CP61
Management of the Deteriorating Patient

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1.0 Policy Statement (Purpose / Objectives of the policy)

- This Policy directs the correct approach to identify deterioration in patients' clinical condition and the subsequent actions that need to be taken.

2.0 Definitions

Definitions DNAR or DNACPR (Do Not Attempt Resuscitation or Do Not Attempt Cardiopulmonary Resuscitation) - A defined ceiling of care for the patient to withhold cardiopulmonary resuscitation following a formal agreement of a Do Not Attempt Resuscitation order and documented in the ReSPECT plan (see CP11 Resuscitation Policy).

- eObs system - An electronic observation system that enables timely collection and recording of patient observations, automated calculation of the Early Warning Score (see below) and, based upon the score, prompts to staff to escalate care if required.
- "Early Warning" and "Track and trigger" systems - System(s) that through periodic physiological observations assist in the identification of deteriorating patients and provides a predetermined graded response that includes the frequency of observations and attendance by appropriately trained staff.
- National Early Warning Score 2 (NEWS2) – A numerical summary of physiological parameters calculated from observations made of pulse rate, blood pressure, temperature, respiratory rate, oxygen saturations, supplementary oxygen therapy and conscious level. NEWS2 is the latest version developed by the Royal College of Physicians (RCP).
- NEWS2 Scale 2 – Oxygen saturation News2 Scale 2 should only be used for patients with hypercapnic (Type 2) respiratory failure who have clinically recommended oxygen saturations of 88-92%. If NEWS2 Scale 2 has been used this must be clearly an explicitly documented on the patient clinical record.
- Paediatric Early Warning Score (PEWS) A numerical summary of physiological parameters calculated from observations made of pulse rate, blood pressure, temperature, respiratory rate, oxygen saturations, supplementary oxygen therapy and conscious level.
- SBARD (Situation Background Assessment Recommendation Decision) - this is a structured tool that aims to improve communication and assist in the exchange of vital patient information. Trust wide – For the purpose of this policy, Trust wide refers to all areas providing clinical patient care that are part of Divisions 1, 2 and 3. Please refer to section 4.3 which outlines the Early Warning Systems and processes in place trust wide.

3.0 Accountabilities

Healthcare organisations have an obligation to provide safe and effective care to their patients and appropriate training to their staff. A suitable infrastructure is required to establish and continue support for these activities. The following will be responsible for implementing this policy throughout the organisation.

3.1 Chief Executive

The Chief Executive is responsible for ensuring that effective systems and processes are in place to implement this policy.

3.2 Group Chief Nurse and Group Medical Director

The Group Chief Nurse and Group Medical Director have strategic responsibility to ensure that this policy is in place.

3.3 Director of Nursing and Medical Director

The Director of Nursing and Medical Director are responsible to ensure that this policy is in place and will ensure that this policy is effectively monitored, implemented and complies with national and international guidelines and reflects best evidence-based practice. The Deterioration Patient Group will monitor performance including compliance with audit standards and report to the quality and safety sub-board committee chaired by the exec directors.

3.4 Divisional Management Teams

Divisional Management Teams must instigate Root Cause Analyses (RCA) of serious untoward incidents (SUI's) that result from failure to follow this policy.

3.5 Directorate Management Teams

Must ensure that this policy is implemented and adhered to in their directorates. Any incidents of failure to follow this Policy must be investigated to understand and remedy the non-compliance. Directorates must escalate any SUI's to Division to ask them to instigate an RCA.

3.6 Ward Managers

Ward Managers must ensure that this policy is communicated, implemented and adhered to ensuring that appropriate training outlined in this Policy is undertaken by their staff.

3.7 Deteriorating Patient Group

The Deteriorating Patient Group will be responsible for the policy content, review, distribution and implementation, and for monitoring compliance. They will ensure the policy complies with national / international guidelines and reflects best evidence based practice. The Deteriorating Patient Group will report to the Quality and Safety Assurance Group (QSAG). Reporting up to board level and down to local management levels will be in accordance with OP10 Risk Management Reporting Policy.

3.8 All Clinical Staff

All clinical staff must adhere to this policy and ensure that they access training that will equip them to competently carry out the duties and responsibilities outlined in their individual posts. The named or on-call Consultant Clinician is responsible for determining ceilings of care, for referring the patient to Critical Care if appropriate and for ensuring there is appropriate management of the patient pending their transfer to Critical Care. Staff to follow appropriate escalation process for early warning scores and where indicated referral to the Critical Care Outreach Team (CCOT) if the $NEWS_2$ score is 7 or more in adult ward areas.

3.9 The Critical Care Outreach Team (CCOT)

The Critical Care Outreach Team are a 24/ 7 service offering advice and support to parent teams and staff members regarding the deteriorating patient. Patients can be referred to the CCOT by the use of bleep 7441. Guidance for referral is available on

eObs system and vital pack intranet page.

3.9.1 Out of Hours (OOH) Practitioners

The OOH Practitioners provide support as part of delivering care out of hours and at night, with the aim of improving patient safety. OOH practitioners are based within Division 2 and occasionally provide support across Division 1. They interface with CCOT to assist in the review of patients and their escalation as required.

4.0 Policy Detail

4.1 Patient at Clinical Risk Systems

4.1.1 There must be a co-ordinated approach to identify any deterioration in patients and the subsequent actions that aim to prevent further deterioration and possible subsequent cardio-respiratory arrest.

4.1.2 Prevention of cardiac arrest requires:

- Monitoring of patients
- Recognition of patient deterioration
- A system to call for help
- An effective response to the deterioration
- Staff training

4.2 Monitoring of patients

4.2.1 All admitted patients will have their physiological observations recorded at the time of their admission or initial assessment with the appropriate Early Warning System.

4.2.2 The frequency and recording of patient's observations may be determined by factors other than the Early Warning System, e.g. blood transfusion, specific pathway post-op monitoring guidance.

4.2.3 The EWS must be regarded as a clinical tool to guide clinicians and not a system that stops clinicians from exercising their judgement. Any decision to adjust triggers or to increase or decrease the frequency of observations for an individual patient must be made by a decision-making clinician, and the decision and the rationale for it must be documented in the patient's notes. The frequency of monitoring must increase if a subsequently abnormal EWS is detected.

4.3 Early Warning Systems

The following Early Warning Systems are in use throughout the Trust:

- CareFlow Vitals National Early Warning Score 2 (NEWS 2) for adults (New Cross, Cannock Chase Hospitals and West Park Hospitals)
- Modified Early Obstetric Warning Score (MEOWS) (for obstetric patients)
- Paediatric Early Warning System (PEWS) (for children/young people)

- Adult Community and Primary Care Services have their own clinical processes and pathways for escalation and management of the deteriorating patient in line with NEWS2.

4.4 Effective Response to the Deterioration in a Patient's Condition

4.4.1 The responses to a deteriorating patient must follow the escalation procedure of the Early Warning System that is in use, including, importantly, escalation to senior clinical decision makers. The SBARD structured communication tool is to be used to ensure effective communication.

4.4.2 Appropriate escalation, interventions and investigations must be performed as early as possible to try to prevent further clinical deterioration.

4.4.3 Details of the referral, the review of the patient and all actions taken must be documented in the patient's notes (see Appendix 9 for NEWS2 and PEWs). It is the responsibility of the named or on-call Consultant Clinician to determine if it is appropriate to refer the patient to Critical Care and to ensure there is appropriate management of the patient pending their transfer.

4.4.4 Where clinically relevant, a decision must be made about defining a ceiling of care, including a DNAR/DNACPR as part of the ReSPECT plan. This must be documented in the notes and communicated explicitly to all relevant members of the clinical team.

4.5 Critical Care Outreach Team (CCOT)

Deteriorating patients are escalated to the CCOT on bleep 7441 as indicated by the patient's early warning score and use of clinical judgement (see Appendices 1-3).

- The clinical team staff MUST refer to the Critical Care Outreach Team all
- Patients that have triggered the NEWS2 of 7 and above.
- The team should consider referral to Critical Care Outreach Team if NEWS2 of ≥5 or single parameter of 3 if they are concerned about risk of deterioration even if they are receiving intervention.

Following escalation by clinical staff, the CCOT will review and support the management and where appropriate facilitate timely admission to critical care.

4.6 Out of Hours Practitioners

The Out of Hours (OOH) Practitioners provide support and advice to wards with regards to patient care, management and escalation out of hours and at night. At the present time, the OOH practitioners are based in Division 2 and occasionally provide support across Division 1.

4.7 Adult Community Services/ Community Urgent Care

There is an escalation pathway within Primary and Community Services for patients who are assessed at being at risk of or showing signs of clinical deterioration in an attempt to avoid admission.

Following detection or after escalation to them, the Community Urgent Care service can assess, review, and implement care on further management of deteriorating patients and where appropriate facilitate timely admission to the acute setting where an admission cannot be avoided.

4.8 Urgent Assessment or Advice by a Specialist Critical Care Physician

The Specialist Trainee or Consultant Intensivist on-call for Critical Care can be contacted by switchboard for immediate advice or review.

4.9 Admission to Critical Care

Referral of a patient for possible admission to Critical Care must be Consultant to Consultant. The agreed escalation process for deteriorating patient on medical wards requiring critical care input is included in Appendix 7.

4.10 Training

All clinical staff will be trained in the recognition and management of the deteriorating patient, Early Warning Systems, including the SBARD communication tool, and the prevention of cardio-pulmonary arrest. This training is incorporated in Mandatory Resuscitation Training and in Trust and local induction for all clinical staff.

5.0 Financial Risk Assessment

A financial risk assessment has been undertaken and no financial risk has been identified as a result of implementing this policy.

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

This policy has been assessed as not affecting the equality of any one particular group of stakeholders.

An equality analysis has been carried out and it indicates that:

Tick	Options
✓	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

7.0 Maintenance

The Deteriorating Patient Group will be responsible for reviewing this policy every 3 years or with local or national guidance change, to ensure that it reflects best evidence based practice and also meets the needs of the Trust.

8.0 Communication and Training

8.0.1 This policy will be communicated at Trust Induction. Approved Trust policies will be made available to staff via the Trusts Intranet page.

8.0.2 Training related to this policy is covered in section 4.8

9.0 Audit Process

Compliance with the policy will be undertaken by the relevant Professional Line Manager and supports delivery of Visions and Values.

Criterion	Lead	Monitoring method	Frequency	Committee
Duties	Deteriorating Patient Committee	Policy Review	3 yearly	Policy Review Group
Early warning systems within the organisation to recognise patients at risk of deteriorating	Deteriorating Patient Committee	Audit (Excellence in care audit)	Monthly	Deteriorating Patient Group
Deteriorating patient pathway (Sepsis)	Sepsis	Sepsis screening and management	Monthly	Deteriorating Patient Group
% of late observations	Ward managers	Calculation of average% of late observations	Monthly	Deteriorating Patient Group
Patient safety incidents	Deteriorating Patient committee	Reports from DATIX	Every 2 months	Deteriorating Patient Group
In-patient cardiac arrests	Resuscitation Group	Cardiac Arrest Audit	Monthly	Deteriorating Patient Group
Learning from deaths	Mortality Review Group Lead	Mortality Review	Every 2 months	Mortality Review Group

10.0 References - Legal, professional or national guidelines

National Institute for Health and Clinical Excellence. Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. NICE clinical guideline 50. London: NICE, 2007.

National Confidential Enquiry into Patient Outcome and Death. Emergency admissions: a journey in the right direction? London: NCEPOD, 2007.

National Confidential Enquiry into Patient Outcome and Death. Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in hospital cardiorespiratory arrest. London: NCEPOD, 2012.

National Patient Safety Agency Recognising and responding appropriately to early signs of deterioration in hospitalised patients. London: NPSA, 2007.

Department of Health. Competencies for Recognising and responding to acutely ill patients in hospital. London DOH, 2009.

Part A - Document Control

Policy number and Policy version: **CP61** **4.0**	**Policy Title** **Management of Deteriorating Patient**	**Status: Final**		**Author: Katrina Creedon** **Chief Officer Sponsor: Director of Nursing**
Version / Amendment History	Version	Date	Author	Reason
	1.0	March 13	Chair of Deteriorating Patient Committee	Creation of Policy
	1.1	Sept 13	Chair of Deteriorating Patient Committee	ViEWS Chart updated to include 'consider contacting CCOT and record all actions in patient's notes' Modified ViEWS chart updated to include all actions in patient notes.
		June 13th 2016	Chair Deteriorating Patient Group Yat Li	Update of CP61 v1.1 with changes recommended in DPG meeting 27.05.2016
		July 11th 2016	Chair Deteriorating Patient Group Yat Li	Added IP12, correction of committee to group in 3.7
		July 18th 2016	Chair Deteriorating Patient Group Yat Li	Updated 3.7 as DPG accountable to Mortality Review Group
		July 30th 2016	Chair Deteriorating Patient Group Yat Li	Added 4.4 to contents
	2.0	Jan 2017	Chair Deteriorating Patient Group	Routine Review
	2.1	Jan 2018	Deteriorating Patient Group	Vital Pac SOP attached as a SOP (Previously CP61)
	2.2	Dec 2019	Chair Deteriorating Patient Group	Reviewed by Chief Nurse-Extended to February 2020
	3.0	Jan 2020	Chair Deteriorating Patient Group	CP61 updated to include NEWS2 reporting to QSIG amendments to responsibilities inclusion of Out of Hours Practitioners, inclusion of the definition of Trust wide and Vitals SOP

	3.1	June 2020	Chair Deteriorating Patient Group	Updates to read in conjunction section of policy
	3.2	Feb 2023	Deteriorating Patient Group	Policy review and update to SOP linked to policy
	4.0	June 2023	Deteriorating Patient Group	Routine review

Intended Recipients: All staff working clinically and in contact with wards

Consultation Group / Role Titles and Date: Deteriorating Patient Group Feb 2023

Name and date of Trust level group where reviewed	Trust Policy Group – June 2023
Name and date of final approval committee	Trust Management Committee – June 2023
Date of Policy issue	July 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	3 years June 2026

Training and Dissemination: Communications on the Intranet and on display in wards, incorporated into audit.

To be read in conjunction with:

CP11 - Resuscitation Policy
CP26 - Blood Transfusion
CP42 – Falls Prevention and Action in the Event of a Patient Fall Policy
CP57 - Prescription and Administration of Emergency Oxygen in Adults
CP05 - Transfer of Patients between Wards, Departments, Specialist Units and Other Hospitals
OP10 - Risk Management and Patient Safety Reporting Policy
OP41 - Induction and Mandatory Training Policy
IP12 – Standard precautions for infection prevention
OP16 - Critical Care Outreach Team Operational Practice Policy
Maternity care record
NEWS2 observation chart (New Cross Hospital)
NEWS2 observation chart (Cannock Chase Hospital)
NEWS2 observation chart (West Park Hospital)
Paediatric Early Warning system
SBART checklist
End of life care

Initial Equality Impact Assessment [all policies]: Completed Yes
Full Equality Impact assessment [as required]: Completed No
If you require this document in an alternative format e.g., larger print please contact Policy Administrator 85887

Monitoring arrangements and Committee	Deteriorating Patient Group Bi-Monthly

Document summary/key issues covered:

This policy directs the correct approach to identify deterioration in patients' clinical condition in different clinical settings and the subsequent actions that need to be taken.

Appendix 1

Escalation process for NEWS2 if based at New Cross Hospital

NEWS2 Score	Frequency based on NEWS2 score	Actions to take
0	6 hourly observations then 12 hourly if stable for 6 hours	If concerned about the patient 1. Inform RN to assess and make decision to contact medical staff or ANP to review patient - If this is not possible contact consultant on-call 2. Inform RN to consider contacting CCOT for advice 3. Review observation interval & target SATs if on O_2 4. Consider ceilings of treatment and DNACPR status 5. Record all actions in patient notes
1, 2	6 hourly observations	1. Inform RN to assess and make decision to contact medical staff or ANP to review patient 2. If this is not possible contact consultant on-call 3. Inform RN to consider contacting CCOT for advice 4. Review observation interval & target SATs if on O_2 5. Consider ceilings of treatment and DNACPR status 6. Record all actions in patient notes
3, 4	4 hourly observations then 6 hourly observations if stable for 4 hours	As for score of 1
Red score 3	Minimum 1 hourly observations	1. Inform RN to assess and make decision to contact medical staff or ANP to review patient within 1h 2. If this is not possible contact consultant on-call 3. **Consider** sepsis screen 4. Inform RN to consider contacting CCOT for advice 5. Review observation interval and target SATs if on O_2 6. Consider ceilings of treatment and DNACPR status 7. Record all actions in patient notes
5, 6	Minimum 1 hourly observations	1. Inform RN to assess and make decision to contact medical staff or ANP to review patient within 1h - If this is not possible contact consultant on-call 2. **Perform** a sepsis screen 3. Inform RN to consider contacting CCOT for assessment 4. Consider continuous patient monitoring and treatment (oxygen, fluid challenge) 5. Review observation interval & target SATs if on O_2 6. Consider ceilings of treatment and DNACPR status 7. Record all actions in patient notes
7+	Continuous monitoring	1. Inform RN to assess and make decision to contact medical staff or ANP for IMMEDIATE review – if this is not possible contact consultant on-call 2. **Perform** a sepsis screen 3. Contact CCOT and consider contacting the cardiac arrest team if cardiac arrest seems imminent 4. Start continuous patient monitoring and consider treatment (oxygen, fluid challenge) 5. Consider transfer to ICCU, ceilings of treatment and DNACPR status 6. Record all actions in patient notes

Appendix 2

Escalation process for NEWS2 if based at Cannock Hospital

NEWS2 Score	Frequency based on NEWS2 score	Actions to take
0	6 hourly observations then 12 hourly if stable for 6 hours	If concerned about the patient 1. Inform RN/nurse in charge to assess and make decision to contact the junior doctor covering the clinical area to review patient - If this is not possible contact consultant on-call 2. Inform RN/nurse in charge to consider contacting the resident CCH anaesthetist for advice 3. Review observation interval & target SATs if on O_2 4. Consider ceilings of treatment and DNACPR status 5. Record all actions in patient notes
1, 2	6 hourly observations	1. Inform RN/nurse in charge to assess and make decision to contact the junior doctor covering the clinical area to review patient - If this is not possible contact consultant on-call 2. Inform RN/nurse in charge to consider contacting the resident CCH anaesthetist for advice 3. Review observation interval & target SATs if on O_2 4. Consider ceilings of treatment and DNACPR status 5. Record all actions in patient notes
3, 4	4 hourly observations then 6 hourly observations if stable for 4 hours	1. Inform RN/nurse in charge to assess and make decision to contact the junior doctor covering the clinical area to review patient 2. If this is not possible contact consultant on-call 3. Inform RN/nurse in charge to consider contacting the resident CCH anaesthetist for advice 4. Review observation interval & target SATs if on O_2 5. Consider ceilings of treatment and DNACPR status 6. Record all actions in patient notes
Red score 3	Minimum 1 hourly observations	1. Inform RN/nurse in charge to assess and make decision to contact the junior doctor covering the clinical area to review patient within 1 hour 2. If this is not possible contact consultant on-call 3. **Consider** sepsis screen 4. Inform RN/nurse in charge to consider contacting the resident CCH anaesthetist for advice 5. Continuously monitor patient & target SATs if on O_2 6. Consider ceilings of treatment and DNACPR status 7. Record all actions in patient notes
5, 6	Minimum 1 hourly observations	1. Inform RN/nurse in charge to assess and contact the junior doctor covering the clinical area to review patient within 1h - If this is not possible contact consultant on-call 2. **Perform** a sepsis screen 3. Inform RN to consider contacting the resident CCH anaesthetist for assessment 4. Contact the consultant on-call covering the clinical area/patient to ensure that they are aware of the patient's condition 5. Continuously patient monitoring and consider treatment (oxygen, fluid challenge) 6. Review observation interval & target SATs if on O_2 7. Consider ceilings of treatment and DNACPR status 8. Record all actions in patient notes
7+	Continuous monitoring	1. Inform RN/nurse in charge to assess and make decision to contact the junior doctor covering the clinical area and the resident CCH anaesthetist for IMMEDIATE review – if this is not possible ring 999 and arrange transfer of patient to New Cross Hospital Emergency Department 2. **Perform** a sepsis screen 3. Start continuous patient monitoring and consider treatment (oxygen, fluid challenge) 4. RN/nurse in charge or the junior doctor to inform consultant on-call covering the clinical area/ patient 5. RN/nurse in charge or resident CCH anaesthetist to inform consultant anaesthetist covering or on-call for CCH of the patient's condition and need to transfer to NXH 6. Record all actions in patient notes

Appendix 3

Escalation process for NEWS2 if based at West Park Hospital

NEWS2 Score	Frequency based on NEWS2 score	Actions to take
0	6 hourly observations then 12 hourly if stable for 6 hours	If concerned about the patient 1. Inform RN/nurse in charge to assess and make decision to contact the on-call medical team to review patient - If this is not possible contact consultant on-call 2. Review observation interval & target SATs if on O_2 3. Consider ceilings of treatment and DNACPR status 4. Record all actions in patient notes
1, 2	6 hourly observations	1. Inform RN/nurse in charge to assess and make decision to contact the on-call medical team to review patient 2. If this is not possible contact consultant on-call 3. Review observation interval & target SATs if on O_2 4. Consider ceilings of treatment and DNACPR status 5. Record all actions in patient notes
3, 4	4 hourly observations then 6 hourly observations if stable for 4 hours	1. Inform RN/nurse in charge to assess and make decision to contact the on-call medical team to review patient 2. If this is not possible contact consultant on-call 3. Continuously monitor patient & target SATs if on O_2 4. Consider ceilings of treatment and DNACPR status 5. Record all actions in patient notes
Red score 3	Minimum 1 hourly observations	1. Inform RN/nurse in charge to assess and make decision to contact the on-call medical team to review patient within 1 hour 2. If this is not possible contact consultant on-call 3. **Consider** sepsis screen 4. Continuously monitor patient & target SATs if on O_2 5. Consider ceilings of treatment and DNACPR status 6. Record all actions in patient notes
5, 6	Minimum 1 hourly observations	1. Inform RN/nurse in charge to assess and contact the on-call medical team to review patient within 1 hour 2. If this is not possible ring 999 and arrange transfer of patient to New Cross Hospital Emergency Department 3. Perform a sepsis screen 4. Contact the consultant on-call covering the clinical area / patient to ensure that they are aware of the patient's condition 5. Continuously monitor patient and consider treatment (oxygen, fluid challenge) 6. Review observation interval & target SATs if on O_2 7. Consider ceilings of treatment and DNACPR status 8. Record all actions in patient notes
7+	Continuous monitoring	1. Inform RN/nurse in charge to assess and make decision to contact the on-call medical team covering the clinical area for IMMEDIATE review – if this is not possible ring 999 and arrange transfer of patient to New Cross Hospital Emergency Department 2. Perform a sepsis screen 3. Start continuous patient monitoring and consider treatment (oxygen, fluid challenge) 4. Record all actions in patient notes

Appendix 4

Escalation Process for Paediatric EWS Protocol Messages

Low 0,1,2,3,4	• If concerned about the patient discuss with NIC • Consider Medical Review • ACP Status • Document Actions
Medium 5,6	• Discuss with NIC • Consider Medical Review within 30 minutes • ACP Status • Document Actions
High 7,8	• Discuss with NIC • Recommend Medical Review within 30 minutes • Consider Continuous Monitoring • Consider Calling Consultant • ACP Status • Document Actions
Critical 9 +	• NIC to attend • Recommend Immediate Medical Review • Consider Continuous Monitoring • Consider Calling Consultant • Consider Calling KIDS Team • Consider 2222 • ACP Status • Document Actions

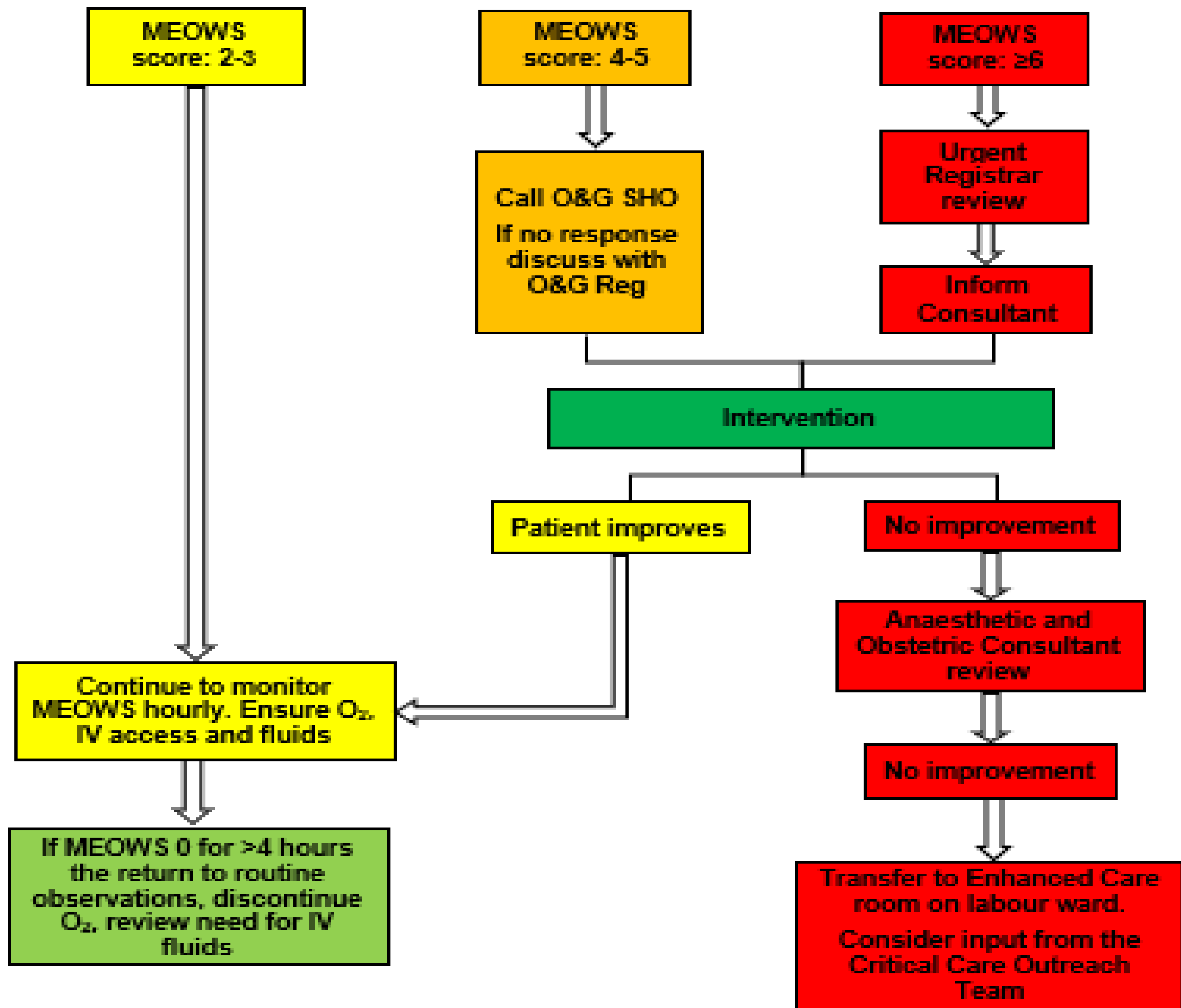
Appendix 5

Escalation Process for Emergency Department

Emergency Department Track & Trigger		
NEWS 2 score	Frequency of monitoring	Clinical Response
0	Minimum 4 hourly	• Repeat Obs prior to discharge
1 - 4	Repeat Obs within 1 hour	• RN to decide whether increased frequency of monitoring and / or escalation of care is required
3 in a single parameter	At least 1 hourly	• RN to inform senior clinician who will review and decide whether escalation is necessary. • Consider sepsis screen • Plan documented
Total 5 or more Urgent response threshold	½ hourly Obs unless clinically indicated	• RN to immediately inform senior clinician who will review and decide whether escalation is necessary. • Patient to be moved into resus or an observable majors cubicle. • Perform sepsis screen • Plan documented
Total 7 or more Emergency response threshold	Continuous monitoring in resus or a visible cubicle	• RN to immediately inform the ED consultant (*Reg between 2am – 8am*) who will review and decide whether escalation is necessary. • Patient to be moved to resus or an observable majors cubicle • Perform sepsis screen • Plan documented

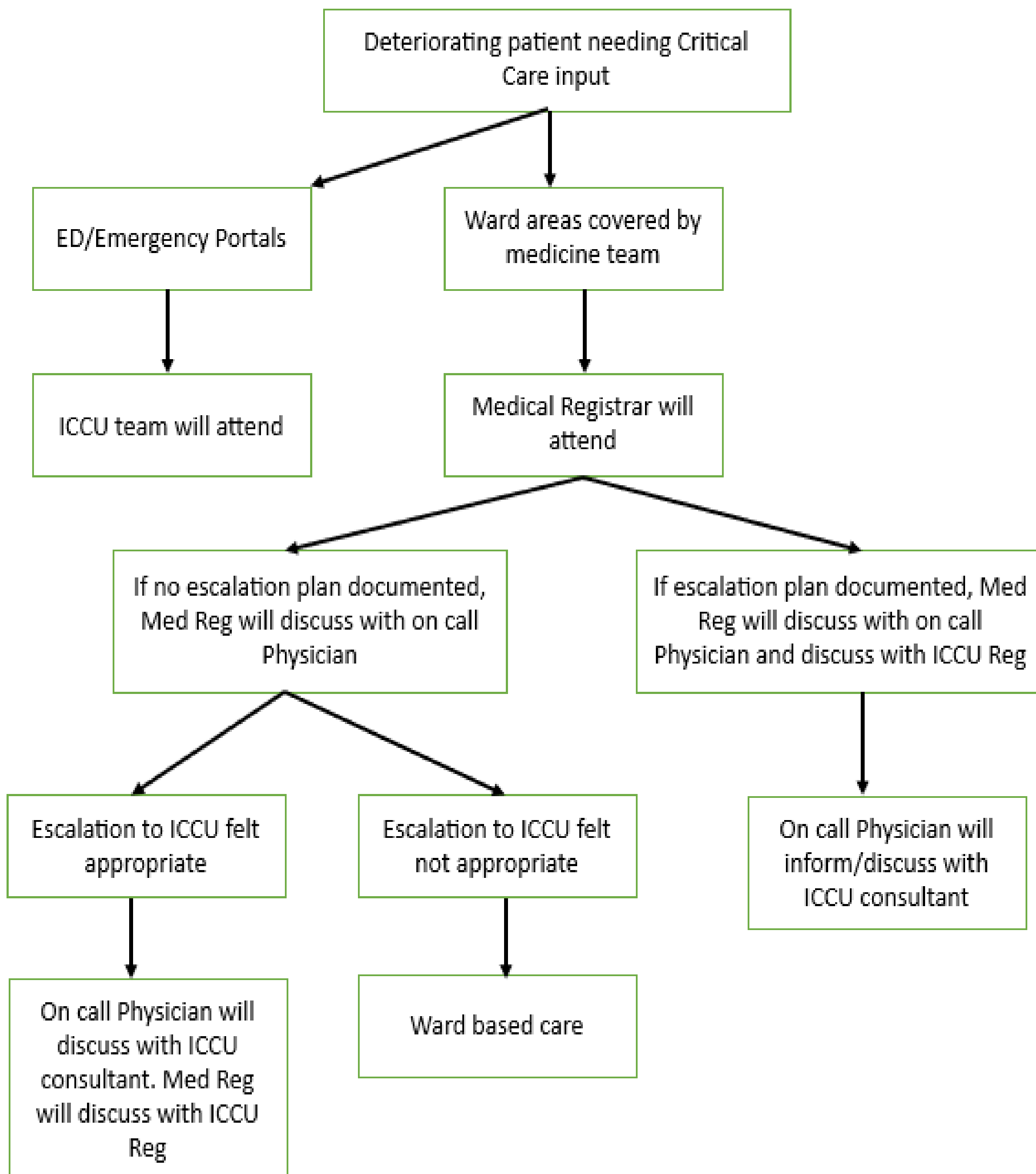
Appendix 6

Modified Early Obstetrics Warning Score (MEOWS) Flowchart and Referral Guideline



Appendix 7

Escalation process for deteriorating patient on medical wards requiring critical care input



The Royal Wolverhampton
NHS Trust

Appendix 8

Deteriorating Patient Concern Stickers For NEWS2

NHS:	
HSP:	Affix small label here
DOB:	
Name:	
Gender:	

The Royal Wolverhampton
NHS Trust

Deteriorating Patient Concern

NEWS2 Score:............................ Time:...................... Date:........................

Detail of concern:

Escalated to: ....

Escalated by: Name:........................... Signature:....................................

Designation: .... Time:............... Date:..................

Reviewed by: Name:........................... Signature:....................................

Designation: .... Time:............... Date:..................

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Appendix 9

CareFlow Vitals Standard Operating Procedure (Adults)

1.0 Procedure Statement (Purpose / Objectives of the Procedure)

This operational procedure explains the process to follow when using CareFlow Vitals (previously Vital PAC) to ensure continuity of observations and promote patient safety for adults. This procedure must be read in conjunction with the listed references.
For use of CareFlow Vitals in Paediatrics please refer to CareFlow Vitals Standard Operating Procedure (Paediatrics).

CareFlow Vitals is a set of applications that has the following functions.

- Captures clinical data on portable hand-held electronic devices in real-time at the point of care.
- Enables analysis and charting of the captured clinical data. This can be accessed via the hospital intranet on desktop PCs, Computer on Wheels (COWS) or tablet devices.
- Provides real-time analysis, reporting and diagnosis to monitor ward working practices. (CareFlow Vitals performance)
- Improves the safety of the acutely ill patient by addressing NCEPOD, NPSA and NICE recommendations. CareFlow Vitals is designed to improve the daily clinical processes of observation-taking, early warning scoring and appropriate escalation.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Accountabilities

This standard operating procedure is applicable to all clinical staff that record, document or review assessments and observations recorded via Vitals.
All areas of the trust have access to the CareFlow Vitals to undertake patient assessments and observations except for:

- Obstetrics.
- Emergency Department.
- ICCU (Limited use for VTE assessment whilst on ICCU and for patient assessment and observations prior to transferring to another ward).

3.0 Procedure/Guidelines Detail / Actions

Recording of Observations:

The registered practitioner caring for the patient is responsible for Early Warning Score observations to be completed in a timely manner. To prevent overdue observations, ensure observation times are known and communicated at handover and during the shift with colleagues. The frequency of observations reflect the clinical condition of the patient, that staff have the knowledge and skills to perform and record EWS observations and equipment is available and in good working order to record observations.

Physiological observations should be monitored at least every 12 hours unless a decision has been made at a senior level decrease this frequency for an individual patient (NICE 2007). If using Vitals an algorithm of frequency of NEWS2 observations is generated based on NEWS2 score. Observations consist of pulse rate, temperature, blood pressure, respiratory rate, conscious level (ACVPU score), oxygen saturation

(SpO2), oxygen (flow rate and mask type), urine output, pain score, nausea score, vomiting score and bowel movements (Bristol Stool Scale).

On admission, on transfer, on change of condition or following a fall, lying and standing observations must be recorded.

The recording of observations for patients who are at the end of life must be reviewed and discontinued unless there is clear rationale for their ongoing requirement and the 'No monitoring' option 'End of Life' selected.
CareFlow Vitals Early Warning Score (NEWS2)
NEWS2 is automatically calculated by the system using the individual scores for temperature, pulse rate, respiration rate, blood pressure, oxygen saturation, supplemental oxygen needs and conscious level (ACVPU score). CareFlow Vitals has a dedicated section (SpO2 Scale 2) for use in patients with hypercapnic respiratory failure (Type 2 Respiratory Failure) who have clinically recommended oxygen saturation of 88–92%. Scale 2 must only be used in patients confirmed to have hypercapnic respiratory failure on blood gas analysis on either a prior, or their current hospital admission.

The Early Warning Score assists in the identification of deteriorating patients by tracking physiological observations and provides a predetermined graded response that includes the frequency of observations and escalation to an appropriately trained member of staff. The current Early Warning Score is displayed on the Teletracking RTLS board if observations are recorded on Vital Pac.

The importance of considering sepsis in patients with known or suspected infection, or at risk of infection, is emphasised. The CareFlow vitals protocol messages will direct the user in accordance with the Risk category.

If a patient's observations cannot be recorded, the 'U' (un-measurable) button must be tapped and the reason for this selected. Options are patient condition, patient refusal, equipment, or other reason. If patient condition is selected, a score of 3 for that NEWS2 element is automatically added (2 for Temperature). If any other reason is selected, the calculated EWS is displayed with a '+' against the value to highlight that the patient's condition/early warning score may be worse/higher than the score suggests.

3.1 Observation Settings, deviation from the Trust Protocol:
Once a set of observations has been recorded, CareFlow Vitals presents them as a summary chart with the ability to edit the values entered. The user MUST check the chart for accuracy before submitting the observations.

CareFlow Vitals will then generate an alert screen, informing the user of the current Early Warning Score (EWS), assists detection of the deterioration in a patient's condition and what action, if any, needs to be taken for the patient.

If a user's clinical judgement dictates a deviation from hospital protocol as displayed on CareFlow Vitals, the reason for this must be clearly documented in the clinical records by the medical staff or nurse in charge.

If a health care professional deems it clinically appropriate to have less frequent observations than is identified by the protocol such as 8, 12 hourly, or no observations,

the health care professional can set this in observation settings for example, if a patient is deemed Medically Fit for Discharge and their Early Warning Score is 0, the setting can be changed to 12 hourly (this setting is in the Limited monitoring section). An audit log is maintained on the handheld device and in CareFlow Vitals ADMINISTRATOR to identify this change from protocol.

Protocol monitoring 4 hours
Set by: Vitals, 05-Oct-2021 09:59

HISTORY

No recent history

15 min

30 min

1 hour

2 hours

3 hours

4 hours

8 hours

12 hours

24 hours

End of life care

Alternative monitoring in place

No monitoring required

Requested by consultant

Requested by nurse in charge

Limited monitoring 12 hours
Set by: AT, 17-Dec-2021 12:03

HISTORY

17-Dec-2021 12:03, AT, Limited 12 hours

Each time an observation is taken, the user will be prompted to either keep with the longer interval or to shorten it in accordance with the latest Early Warning Score.

It is also possible for the user to increase the frequency of observations, for example for a patient who has returned from a procedure. This is done via Patient options>observation settings.

3.1.1. NEWS$_2$ Scale 2
CareFlow Vitals has a dedicated section (SpO2 Scale 2) for use in patients with hypercapnic respiratory failure (Type 2 Respiratory Failure) who have clinically recommended oxygen saturation of 88–92%. Scale 2 must only be used in patients confirmed to have hypercapnic respiratory failure on blood gas analysis on either a prior, or their current hospital admission.

3.1.2. Partial Observation
Users can choose to take a small subset of the standard observation set. These “partial observations” can be taken at any time until it is near to the time a full set of observations is due. In this case CareFlow Vitals will prompt the user to complete a full set of observations.

3.1.3. Overdue Observations

The time until the next observation is due is shown with the patient’s name on all applications. An orange clock will indicate that the observation is overdue by 10% of observation timed interval for observations over 60 minutes.

A red clock will indicate that the observation is overdue by a third % of observation timed interval.

Users and Senior Sisters/Charge Nurses will monitor these clocks regularly to ensure optimal safety of patients and avoidance of late observations.

3.1.4. Patient is ‘off the ward’:
Where a standard set of observations is overdue and cannot be taken because the patient is off the ward, the user must record this by clicking on the clock or by selecting ‘off ward’ in ‘patient options > bed location’ on the handheld device. The user must then consult the Registered Health Care Professional to alter the monitoring interval to ‘No monitoring’ required or ‘Alternative monitoring’ in place. When discharging a patient who has been ‘off ward’ the patient must be put back on ward and discharged through PAS.

The user must ensure that the patient has the ‘off ward’ setting removed upon returning to the ward and the monitoring option is amended to protocol monitoring.

3.1.5. Special Observations
Special observations MUST be recorded in accordance with the patient’s medical condition or in accordance with the relevant Trust Policies. These observations can be recorded at any time using the handheld devices and can be accessed through observation/assessment and then by selecting the options screen.

3.1.6 Incorrect Log in Details
If the user has forgotten their PIN or enters their PIN incorrectly a warning will appear. Upon the second incorrect PIN entry, a warning message will appear stating that a third

wrong attempt will lock the handheld device. If this happens, the user account and the handheld device will be locked, and the user will be unable to search for their name.
The handheld device can be unlocked by another user successfully logging in although the first user's account will remain locked.

If the second user incorrectly logs in on their first attempt (4th attempt on the handheld device), the handheld device will remain locked for all users and will require system administration to unlock the handheld device.

3.17 Logging Out

A user must always logout after they have finished using CareFlow Vitals to maintain security for the user and that of the system. The Trust's IT security policy gives further details on how the organisation manages system security.

For any issues regarding logins or access thereafter the IT Department MUST be contacted on extension 8888.

3.2 Sepsis Module

The Sepsis module is triggered by a patient's vital observation when they have a qSOFA score of 2 or more; an individual NEWS2 score of 3; or an aggregate NEWS2 score of 5 or more. It can also be selected manually from the patient observations list within the patient screen if there is clinical suspicion of sepsis. If after completing the sepsis risk assessment the patient is found to be at moderate to high risk of sepsis, the sepsis six checklist will be triggered and will be available in the patient observations due now list. All parts of the sepsis six checklist will need to be completed by recording the time and date those steps were performed.

3.3 Nutritional Screening

Nutrition screening is an essential element of patient care - it assists the identification of those patients with or at risk of malnutrition (MUST Score). Patients at high or medium risk should then have an appropriate plan of nutritional care to help treat malnutrition or prevent deterioration of their nutritional status. The screening should be completed by the Registered Health Care Professional or students under their supervision.

Once the user has recorded The MUST score for the first time, they will then be prompted by the handheld device to weigh and the patient on a weekly/daily basis depending on patient need. If there has been a change in the patient's condition that would impact on their nutritional status the patient can be rescreened at any time by scrolling down the new observation/assessment screen and selecting nutritional screening. As before, opting to do this later will generate a reminder each time a set of observations is recorded.
Height and Weight MUST be recorded as part of the Nutritional Screening Module.

3.4 Inserting a New Peripheral Venous Cannula (PVC)

The insertion of a new cannula, where possible, will be recorded by the member of staff who inserted the cannula. The insertion point, date and time, reason for cannulation, gauge and use of dressing are recorded on CareFlow Vitals. In the event of medical staff inserting the cannula, the registered health care professional caring for the patient will enter these details.

3.4.1. Checking a Peripheral Venous Cannula (PVC)

CareFlow Vitals prompts the routine VIP Score checking of the cannula site every 8 hours. The Registered Health Care Professional or students under their supervision will complete the

cannula check on CareFlow Vitals and review the new VIP score and new time for checking or removal.

3.4.2. Removing a Peripheral Venous Cannula (PVC)
Staff must record the routine removal of the cannula on CareFlow Vitals. If the removal of the cannula is prompted but not completed, staff will record the reason for not removing the cannula on CareFlow Vitals.

3.5 Urinary Catheter Module:
This will be completed when the patient has a urinary catheter inserted or on admission for patients with long standing catheters. CareFlow Vitals will prompt assessments relating to the Catheter Care Bundle.

Urinary Catheter - Removal Breach Times

- Short term PVC catheters 7 days
- Medium term PTFE coated latex catheter – 28 days
- Silicone/suprapubic catheter – 84 days
- 3-way irrigation catheter – 7 days
- Urinary sheath – 10 days

3.6 Venous Thromboembolism (VTE) Risk assessment
CareFlow Vitals VTE Risk Assessment requires that all patients are risk assessed for VTE and that preventative treatment is prescribed, as necessary.

Completion of VTE Risk Assessment
VTE Risk Assessment must be completed as per the policy CP58 Prevention and Treatment of Venous Thromboembolism (VTE) using CareFlow Vitals Ward or CareFlow Vitals Clinical by the Clinical Team.

Confirmation of Prophylaxis
Following the risk assessment, and when prompted, clinical staff will confirm that the VTE preventative treatment has been prescribed and mechanical treatment fitted where clinically indicated.

Monitoring and Review of Prophylaxis
CareFlow Vitals will display alerts to indicate when the VTE risk assessment is due, overdue or requires prophylaxis confirmation. Responsibility for the completion and review of VTE risk assessment is detailed in CP58.

3.7 Pain Assessment Module:
If a patient's pain score is 2 or more, pain assessment is removed from standard observations and the Pain Assessment module is entered.
Pain Assessments will now be due hourly and are directly linked to the standard observation time/clock. On the handheld device a patient list, will show a circular 'Pain' task icon against the patient's name – white if due, amber if overdue and red if breached.
Any patient with Patient Controlled Analgesia or an epidural is to be assessed using the appropriate observations required on the CareFlow Vitals.

3.8 Neurological Observations
A competent registered practitioner must complete all neurological observations. E-Learning training must have been completed before undertaking neurological observations.
Neurological observations must be recorded simultaneously with NEWS2 observations which

include pulse rate, temperature, blood pressure, respiratory rate, conscious level, oxygen saturation (SpO2) oxygen (flow rate and mask type). Please refer to Neurological Observations Guideline for the indication and frequency of neurological observations to be completed. Under no circumstances neurological observations are omitted if the patient is asleep.

3.9 Incorrect Recording of Observations

If an incorrect standard or special observation has been entered, some clinicians with permissions can strike through the last observation taken on the handheld device if it was taken within the past two days. After that time, or if any observation apart from the last one needs to be struck through, a request for a strike through MUST be put to the Senior Sister/Senior Charge Nurse/Sister/Charge Nurse who can make the strike through on CareFlow Vitals ADMINISTRATOR.

Only a standard or a special observation can be struck through on the handheld device. Any additional observations such as height, weight or cannula observations can only be struck through on CareFlow Vitals Administrator by the Senior Sister/Senior Charge Nurse/Sister/Charge Nurse.
In such cases, full details must be given to the Ward Manager/Sister to ensure the correct observations are removed. The following information must be recorded in the patient health record.

- Full details of patient including forename, surname, hospital or NHS number, hospital, and ward.
- Full details of observations including precise date and time plus the type of observation.
- The reason the observation needs to be struck through (either wrong patient or wrong data).
- Full details of any hardware including HANDHELD DEVICE asset number which can be located in settings on the device.
- The full name of the user who has made the incorrect entry.

Any struck through observations can clearly be seen on all charts throughout all CareFlow Vitals applications, a strike through report for each patient can also be printed.

3.10 Transfers, Discharges and Transfers Off the Ward

Early Warning Score observations must be recorded within 30 minutes prior to transfer to ensure the most up to date observations and score are available and appropriateness of the transfer.

Investigation and Procedures off the Ward

When a patient leaves a CareFlow Vitals ward for investigations or a procedure in a location where CareFlow Vitals is not used the patient MUST be marked as off-ward by the Registered Health Care Professional within the patient options > bed location setting on the handheld device. The Registered Health Care Professional must then amend the monitoring option to ‘No monitoring required’ or ‘Alternative monitoring’ in place. The user must ensure that the patient has the ‘off ward’ setting removed upon returning to the ward and the monitoring option is amended to protocol monitoring. Ensure the patient setting of ‘off ward’ has been removed back onto ‘on ward’ prior to discharging a patient from the PAS system.

Transfers to a Non-Vital PAC Ward

When transferring a patient from a CareFlow Vitals to a non-CareFlow Vitals ward, a full set of

observations charts MUST be printed off via CareFlow Vitals clinical. These must be sent to the receiving ward along with the patient's case notes.

The patient's transfer MUST be recorded on the Trust's patient administration system. The receiving ward can continue to record observations on the chart printed by CareFlow Vitals.

Patients transferring from critical care to a CareFlow Vitals Ward will record the last two set of standard and special observations taken on critical care prior to transfer of the patient to the CareFlow Vitals ward.

When transferring a patient between two CareFlow Vitals wards, the transferring Health Care professional informs receiving area of current NEWS2 score using the SBART transfer form. There is no need to print off observation charts.

When the patient is transferred on the patient administration system (PAS), the Health Care Professional on the receiving ward will amend the bay and bed information on CareFlow Vitals on the handheld device.

Finding a Patient Following Transfer of Wards

It is important that the patient is admitted using PAS and after confirming this then search for the patient.

If the patient is not yet on the receiving ward patient list, this is probably because the patient administration system has not yet been updated. In this case the user MUST search for the patient on CareFlow Vitals on the handheld device using the hospital or NHS number.

Once found, a new observation can be recorded, or the patient allocated a bed without recording observations at this time. From this point on the patient will be displayed on the new ward within all CareFlow Vitals applications.

Note: If no subsequent observations are recorded for the patient within the next 30 hours, CareFlow Vitals assumes the patient has been selected in error and will remove the patient from CareFlow Vitals lists for that ward. To remove the patient from the CareFlow Vitals ward list before the 30 hours are up, contact IT Helpdesk on 88888.

3.10.1 Escalation if unable to enter observations on Vitals

If a patient is unable to be located on Vitals or observations entered against that patient, this must be escalated immediately to the nurse in charge. Record the observations on approved EWS chart. Report incident to Information Technology and report the inability to record observations on Vitals on DATIX.

3.11 Discharging from a CareFlow Vitals Ward

On a patient's discharge, transfer to the discharge lounge or death use the no monitoring option in the settings to ensure the system does not continue to require the data.

When a patient is being discharged to another hospital, a full set of observation charts for the patient's stay on the ward must be printed out and inserted in the patient medical notes. It is not necessary to print out the observation chart if the patient is being discharged home or if they are deceased as the information is stored electronically.

The patient MUST be discharged from the ward via the Trust's patient administration system

(PAS). This ensures the patient is then removed from the patient list on CareFlow Vitals.

3.12 Opening and Closing of Clinical Areas

When new clinical areas are established or de-established that Vitals and other key systems are updated.

4.0 Equipment Required

Observations and assessments will be entered onto Vital Pac via a handheld device. VTE assessments will be completed via computer on wheels or static computer. If observations or assessments cannot be recorded due to equipment issues this must be reported to the nurse in charge, record observations on paper and report on DATIX.

4.1 Care of Equipment

Handheld devices and Computers on Wheels (COWs) will be cleaned regularly (after each use) with detergent wipes to minimise the risk of contamination and cross infection.

4.2 Recharging the Handheld Devices

The handheld device has about three to four hours of battery life.

The handheld device must be replaced on the charger when not being used to ensure that it remains fully charged and available for use. Users MUST not wait until the handheld device alarms to charge it. Users must ensure that the orange charging light of the handheld device lights up when on charge.

Users can easily see the level of charge remaining on the handheld device when put back on charge with the CareFlow Vitals Battery screen saver. The charge level is also shown through the battery icon at the top of the screen – it is green if the handheld device is charged and red/orange if the charge is low. Tapping on the icon will display the precise percentage of battery life left.

The handheld device can be used until it reaches 20% of battery charge. Below this level, the handheld device cannot be used until it is recharged back to 20%.

A ratio of one device to enter observations and assessments for every six patients is recommended where this drops below 50% availability of devices this is escalated to nurse in charge and ward/unit manager and reported on DATIX.

The handheld device and manufacturer's recommended charger will be in the allocated cupboards provided on the ward. The number of devices will be observed and signed for at the beginning of each shift (Appendix 1).

4.3 Recharging Computers On Wheels (COWS)

Computers on Wheels will be plugged into a socket following use to allow recharging.
After completing the task on the COWS or CareFlow Vitals the user must log out of the device to maintain confidentiality.

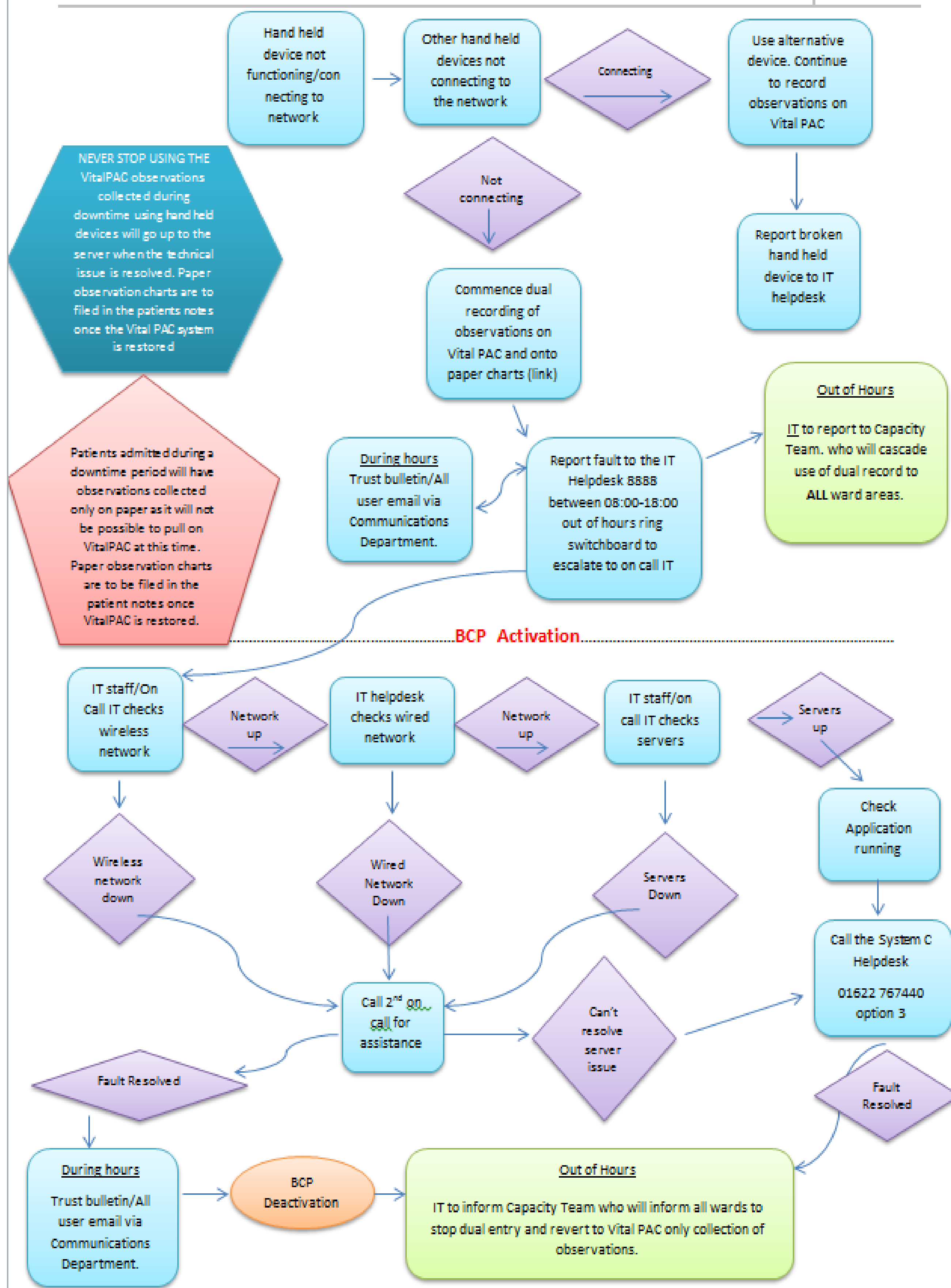
4.4 Faulty Equipment

Faulty equipment will be reported to IT.

Should CareFlow Vitals not be available to access all users must resort to the paper copy appropriate to their hospital. The protocol messages are different for each hospital, so it is

important to print out the correct form.

See Links for each hospital or Trust Intranet:
New Cross Hospital
Cannock Chase Hospital
West Park Hospital


Business Continuity Plan for Vital PAC
2019
Hand held device not functioning/connecting to network
Other hand held devices not connecting to the network
Connecting
Use alternative device. Continue to record observations on Vital PAC
Not connecting
Report broken hand held device to IT helpdesk
NEVER STOP USING THE VitalPAC observations collected during downtime using hand held devices will go up to the server when the technical issue is resolved. Paper observation charts are to filed in the patients notes once the Vital PAC system is restored
Commence dual recording of observations on Vital PAC and onto paper charts (link)
Out of Hours
IT to report to Capacity Team. who will cascade use of dual record to ALL ward areas.
Patients admitted during a downtime period will have observations collected only on paper as it will not be possible to pull on VitalPAC at this time. Paper observation charts are to be filed in the patient notes once VitalPAC is restored.
During hours
Trust bulletin/All user email via Communications Department.
Report fault to the IT Helpdesk 8888 between 08:00-18:00 out of hours ring switchboard to escalate to on call IT
BCP Activation
IT staff/On Call IT checks wireless network
Network up
IT helpdesk checks wired network
Network up
IT staff/on call IT checks servers
Servers up
Check Application running
Wireless network down
Wired Network Down
Servers Down
Call the System C Helpdesk
01622 767440 option 3
Call 2nd on call for assistance
Can't resolve server issue
Fault Resolved
Fault Resolved
During hours
Trust bulletin/All user email via Communications Department.
BCP Deactivation
Out of Hours
IT to inform Capacity Team who will inform all wards to stop dual entry and revert to Vital PAC only collection of observations.

5.0 Training

The Trust induction for Nursing and Health Care Assistant staff includes:

- Completion of My Academy CareFlow Vitals and Royal College of Physicians NEWS2 eLearning.
- CareFlow Vitals Training provided by the IT department.
- Observation competency completed by Health Care Assistants on their ward/department following completion of training. The Trust induction for medical staff includes CareFlow Vitals training via the Postgraduate team.
- Access and user issues to CareFlow Vitals is via the IT department and some clinicians with permissions on the ward and departments. Nursing and Health Care Assistant staff complete the Medical Device Self Competency form and identified training is provided by the Medical Devices department prior to using Careflow Vitals for the recording of observations. Clinicians with permissions on wards and departments and the IT department provide Usernames and PIN number for staff and can assist with access issues.
- All staff MUST only use their own username and PIN number to access and utilise CareFlow Vitals.

6.0 Financial Risk Assessment

	Does the implementation of this document require any additional Capital resources	No
	Does the implementation of this document require additional revenue resources	No
	Does the implementation of this document require additional manpower	No
	Does the implementation of this document release any manpower costs through a change in practice	No
	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programs or allocated training times for staff.	No
	Other comments	

7.0 Communication and Training

Summary of key changes to this procedure will be circulated via communications. All nursing and health care support workers will be expected to complete training as part of induction either face to face and/or My Focus which is mandatory. All health care support workers must in addition must complete an early warning score competency document (Appendix 2). Vitals face to face training occurs twice weekly and can be accessed via contacting IT or Nurse Education team.

8.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Evaluation
Handheld devices are in good working order and numbers are in line with 1:6 ratio of patients	Ward managers/matrons/quality team	Leadership audit	Monthly	To be reviewed at Deteriorating Patient Group (DPG)
Scale 2 audit – appropriateness of patients with Hypercapnic respiratory failure	Quality team	Scale 2 audit	Quarterly	To be reviewed at DPG
Appropriate escalation of the deteriorating patient	Ward managers/matrons/quality team	Excellence in care audit	Monthly	To be reviewed at DPG

11.0 References - Legal, professional or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

CP61 Management of the Deteriorating Patient

CP11 Resuscitation Policy

CP17 Identification and management of Patients at risk of Under Nutrition

CP 58 Prevention and treatment of venous thromboembolism (VTE)

IP03 Prevention and Control of MRSA, VRE and other Antibiotic Resistant Organisms

IP08 Infection Prevention Operational Policy

NICE Guideline CG 50 – Introduction | Acutely ill adults in hospital: recognising and responding to deterioration | Guidance | NICE

NICE Guideline CG 31- Overview | Care of dying adults in the last days of life | Guidance | NICE

OP07 Health Records Policy

OP10 Risk Management and Patient Safety Reporting Policy

OP12 IT Security Policy

OP13 Information Governance Policy

OP41 Induction and Mandatory Training Policy

Guideline on Frequency of Neurological Observations
Guideline_Frequency_Neurological_Observation.pdf (xrwh.nhs.uk)

Links:
http://intranet.xrwh.nhs.uk/departments/preventing_harm_campaign/deteriorating_patient/vital_pac.aspx

Part A - Document Control

Procedure/ Guidelines number and version Version 4.0 CP61 – Appendix 9	**Title of Procedure/Guidelines** CareFlow Vitals Standard Operating Procedure (Adults)	**Status:** Final		**Authors:** Katrina Creedon Dr Yat Wah Li **For Trust-wide Procedures and Guidelines Chief Officer Sponsor:** **Chief Medical Officer (BM)**
Version / Amendment History	Version	Date	Author	Reason
	1	Jan 2018	Matron Karen Wooding	Development of SOP
	2	Dec 2019	Dr Yat Wah Li	Amends to SOP
	3	Jan 2022	Dr Yat Wah Li /Kuldip Feist/Katrina Creedon	Amends to SOP to reflect updates in practice
	4	Feb 2022	Katrina Creedon Dr Yat Wah Li	Amends to SOP to reflect updates in practice
Intended Recipients: Health care support workers involved in recording observations following completion of a competency Health Care Professional involved in recording or reviewing observations and assessments in Vitals modules				
Consultation Group / Role Titles and Date: Deteriorating Patient Group February 2023				
Name and date of group where reviewed		Deteriorating Patient Group – Feb 2023 Trust Policy Group – June 2023		
Name and date of final approval committee(if trust-wide document)/ Directorate or other locally approved committee (if local document)		Trust Management Committee – June 2023		
Date of Procedure/Guidelines issue		July 2023		
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)		June 2026		

Training and Dissemination: Summary of changes to standard operating procedure will be shared with communications team for circulation including information on training to support	
To be read in conjunction with: CP61 Management of the Deteriorating Patient CP11 Resuscitation Policy CP17 Identification and management of Patients at risk of Under Nutrition. CP 58 Prevention and treatment of venous thromboembolism (VTE) IP03 Prevention and Control of MRSA, VRE and other Antibiotic Resistant Organisms IP08 Infection Prevention Operational Policy NICE Guideline CG 50 – Recognition of and response to acute illness in adults in hospital NICE Guideline CG 31- Care of dying adults in the last days of life OP07 Health Records Policy OP10 Risk Management and Patient Safety Reporting Policy OP12 IT Security Policy OP13 Information Governance Policy OP41 Induction and Mandatory Training Policy OP98 Data Protection Policy Clinical guideline for the frequency of Neurological Observation recording in adults Links:http://intranet.xrwh.nhs.uk/departments/preventing_harm_campaign/deteriorating_patient/vital_pac.aspx	
Initial Equality Impact Assessment: Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Management Officer 85887 for Trust- wide documents or your line manager or Divisional Management office for Local documents.	
Contact for Review	Katrina Creedon and Dr Yat Wah Li
Monitoring arrangements	Dashboard of audit results presented at Deteriorating Patient Group
Document summary/key issues covered. Standard operating procedure on use of Vitals in relation to record observations and assessments, frequency of observations, use of NEWS2 scale 2, maintenance of equipment and training in use of Vitals.	

Key words for intranet searching purposes	Vitals, Vital PAC, observations, NEWS2, Scale 2

Appendix 9 - Attachment 1

Month: _______________
Ward: ________________

Vitals Device Checklist - Ratio 1 Device = 6 patients

- If number of devices falls below 3 escalate to ward manager; incident report **Please check twice daily @ shift handover.**
- Check the case insitu. Check device is clean? Per IPC Protocol Is it fully charged using appropriate cable? Inappropriate cables drain battery and damage device. If faulty – Decontaminate - Remove from Use If any are missing contact nurse in charge for the shift.

Date	Number of devices	Am Time	Sign	Print	Number of devices	PM time	Sign	Print
1st								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
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27th								
28th								
29th								
30th								
31st								

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust
Care Colleagues Collaboration Communities

RECORDING PHYSIOLOGICAL OBSERVATIONS COMPETENCY FOR HEALTHCARE SUPPORT WORKERS

1. Summary	For Healthcare Support Workers (HCSW's) Bands 2 to 4 (not applicable to Nursing Associate as covered in their training), to demonstrate competence in recording physiological observations through knowledge, skills demonstration and application. Competency is expected to be achieved within **1** month of completion of physiological observations training on the HCSW induction programme. Competency achievement is required before the HCSW is able to measure and record patient observations unsupervised.
2. Scope	For measuring and recording respiration rate, oxygen saturations, blood pressure (using electronic equipment), heart rate, urine output measurement, consciousness level (ACVPU), temperature and pain assessment.
3. Applicable	To HCSW's Bands 2 to 4 required to undertake recording of physiological observations as part of their clinical role.
4. Related Policy and Legislation	**All relevant policies/ procedures at Royal Wolverhampton NHS Trust. All current policies and procedures are on the Trust intranet site. You must always ensure you refer to the most recent policy available.** CP61 - Management of the Deteriorating Patient CP11 - Resuscitation Policy CP26 - Blood Transfusion CP42a and CP42b - Patient Falls CP57 - Prescription and Administration of Emergency Oxygen in Adults CP05 - Transfer of Patients between Wards, Departments, Specialist Units and Other Hospitals OP10 - Risk Management and Patient Safety Reporting Policy OP41 - Induction and Mandatory Training Policy IP12 – Standard precautions for infection prevention Maternity care record - MEOWS ViEWS chart (New Cross) ViEWS chart (Cannock) ViEWS chart (West Park Only) Paediatric Early Warning system SBARD report on deteriorating adult patients End of life care Critical care outreach operation policy **This list is not exhaustive**
5. Eligible to Assess	A registered healthcare practitioner who is a qualified assessor with either a formal assessor qualification or as a minimum a recognised university based study regarding assessing. The assessor must be able to perform the skill but also be able to teach and role model the stated skill according to the standards set out by RWT policies/procedures and current evidence based practice.
6. Standard to be Achieved	The HCSW must be able to perform the measuring and recording of physiological observations safely and effectively without supervision and demonstrate the underpinning knowledge for each physiological observation procedure.

7. Training Required	Supervised practice and assessment of competence within the clinical setting and completion of trust VITALS training and also completion of medical device training for the physiological observation equipment? Attendance at the HCSW induction programme for unregistered staff. Sessions can be arranged through the Nurse Education Team
8. Method of Assessment	Competency will be established through observation and assessment of knowledge, skills and record keeping within the clinical setting. It is advised that HCSW's perform this skill under supervision in full for a minimum of ten patients and documented, staff who have gained competence in this skill previously but have no evidence of competency document completion, to perform this skill under supervision in full for a minimum of five patients, prior to requesting assessment of competence from a practice assessor. All supervised practice must be documented within the supervised practice log.
9. Author	Nurse Education Team and Quality Team
10. Review Date	2024 or change in clinical practice.

DRAFT

Patient Physiological Observations Supervised Practice Log

It is the responsibility of each HCSW to undertake supervised practice in the clinical setting. You must complete observations in full for a minimum of ten patients.
For HCSWs who completed the skill in another setting, they must complete observations in full for a minimum of five patients. The supervisor will be a competent registered healthcare professional with the knowledge and skills to complete and record observations.
(Additional supervised practice can be recorded on supplementary sheets should you require it)

Date of supervision	**Physiological observations performed**	**Comments**	**Observed by** (print name)	**Signature and designation**

DRAFT

Criteria for achieving competence **To demonstrate competence the practitioner must be able to:-**	**Assessment of Competence (please indicate pass/ fail against each statement)**	**Core questions for knowledge assessment**
Preparation ▪ Demonstrate gathering and checking of equipment ensuring that it is clean and safe to use. ▪ Demonstrate knowledge of specific instructions i.e. regarding observation frequency or if the patient is on comfort observations. ▪ Demonstrate effective communication informing patient of procedure to be performed and introducing self to the patient i.e. "Hello, my name is…" ▪ Demonstrates the correct process in line with Trust policy for confirming patient identification prior to measuring and recording the physiological observation results. ▪ Discuss informed consent in relation to undertaking the recording of physiological observations and the action to be taken if a patient refuses to have their physiological observations undertaken. ▪ Explain the rational for performing physiological observations at the prescribed time and discuss when observations may need to be performed at other times. ▪ Explain why the patient should be at rest when measuring physiological observations and check when last mobile. **Universal Precautions** ▪ Demonstrate the correct procedure for hand decontamination in line with Trust policy. ▪ State when the use of personal protective equipment would be necessary e.g. gloves and aprons.		1. If a patient refused to have their observations recorded what action would you take? 2. If a new blood pressure monitor appeared in your area and you had not received any training to use it, what would you do? 3. Explain what you understand by the following terminology:- ▪ Pyrexia ▪ Apyrexia ▪ Hypothermia ▪ Hypotensive ▪ Hypertensive Tachycardia ▪ Bradycardia ▪ Systolic blood pressure ▪ Diastolic blood pressure ▪ Hypoxia ▪ Hypercapnia 4. Give two reasons for each of the following: (e.g. faster pulse rate - running) ▪ Fast pulse rate ▪ High blood pressure ▪ High temperature ▪ Low oxygen saturations

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▪ Demonstrate cleaning of equipment between patients in line with Trust policy. **Recording Respirations** ▪ Demonstrate the correct procedure for accurately assessing the patients respiratory rate for the required length of time ▪ Explains why the patient should not be aware that respiratory rate is being assessed. ▪ State the parameters for normal respiratory rate. ▪ Discuss additional information that can be obtained from observing the patients respiratory rate i.e. depth, sound, effort of breathing. ▪ Discuss signs of respiratory distress and what action to take. **Recording Oxygen Saturations** ▪ Demonstrate the correct procedure for obtaining oxygen saturation levels. ▪ Demonstrate the correct positioning of the saturation probe to gain an accurate recording. ▪ Discuss probe positioning and why correct probe is necessary and the outcome of not using the correct probe for the site being used. ▪ Identifies the normal parameters for oxygen saturation levels. ▪ Discuss knowledge of specific instructions for alternative saturation ranges i.e. patients on COPD/saturation scale 2. ▪ Discuss the actions to be taken if the oxygen saturations are outside the normal parameters. **Recording Pulse** ▪ Demonstrate the correct procedure for taking a manual pulse for the required length of time. ▪ Discuss why a manual pulse recording is more accurate		5. Identify two types of oxygen delivery systems to deliver oxygen to a patient 6. Why must the pulse rate be taken for 60 seconds? 7. What factors can affect the heart rate? 8. What is the most common cause of an irregular pulse?

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▪ Discuss what other elements are being assessed other than pulse rate when palpating the pulse which is not able to be assessed using pulse oximeter or blood pressure monitor. ▪ Identifies the normal parameters for pulse rates. ▪ Discuss the actions to be taken if the pulse rate is outside the normal parameters and/or the pulse rate is not regular. **Recording Blood Pressure** ▪ Discuss factors to consider before performing a blood pressure on specific patients i.e. contraindications. ▪ Demonstrate the correct position for placing the cuff on patient's limb. ▪ Discuss how to ensure the cuff size is correct for the intended patient. ▪ Demonstrate the correct procedure for obtaining a blood pressure. ▪ Identifies the normal parameters for systolic and diastolic blood pressure. ▪ Discuss the actions to be taken if the blood pressure is outside the normal parameters. ▪ Explains the rationale and contraindications for carrying out a lying and standing blood pressure. ▪ Demonstrates the ability to safely perform a lying and standing blood pressure. **Recording Consciousness Level (ACVPU)** ▪ Recalls what ACVPU stands for. ▪ Discuss how to assess each element of the ACVPU tool to accurately assess level of consciousness. ▪ Demonstrate the ability to assess the patient's level of responsiveness. ▪ Discuss the actions to be taken if consciousness level was decreased.		

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Recording Temperature ▪ Demonstrate the correct procedure for obtaining a patients temperature. ▪ Identifies the normal parameters for body temperature. ▪ Discuss the actions to be taken if the temperature is outside the normal parameters. **Documentation** ▪ Demonstrate correct information required on observation chart i.e. patient details, correct date and time. ▪ Demonstrate documentation if patient is on room air or oxygen therapy. ▪ Demonstrate clear and precise recording of patient's observations on the physiological observation chart. ▪ Discuss the importance of clear, timely and accurate recording of patient observations at the point of care. ▪ Demonstrate documentation of patients urine output. ▪ Demonstrate documentation of patients pain score using the Trusts pain assessment tool. **Early Warning Scores** ▪ Identify the Early Warning Score (EWS) used in the clinical setting. ▪ Identify the physiological observations which constitute a full set of physiological observations and provide an EWS. ▪ Demonstrate correct calculation of EWS score. ▪ Discuss the significance of the EWS score. ▪ Discuss the action to be taken in relation to EWS score and associated EWS triggers for escalation. **Reporting and Escalation Process**		9. If the patient has not passed urine in the last 6 hours what would you do? 10. How often must you document the patient's pain score? 11. State the observations you need to measure to generate an early warning score? 12. List 3 signs of poor circulation? 13. What score would alert you to consider 'Sepsis'?

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▪ Demonstrate the correct process for reporting physiological observations you have measured and recorded, to include who you would report to, what you need to report, how you would report and when to escalate. **Knowledge** ▪ Discuss the principles of soft signs of deterioration and application of the look, listen and feel approach when undertaking physiological observations. ▪ Discuss what is normal for the patient in relation to 'normal parameters'. ▪ Demonstrate decontamination, recharging and replacing equipment after use.		

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Completion of Competence

This is to state that ………………………………………………… has passed the **Recording of Physiological Observations Competency for Healthcare Support Workers** within the standards set by RWT on …………………. (date).

This has incorporated the individuals ability to:

- Demonstrate the correct procedure of accurately measuring and recording:
    - respiratory rate
    - oxygen saturations
    - blood pressure
    - pulse rate
    - level of consciousness
    - temperature
    - Early Warning Score
    - Urine output
    - Pain score

    - Report and escalate physiological observations to the registered healthcare professional staff as required

First Attempt: Pass ☐ Fail ☐ Second Attempt: Pass ☐ Fail ☐

If failed on second attempt, please refer to Nurse Education Or Clinical Practice Education Facilitator

I confirm that at the point of assessment the member of staff has met all the required assessment outcomes within the competency document.
Assessor Name…………………………………….. Date ……………………………….
Assessor Signature………………………………. Stamp ……………………………………….

I confirm that I accept my responsibility and accountability with regard to Recording Physiological Observations as outlined in the competency document and in line with Trust policies and procedures..

Staff Name…………………………………….. Date………………………………
Staff Signature……………………………….. Stamp……………………………………….

COPY TO BE PLACED ON PRACTITIONER'S PERSONAL FILE

Evidence of completion to be entered on to Kite/My Academy
If area of practice has Vitals Completion of Vitals eLearning will be issued on completion of Vitals training

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