appendix B) should be taken and the staff member should ensure that it contains all essential items.

6.4 Inpatient Self Discharge during home visits

6.4.1 Should the patient refuse to return to the hospital the Therapy staff should encourage them to return and advise them of the implications of not doing so.

6.4.2 If the patient still wishes to remain at home, the Therapy staff must contact the lead Nurse from the patients ward as soon as possible, to inform them of the situation and for them to arrange relevant health/social care support.

6.4.3 On return to the hospital the Therapy staff must

- inform the medical/nursing staff and Therapy Team Leader
- complete an incident form (DATIX)
- record the details in the Therapy record and patient case notes

6.5 Medical Emergency or Medical Assistance Required

6.5.1 First establish the need for medical assistance, if the therapist is in any doubt medical assistance should be summoned, and:

- Delegate to staff and/or carer to ring 999 for an ambulance
- Carry out basic first aid if competent to do so
- If you suspect the patient may have died; complete assessment according to current guidelines and if the patient has stopped breathing and shows no signs of life, start cardio-pulmonary resuscitation (CPR) according to current guidelines. Continue resuscitation until someone else assumes lead responsibility i.e. EMAS by phone or ambulance crew
- If permitted and in the absence of a relative/carer etc being unable, one member of staff should accompany the patient to ED and remain with them until they are admitted via ED or returned to their original ward
- At the earliest opportunity telephone the ward, speak to the nurse in charge. Inform them of incident and action taken. Ask the nurse to inform the Medical staff and Therapy Team Leader.

6.5.2 If a ReSPECT form is in place and CPR is not appropriate for the patient and you suspect the patient has died following ABC assessment:

- Delegate to staff/carer to ring 999 with the information that the patient has aReSPECT form declining CPR
- Await for EMAS to assume lead responsibility.
- At the earliest opportunity telephone the ward, speak to the nurse in charge. Inform them of incident and action taken. Ask the nurse to inform the Medical staff and Therapy Team Leader.

6.5.3 On return to the hospital an incident report (DATIX) must be completed.

6.6 Violent or Aggressive Behaviour

6.6.1 Staff must follow the following Trust policies:

- Violence and Aggression at Work – A Guide for All Trust Staff Lone Working Policy

6.6.2 In the event of any threatening behaviour or violence, by the patient or members of his/her household, towards them, Therapy staff must leave the household calmly without engaging in any argument. In the event of a member of the Therapy staff being attacked,

they are entitled to protect himself/herself with only such degree of force as is necessary and reasonable. If a lone worker device is available it should be used according to guidelines to record the incident and summon help as appropriate.

6.6.3 On return to the hospital the Therapy staff must report the incident to a Therapy Team Leader and complete an incident form (DATIX)

6.7 Money / Valuables

6.7.1 If money/valuables are found in quantity during the course of the assessment the patient should confirm they are aware of this and be advised that they are responsible for its safekeeping. This should be noted in the Therapy record.

6.7.2 If the patient wishes to bring valuables back to the hospital for safe keeping, the value/details should be placed in an envelope, with the valuables listed, sealed and signed over, and witnessed. The patient must be informed that any money deposited at the hospital will be held in a central safe off the ward and a limited amount will be returned in cash, (this varies with each hospital in the Trust) the rest will be returned in the form of a cheque. Any valuables/property taken at the patient's request must be handed to the Nurse in charge on return for taking into safekeeping as per the Safeguarding And Custody Of Patients Property Policy.

6.8 Medication

6.8.1 If a quantity of medicine is found in the patient's home that is considered inappropriate or hazardous, the Therapist should advise the patient to take it to the ward and hand over to the nurse in charge. If medication is left at home, the Therapist must alert the Consultant/medical Team.
For Community-dwelling patients the Therapist should contact the patient's GP or the Community Pharmacist that issued the medication at the earliest opportunity to enable appropriate steps to be taken.

6.8.2 In the event of a patient attempting to take medication or other substances e.g. alcohol found at home, the Therapist must advise against it. Where the inpatient takes such substances, against the therapist's advice, the therapist must inform the team doctor/nurse in charge at the earliest opportunity upon return to the hospital, and an incident form (DATIX) must be completed. In the case of an outpatient /community patient taking medication against advice of the therapist then the therapist should seek further professional advice, for example from G.P.

6.9 Gas Heating Appliances in Sleeping Accommodation

6.9.1 If it is recommend that the patient's sleeping arrangements change and that they are to sleep in a room with a gas heating appliance the Therapy staff should advise the patient, or their carer, to have the appliance checked, issue a letter (see Appendix C for representational copy) and inform the Social Worker, if appropriate. A copy of the letter should be retained in the patient's case notes, including their hospital number.

6.9.2 If during the home assessment it is noticed that any gas appliance appears dangerous (covered in soot, fumes etc) then the Therapy staff should advise the patient, or their carer, to have the appliance checked by a Gas Safe registered engineer. A record of the advice given should be made in the Therapy records.

6.10 Pest Infestation and environmental safety

6.10.1 If, on arrival at the property, it is found to be infested,or dangerously unsanitary the visit should be curtailed. Personnel should return to the hospital and report to the ward or for community staff the appropriate council or Social Services department.

6.10.2 Further advice should then be sought from the Environmental Health Department of the District Council

6.10.3 Members of staff involved should also seek advice from Occupational Health

6.11 Following the visit

6.11.1 The Therapy staff must give a verbal summary to the multi-disciplinary team at the earliest opportunity. This is particularly relevant where hospital discharge is imminent and the home is unfit to return to or the patient is unsafe. A summary of the visit will be written in the medical notes stating what is essential for a safe discharge.

6.11.2 A home assessment report must be completed after each home assessment, which should be filed within the therapy notes within two working days. The report should be typed and copies may be sent to other member of the multi-disciplinary team as appropriate, and in line with Data Protection procedures.

6.11.3 When writing reports staff should be mindful of the fact that patients may access their own records and therefore the report must be written objectively, stating facts and observations, all of which should have been discussed with the patient during their visit.

6.11.4 If any equipment or minor adaptations are required these must be ordered in accordance with the Integrated Community Equipment Loan Service Eligibility Criteria and arrangements.

6.11.5 Community staff will record the outcome of the visit in the patient records appropriate to their service.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Incidents associated with community visits, Home Visits, Access visits	Therapy Operational Managers	Review of Datix reported	On receipt of Datix	Learning/actions from Datix will be discussed with individuals/teams involved by the datix handler and where appropriate at Therapy Specialty Governance / Divisional Governance.
Reading and understanding of policy	Therapy Team Leaders/ Practice and Professional Development Therapists	At local induction policy will be discussed with new starters / locums who will undertake community visits. Induction sheet will be kept within personal file.	Monthly	Therapy Operational Management Meeting

8.0 TRAINING AND IMPLEMENTATION

There is no specific training required for the application of this policy.

All relevant staff need to be aware of, read and follow the policy as required. If in doubt liaise with a senior member of the therapy services team.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix E
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix F

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Chartered Society of Physiotherapists Code of Members' Professional Values and Behaviours 2019
- -Professional standards for occupational therapy practice,conduct and ethics 2021

Related SFHFT Documents:

- Management of Work-Related Violence and Aggression Policy
- Lone working Policy
- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy Safeguarding And Custody Of Patients Property Policy

11.0 KEYWORDS

Home Visit, Therapy, Occupational Therapy, Physiotherapy, for adult patients, patient

12.0 APPENDICES

Appendix A – Inpatient Home Visit Checklist
Appendix B – Contents of Inpatient Home Visit Kitbag and Community Visit Kitbag
Appendix C – Letter regarding gas heating appliances in sleeping accommodation (representational copy)
Appendix D – Patient discharges self from inpatient care during home visit (representational copy)
Appendix E – Equality Impact Assessment Form
Appendix F – Environmental Impact Assessment Form

Appendix A

Sherwood Forest Hospitals
NHS Foundation Trust

Name _____

Date of birth _____

Address _____

_____

_____

District or NHS Number _____

Inpatient Home Visit Checklist

	Date	Initial
Initial assessment carried out		
Need for home visit identified		
Patient's consent obtained		
ReSPECT form wishes discussed and recorded		
Patient fit for visit (liaised with ward staff)		
Need for visit discussed with N.O.K. / carers		
Visit booked		
2nd staff member able to attend		
Relative aware of visit arrangements		
Carer (formal or informal) aware of visit arrangement		
Patient address is checked and correct		
Patient has suitable outdoor clothes		
Key is available or keysafe access arranged		
Transport arranged		
All necessary equipment present (including home visit kit bag)		
Medication needs for patient checked and organised		
Therapist contact details left with team member or in diary / fireboard including anticipated time of return		
If not returning to the hospital directly from the visit permission should be obtained beforehand and the department should be contacted immediately on completion of the visit		

- Once completed please retain within the patients hospital therapy record

Author: Therapy Team Leaders (KL/SK) Page 1 of 1 Issue Date: November 2023 (v4.0)
To be filed in: Patients hospital therapy record Review Date: October 2024

For use in practice, print this appendix from policy on intranet

Appendix B **Contents of Inpatient Home Visit Kitbag, and Community Visit Kitbag**

Contents of Inpatient Home Visit Kitbag, Therapy Services

- Personal Protective Equipment e.g. gloves, apron in accordance with current Infection Control guidelines.
- Incontinence pads
- Disposable vomit bowels & urinals
- Clinical waste bags
- Hand sanitiser
- Cleaning wipes e.g Clinell

It is the responsibility of the visiting Therapist to replace any items used immediately on returning after the visit. The above list is not exhaustive and therapists should consider the needs of individual patients prior to arranging the visit and ensure availability of any additional equipment.

Contents of Community Visit Kitbag, Therapy Services

The above Inpatient Kitbag list should be included, and any additional items such as listed below may also be appropriate according to individual patient's needs:

- Contact details and other information for onward referral, community services, Call for Care, Social Services, British Red Cross and ICELS (Integrated Community Equipment Loan Service)
- Scissors, tape measure, notepad
- Ferrules for walking aids

It is the responsibility of the visiting Therapist to replace any items used immediately on returning after the visit. The above list is not exhaustive and therapists should consider the needs of individual patients prior to arranging the visit and ensure availability of any additional equipment.

Appendix C Letter Regarding Gas Heating Appliances in Sleeping Accommodation
(representational copy)

Sherwood Forest Hospitals
NHS Foundation Trust

[Insert date]

Dear **[Insert Patient Name]**

RE: GAS HEATING APPLIANCES IN SLEEPING ACCOMMODATION

It has been noted that there is a gas heating appliance in the room you are planning to use as sleeping accommodation.

This appliance may be dangerous if it is not of the 'room sealed' type. The law states, under the Gas Safe (Installation and Use) regulations 1994, that a room to be used for sleeping must have a heating appliance of the 'room sealed' type and not an open flue.

You are advised to have your appliance and its flue outlet checked immediately by either a British Gas or Gas Safety Register (previously known as CORGI) engineer, to assess its suitability for use in a room used for sleeping.

If you are in privately rented or council property, please notify your landlord of the new sleeping arrangements.

It is also advised that a carbon monoxide detector is fitted prior to discharge if you are to sleep in a room with a gas fire.

In the event of any queries advice should be sought from a British Gas or Gas Safe Register engineer.

Yours sincerely

[Insert name & designation]

Appendix D – Patient discharges self from inpatient care during home visit
(representational copy)

Sherwood Forest Hospitals
NHS Foundation Trust

[Insert date]

I **[Insert Patient Name]** confirm that I request to be discharged from inpatient care by Sherwood Forest Hospitals NHS Foundation Trust. I have been made aware of the concerns of the therapy team and that this action is against their direct advice.

Specific concerns may be highlighted below:

Patient / Patient Representative Signature: ……

Therapist Signature: ……..

Print Name: ……

APPENDIX E – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: **Community Visit Policy**			
New or existing service/policy/procedure: **Existing**			
Date of Assessment: **27/10/2023**			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	none	none	none
Gender:	none	none	none
Age:	none	none	none
Religion:	none	none	none
Disability:	none	none	none
Sexuality:	none	none	none
Pregnancy and Maternity:	none	none	none
Gender Reassignment:	none	none	none
Marriage and Civil Partnership:	none	none	none

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	none	none	none

What consultation with protected characteristic groups including patient groups have you carried out?

- Raised at Therapy Clinical Governance meeting November 2017/ October 2020/ October 2023
- Attained feedback from relevant colleagues including inpatient and community based therapy staff, wards leads, workplace Trade Union Representative

What data or information did you use in support of this EqIA?

- Home Visit Policy 2014

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EqIA guidance document, please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Sally Kennedy/ Kate Lyons

Signature:

Date: 27/10/2023

APPENDIX F – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	