

ADULT PATIENT OBSERVATION POLICY	Type: Clinical Guidelines Register No: 10080 Status: Public
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Consulted With:	Post/Committee/Group:	Date:
Katherine Rowe	Consultant ITU	22.06.2018
Rebecca Martin	Consultant Anaesthetics	22.06.2018
Daniel Spooner	Deputy Director of Nursing	22.06.2018
Ellie Makings	Chief Medical Officer	22.06.2018
Helen Clarke	Head of Governance	22.06.2018
Ian Edwards	Trigger Response Team	22.06.2018
	Associate Directors of Nursing/ Clinical Directors	22.06.2018

Professionally Approved By:		
Lyn Hinton	Director of Nursing	28.06.2018

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Author/Contact for Information	Dr James Orpin, Consultant Geriatrician
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1.0 Purpose

- 1.1 The purpose of this policy is to enhance adult patient safety across Mid Essex Hospital Services NHS Trust using the National Early Warning Score 2 (NEWS2)
- 1.2 Trend information is important in judging the success of treatment and in identifying deterioration in a patient's clinical condition. There is good evidence that many patients having cardiac arrest in hospital show premonitory signs for many hours before they arrest (NPSA 2007). By identifying the early signs of patient deterioration, staff will have the opportunity to intervene before cardiac arrest.
- 1.3 The policy provides a clear procedure for all Trust staff in the assessment and recording of patient observations and the use of the National Early Warning Score (NEWS2) system, also referred to as a 'Physiological Track and Trigger' system (NICE, 2007) for all adult patients across Mid Essex Hospital Services NHS Trust (MEHT)

2.0 Scope of Policy

- 2.1 This policy applies to all patients over the age of 16 years admitted to wards and departments within the Trust.
- 2.2 All Healthcare Professionals working within the Trust must adhere to this policy. This includes all Medical Staff, all Registered Nurses, Healthcare Assistants (HCA), Healthcare Support Workers (HCSW) and Student Nurses.
- 2.3 For information on the management of pregnant patients refer to the guideline for the management of the severely ill pregnant patient.
- 2.4 For information on the early warning scores in children refer to the Guideline for using Children's Early Warning Tool CEWT.
- 2.5 This policy does not apply to inpatients on ICU/HDU or theatre recovery. These patients are either continuously monitored or monitored using different protocols.

3.0 Roles and Responsibilities

3.1 Chief Executive

The Chief Executive is responsible for ensuring that processes are in place for the assessment and recording of patient observations that facilitate the early recognition of patients at risk of deterioration. This responsibility is delegated to the Medical Director and Chief Nurse.

3.2 Chief Medical Officer and Director of Nursing

The Chief Medical Officer and Director of Nursing are responsible for ensuring that systems are in place to support the implementation of this policy.

3.3 Associate Directors of Nursing and Divisional Directors

The Associate Directors of Nursing and Divisional Directors are responsible for ensuring that systems are in place to support the implementation of this policy.

3.3 Medical and Nursing Staff

- It is the responsibility of the Registered Nurse designated to the patient to ensure that observations are undertaken and documented in accordance with this policy.
- Medical Staff and Registered Nurses can delegate the task of undertaking observations to competent staff (including students). Once the observations have been undertaken, Medical Staff and Registered Nurses are responsible for ensuring timely interpretation of the observations and consequences of decisions made.
- Once the Trust's NEWS2 Trigger Process is activated, it is the responsibility of the Registered Nurse and Medical Staff to ensure compliance with the escalation process and this should be recorded on the observation chart.
- In line with all Trust policies, a breach in policy will be addressed. This may invoke the disciplinary process.

3.4 Senior Sisters / Charge Nurses, Matrons and Department Managers

- Ensure that all patients admitted to the Trust will have their physiological observations recorded on the Trust Observation chart and their NEWS2 score recorded.
- Ensure that staff attend all relevant mandatory training
- Ensure adequate stocks of equipment required to undertake patient observations are maintained.

3.5 The Matrons will review relevant information from audits and develop action plans to ensure improvements in compliance with the policy and inform the training and education agenda to develop skills and abilities of staff in delivering high quality care.

3.6 Deteriorating Patient Group (DPG)

- The Trust's Deteriorating Patient Group (DPG) is responsible for all resuscitation issues within the hospital including the regular review of the NEWS2 system. This will include review of the annual audit findings.
- The Deteriorating Patient Group will report to the Patient Safety Group

4.0 Observations

4.1 At MEHT adult observations should be recorded electronically on the VitalPac system which includes an automatic NEWS2 score calculator. Certain areas do not have

access to VitalPac, in those areas observations should be recorded on the MEHT Vital Signs Observation Chart, this requires manual calculation and recording of the NEWS2 score.

For the rest of this policy use of VitalPac will be assumed but the same processes should apply to paper recording unless otherwise indicated. If VitalPac is unavailable staff should revert to the paper Vital Signs Observation Chart until VitalPac becomes available again.

<p>It is <u>essential</u> that each of the following observations are recorded as a baseline</p>	<ul style="list-style-type: none"> • Blood pressure • Heart Rate • Respiratory rate • Temperature • Oxygen saturation • ACVPU score (See Section 10.6) • NEWS2 score • Urine Output (where indicated) • Pain, nausea and sedation score (where indicated)
<p>The following additional observations or monitoring can also be required following patient assessment and specific patient presentation</p>	<ul style="list-style-type: none"> • Glasgow coma score (GCS) <i>[if head injury suspected or reduced level of consciousness]</i> • Capillary Refill Time • ECG <i>[cardiac or respiratory symptoms; collapse with unknown cause, all patients in resus]</i> • BM <i>[confused, altered level of consciousness, diabetic, drug / drink overdose; all resus patients]</i> • Peak flow <i>[those requiring nebulisers]</i> • Bilateral blood pressure <i>[chest / abdominal pain radiating to back]</i> • Urinalysis <i>[confused, unconscious, diabetic patients, unexplained vomiting, suspected UTI]</i> • Pregnancy test <i>[menstruating females]</i> • Distal pulse and capillary refill time <i>[vascular and circulatory problems]</i> • Visual Acuity <i>[all eye related problems]</i>

5.0 Process

5.1 The frequency of vital signs assessment (observations) should be updated on Vital Pac and updated as the patient's clinical condition dictates and as recommended by their NEWS2 score. The frequency will be determined by Registered Nurses in consultation with Medical Staff. A full assessment of vital signs is required twelve hourly as a minimum unless a decision has been made at a senior level to decrease this frequency, this should be a doctor of registrar level or above (NICE, 2007).

Frequency of observations	Interval
QDS	6 hourly
TDS	8 hourly
BD	12 hourly
Or More frequently where clinically indicated	

- 5.2 Where a clinical decision has been made that daily observations are appropriate, this must be clearly documented on VitalPac and should be recorded in the notes.
- 5.3 Where a patient has refused vital signs assessment despite an explanation being given, the Registered Nurse should inform Medical Staff to determine whether non-compliance may be attributed to an underlying medical condition. Any action taken must be recorded and also documented in the nursing documentation. It is essential that a Mental Capacity Act assessment be considered for patients who refuse observations as confusion / delirium are common signs of worsening condition. Referral to the Safeguarding Team should be considered. For further information refer to the Mental Capacity Act Policy.
- 5.4 VitalPac requires a logon and will use this to record who took the observations on the paper chart the person undertaking the observations should record their initials in the box at the bottom of the chart.
- 5.5 The appropriate observations for the individual patient should be used to calculate the NEWS2 score. VitalPac will calculate this automatically. This must be calculated and recorded manually on the Adult Vital Signs Observation chart on every set of observations.
- 5.6 The purpose of NEWS2 scoring is to support HCA and nursing staff in monitoring the condition of patients so that failure in treatment or acute deterioration because of clinical deterioration is promptly and appropriately managed by the medical team. It is designed to support decision making, not replace it. If a nurse thinks that the doctor should see a patient, their expert view should over-ride the NEWS2 score. It is not designed to be scientifically exact; it is a quick assessment tool and as such will not be flawless.
- 5.7 If the assessment has been delegated, the Registered Nurse responsible for the patient must be informed when the NEWS2 Score is greater than 0.
- 5.8 With a NEWS2 above 0, the registered nurse responsible for the patient must assess the patient and commence escalation of the patient to their nurse in charge by completing the SBAR tool (appendix 2) and contacting the relevant grade of doctor (dictated by their NEWS2 score) if the nurse in charge deems that it is necessary.
- 5.9 Nursing staff must document all escalation attempts and responses in the nursing notes. They should also document any interventions undertaken. If Sepsis is likely the sepsis 6 screening tool should be completed on VitalPac.
- 5.10 Once a nurse has identified that a patient requires a medical review, the escalation must be acknowledged **within 20 minutes**. The minimum grade of doctor responding must be an FY2. If a review is not received within this time period, this should be documented. Escalation up the chain must continue until an appropriate medical response is achieved.
- 5.11 The doctor is responsible for identifying a clear medical management plan or seeking advice from appropriate senior medical staff. Once the patient is reviewed the

management plan must be documented and communicated by the Medical Staff to the Nursing Staff looking after the patient.

- 5.12 If the FY2 doctor does not respond, the registered nurse responsible for the patient must contact senior medical staff in accordance with the escalation process.
- 5.13 Any patient with a NEWS2 score above 0 should have a clear management plan documented either nursing (if the nurse in charge has deemed that a doctor is not necessary) or medical, which includes required frequency of observations as defined in this policy.
- 5.14 It may be appropriate to re-set the trigger to a different level where maximal treatment is already in place. Trigger reset should be undertaken by Medical Staff or by a Senior Nurse. It should only be done when treatment for the physiological markers tripping a high score are maximally treated. This should be documented in the patient's notes.
- 5.15 The ACVPU (alert, confusion, voice, pain, unresponsive) is an initial neurological assessment tool for NEWS2. (See Section 10.6 which explains ACVPU in more detail). Where a more detailed neurological assessment is required, the Glasgow Coma Score (GCS) should be used. There is a separate form for this.
- 5.16 NEWS2 Score and DNAR (Do Not Attempt Resuscitation) orders may still be appropriate together. Because a patient is not for resuscitation it does not mean that they should not be for active treatment. It is important for all patients, but particularly patients with a DNAR order that a treatment escalation plan (TEP) is documented by the medical team in the event of a clinical deterioration. This ensures that those patients with a DNAR order but for full active management up to this point are managed in a different and appropriate way to those at the end of life receiving symptomatic relief only. For the latter patients with a DNAR order in place NEWS2 Scoring may be inappropriate.
- 5.17 If a patient has a NEWS2 score of 9 or more, the responsible person must put out a cardiac arrest 2222 call unless there is clearly documented instruction to the contrary. A 2222 call may not be necessary if there is a consultant or registrar already in attendance and the decision should rest with them.
- 5.18 In the event of a medical emergency, that requires immediate airway support, or cardiovascular collapse the cardiac arrest call **MUST** be put out unless a DNACPR is in place.
- 5.19 Patients should be escalated using the SBAR tool (Refer to appendix 2)
- 5.20 Ward Escalation Parameters and Responses. Table of NEWS2 scores, monitoring frequency and expected clinical responses. These differ in AE and in Braintree Community Hospital.

ward/anaesthetist on call). Decisions relating to transfer of unstable patients should be made by doctors at registrar level or above

6.4 Features and Guidance Notes for Adult Vital Signs Observation Chart

- 6.4.1 Any deteriorating trend in physiological parameters should be regarded with suspicion. Stability is only appropriate if physiological markers are within a normal range for a given patient.
- 6.4.2 For people with chronic illness, chronically deranged physiology may be appropriate for that individual but changes in physiological markers may be highly significant.
- 6.4.3 The demographic data (Patient Name, DOB, and Hospital/NHS Number) must be documented on each chart.
- 6.4.4 Instigation of the trigger process and further calls to medical staff should be recorded in the in the nursing notes. Action taken if medical staff do not respond within 20 minutes should also be recorded. Any entries must be legible and the signature, printed name and designation should be recorded. Escalation must continue in the event of non-contact with an appropriate doctor such that the SpR or consultant should be contacted.
- 6.4.5 Weight should be recorded on admission. The frequency for further weight assessment must be documented.
- 6.4.6 Not all patients require regular Blood Sugar monitoring. Individual assessment is required by the Medical Staff/Registered Nurse. Where Blood Sugar monitoring is indicated, this must be documented on the front of the chart. See section 10.12 for details on blood glucose monitoring for diabetic patients
- 6.4.7 Fluid balances are recorded on a separate chart, and a daily assessment should be made by nursing staff as to whether for each patient a fluid balance chart is necessary or not, with the decision documented.

7.0 Medical Records

- 7.1 VitalPac automatically stores the patient's data and this is archived after discharge and can be accessed as historical data.
- 7.2 All Adult Vital Signs Observation charts should be filed within the patient's health records when completely filled in or the patient no longer requires assessment; or at discharge or death.

8.0 Equipment

- 8.1 The equipment required to undertake and carry out the observations referred to within this policy includes:
- An automatic non-invasive blood pressure recording machine
 - A manual sphygmomanometer and stethoscope
 - Blood pressure cuffs (various sizes)
 - Pulse oximetry probes
 - A urinalysis machine or testing strips
 - Blood glucose monitoring equipment
 - A pen torch
 - A thermometer
 - A peak flow recorder
 - Weighing scales
 - ECG Machine
 - Ophthalmoscope
- 8.2 Access to VitalPac is via portable handheld devices, larger 'tablet' devices or can be through the trust intranet
- 8.3 It is the responsibility of the Senior Sister / Charge Nurse to ensure adequate equipment / resources, as set out in section 8.1 are available and if not, this should be escalated to the Lead Nurse for the service. Out of hours this should be escalated to the clinical operations manager / senior on-call manager.
- 8.4 It is the responsibility of the Senior Sister / Charge Nurse to ensure that in liaison with their Lead Nurse, funds are kept available to repair / maintain, or purchase equipment, so safe levels of equipment listed in section 8.1 are available to nursing staff. This must be in conjunction with Biomedical Engineering Services (BME).

9.0 Staff Training

- 9.1 In accordance with the Trust's Training Needs Analysis (Mandatory Training Policy), all Healthcare Professionals caring for adult patients are expected to attend NEWS2 training.

10.0 Recording Vital Signs assessment

10.1 Systolic blood pressure

10.1.1 This is the upper blood pressure number derived from a “dynamap” or a manual device. The gold standard for assessing a patient is to use a manual device although there is a role for using an electronic device for regular frequent recordings. There should be a high level of suspicion of the accuracy of electronic devices particularly with older devices and patients who are tachycardic or hypotensive or both. The systolic blood pressure is the component of the BP which is used to calculate NEWS2 Score. On paper charts blood pressure must be plotted with markers not numerically.

10.1.2 Although BP is important to monitor in patients, it does tend to be a late sign of clinical deterioration. Sick patients can physiologically compensate and only fail to maintain their BP when they are very sick.

10.2 Heart Rate / Pulse

10.2.1 This must be plotted as a dot on the chart not numerically. The best way of recording the pulse rate is by feeling for it – the radial pulse being the most common site.

10.2.2 Pulse irregularity should be documented on Vital Pac or in the patient’s notes.

10.2.3 Pulse, pulse volume and peripheral clamminess and temperature are all important measures of perfusion. If there are concerns about a patient’s well-being then measuring capillary refill time may be helpful.

10.3 Respiratory rate

10.3.1 Respiratory rate is regarded as a very significant marker of severity of illness in hospital. A respiratory rate below 10 is significant. In the case of a patient receiving opiate analgesia or an epidural, the protocol of the acute pain team should be followed. (See Section 10.11 for pain team advice). A respiratory rate above 20 is deemed as significant and is highlighted on the chart. Any increase in respiratory rate, which is acute and sustained and cannot be explained easily should be reported. A rate above 30 is very significant.

10.3.2 In people with chronic respiratory disease, the patient’s normal rate may be high. Changes in respiratory rate are still significant, and the requirement for respiratory rate monitoring is greater.

10.3.3 Respiratory rate should be counted for a full minute to rule out influence of irregular breathing patterns. Irregular breathing of itself is likely to be highly significant and should be documented in the patient’s notes.

10.4 Oxygen Saturation (SpO₂)

10.4.1 Oxygen Saturation measures the percentage of oxygen that the blood is carrying. Most patients will have oxygen saturation of 95% or above. A level of below 95% is clinically significant.

10.4.2 SpO₂ significantly below 90% requires urgent attention.

10.4.3 In patients with chronic respiratory disease and the elderly, usual level of SpO₂ may be towards the lower ranges. If this is the case, this needs to be clearly identified in the patients' notes prior to the trigger being reset.

10.4.4 Levels of SpO₂ should be recorded using a fully operational pulse oximeter on Vital Pac.

10.4.5 If the device does not record a saturation level, this may be a sign that the patient is not perfusing their peripheries appropriately. This should be noted and escalated to the Registered Nurse designated to that patient. The Registered Nurse must then seek Senior Nursing and/or Medical Advice.

10.4.5 If oxygen is administered to maintain saturations – this adds 2 points on to the patient's total NEWS2 score. Oxygen administered should be recorded as a percentage e.g. 40%, litres of oxygen per minute is only appropriate for nasal cannulae.

10.4.6 Some patients with COPD and other conditions are vulnerable to hypercapnic respiratory failure. This is where administration of excess oxygen can lead to CO₂ retention. For those patients lower target saturations 88-92% may be acceptable and saturations in that range should not trigger a NEWS2 score. On VitalPac this can be achieved by switching a patient's observations to 'Scale 2' which will automatically alter the target parameters.

10.5 Temperature

10.5.1 The importance of temperature is well known for pyrexia but is often ignored when the temperature is falling. If there is a downward trend in temperature, this is often highly significant. Many patients with sepsis or severe infection may become hypothermic. Currently this often goes unnoticed. Falling temperature is particularly important when associated with falling blood pressure and reduced urine output. The NEWS2 Score triggers scores for temperatures inside and outside this range. Abnormally low temperatures should be repeated to confirm the accuracy of the monitoring device.

10.6 Neurological assessment (ACVPU or GCS)

10.6.1 Neurological condition is an important marker of deterioration in clinical condition. Changes in neurological status are highly significant. There are particular difficulties with assessing neurology at night. Sleep and unconsciousness are not the same but may look similar. If a patient requires close neurological monitoring then a Glasgow Coma chart should be used. For normal purposes a simple ACVPU score is adequate.

10.6.2 ACVPU is a basic standard of routine vital signs assessment. The ACVPU scale is simple. Each letter describes a neurological state that can describe a patient.

A = Alert

C = Confusion

V = Responds to voice

P = Responds to pain only

U = unconscious or unresponsive to pain.

10.6.3 Any reduction in conscious level is significant and may be an early indication of deterioration and should always be reported to the registered nurse.

10.6.5 ACVPU is an essential element of the NEWS2 score observations. It is not a replacement for the Glasgow Coma Scale which involves a more detailed neurological assessment

10.6.6 Confusion, this should be used to highlight **new onset** confusion. Patients with longstanding confusion e.g. dementia should not be flagged in this way unless there is a significant change from their baseline.

10.6.7 If any significant head injury is suspected neurological observations should be performed. If the patient has a reduced level of consciousness, neurological observations should be performed and recorded on a half-hourly basis until the GCS is 15. If the patient has a GCS equal to 15 neurological observations should be half-hourly for two hours, hourly for four hours, and then two hourly thereafter. Should a patient with GCS equal to 15 deteriorate at any time after the initial two hour period, observations should revert to half-hourly and follow the original frequency schedule (**NICE 2014**). Ensure that all other vital signs are recorded at the same time as the GCS.

10.7 Capillary Refill Time (CRT)

10.7.1 If you press on a patient's skin centrally e.g. on the chest, quite firmly for five seconds and then release the pressure, the capillary refill time is the number of seconds that it takes full colour to return to the area that has been pressed. Normal capillary refill time is less than 2 seconds. If it is extended beyond that time then it indicates poor perfusion. A CRT of > 3 seconds is likely to be clinically significant. It is dependent on the clinical condition of the patient as to how often CRT should be recorded.

10.8 Fluid balance monitoring

10.8.1 Medical Staff and Registered Nurses are required to assess the need for fluid balance monitoring and this should be documented in the patient's notes and on the observation chart.

10.8.2 Fluid balance monitoring should be initiated for any patient who with the following conditions:

- General concern with fluid balance status

- Acute kidney injury
- Haemorrhage
- Severe or prolonged vomiting
- Severe or prolonged diarrhoea
- Gastrointestinal fistula or nasogastric tube losses
- Diuretic therapy
- Pulmonary oedema
- Sepsis
- Drug Overdoses
- Acute myocardial infarction
- Arrhythmias with poor cardiac output
- Cardiomyopathy
- Cardiac tamponade

10.8.3 A separate 24 hour fluid balance chart should be completed for patients' whose fluid balance is being monitored. This must be accurately completed and the 24 hr input/output balance calculated

10.8.4 If the urine output is being monitored and the output falls to zero in an hour, the catheter should be checked for patency, as outflow obstruction should always be excluded in totally anuric patients.

10.9 **Vital Signs observations for Tracheostomy patients**

- Any patient admitted to hospital as an emergency with a tracheostomy should be on 4 hourly NEWS2 Score calculation for 24 hours whilst awaiting senior review. This does not include critical care where a high level of surveillance and monitoring is routinely maintained.
- Any patient on the ward with a recent tracheostomy should have 4 hourly NEWS2 Score calculated until its discontinuation is advised by a "clinical expert" (experienced ward staff, outreach or critical care team, anaesthetist, head and neck nurse, respiratory nurse specialist, or ENT medical team). Any concern about positioning of the tracheostomy or respiratory compromise in a patient with a tracheostomy should urgently be referred directly to the anaesthetic registrar on call #6555 1310

10.10 **Pain Assessment and monitoring**

- A separate Pain, Sedation and Nausea Measurement tool is available on the GCS chart. Patients prescribed analgesia must be assessed for nausea and sedation using this tool and documented on the chart.
- Patients receiving iv opioid PCA (Patient Controlled Analgesia) require monitoring of the following parameters: respiration rate, pulse, blood pressure, sedation score 0-3, pain assessment 0-3, nausea, vomiting
- Record at 15 minute intervals for first 2 hours, 30 minute intervals for next 2 hours, then 1- 2 hourly as clinically indicated. After 24 hours, 4 hourly observations may be agreed with senior ward staff as clinically appropriate

- Patients receiving epidural infusions require monitoring of the following parameters: respiration rate, pulse, blood pressure, sedation score 0-3, pain assessment 0-3, nausea, vomiting, motor function 0-3
- This should be recorded at 15 minute intervals for first 2 hours, 30 minute intervals for the next 2 hours then 1 hourly for a minimum of 24 hours, changing to 2 hourly as clinically indicated
- The running total of solution used must be recorded hourly as read from the pump display for both PCA and epidural infusions

10.11 Blood glucose monitoring

- All patients with diabetes require blood glucose monitoring to establish a baseline
- Patients with diabetes treated with tablets, who are stable, should have a random blood glucose measurement once per day
- All patients treated with insulin (all Type 1 diabetics) should be tested a minimum of 4 times per day (pre-meal and before bed)
- Pregnant women with Type 1 diabetes should be tested as outlined above
- Pregnant women with diabetes (other than Type 1) must be tested pre-breakfast and one hour post breakfast, lunch and evening meal
- With the exception of ITU (general and burns), patients on sliding scale insulin require hourly blood glucose measurements, proceeding to 2 hourly once stable on sliding scale Please note sliding scales should not be run for more than 24 - 48hours unless in exceptional circumstances. These patients must be referred to the diabetes nursing team.

11.0 Equality and Diversity

- 11.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

12.0 Infection Prevention

- 12.1 All staff should follow Trust guidelines on infection control by ensuring that they effectively decontaminate their hands between each patient.
- 12.2 All observation monitoring equipment will be decontaminated between each patient and disposable attachments used where supplied.
- 12.3 Where patients are high risk of infection, disposable monitoring equipment should be used for single patient use. Disposable equipment should be disposed of as per Trust policy, and any non-disposable equipment should be decontaminated as per Trust policy.

13.0 Audit and Monitoring

- 13.1 Any instances of non-compliance with this policy should be recorded on a risk event form in accordance with the Incident Policy.

13.2 A quarterly audit of compliance with this policy will be undertaken by Lead Nurses, coordinated by Clinical Audit in accordance with the Clinical Audit Strategy and Policy. The audit will assess compliance with:

- the requirement to record frequency of observations;
- documentation of appropriate observations;
- NEWS2 scoring;
- Escalation processes.

See Appendix 1 for more information about how to audit the trigger and escalation process.

13.3 Findings from the audit will be reported to the Heads of nursing and the Patient at Risk Group. An action plan with identified leads and timescales will be developed and approved by representatives from these groups. Progress with implementation of the actions will be monitored by these groups.

14.0 Communication

14.1 The policy will be made available on the Trust's intranet & website. The Resuscitation team / professional development nurses will be responsible for issuing copies to Lead nurses for dissemination within their departments.

14.2 The approved policy will be notified in the Trust's Staff Focus that is sent via e-mail to all staff.

15.0 References and Further Reading

Royal College Of Physicians 2018 "National Early Warning Score (NEWS) 2 Standardising the assessment of acute-illness severity in the NHS

Buist et al. (2004). "Association between clinically abnormal observations and subsequent in-hospital mortality: a prospective study". Resuscitation. 62. 137 – 141.

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Gao et al. (2007). "Systematic review and evaluation of physiological track and trigger warning systems for identifying at risk patients on the ward". Intensive Care Medicine 33: 667–79.

McQuillan et al. (1998) Confidential inquiry into quality of care before admission to intensive care. British Medical Journal. 316: 1853–8.

NCEPOD. (2005)" An acute problem? A report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)". London: NCEPOD.

NCEPOD (2007). "Emergency Admissions: A journey in the right direction? A report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). London. NCEPOD

National Institute for Health and Clinical Excellence (2007): "Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital". Clinical Guideline 50. NICE. London

National Patient Safety Agency. (2007) "Safer care for the acutely ill patient: learning from serious incidents. NPSA. London

NICE CG176 (2014): "Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults" NICE London.

Assistance with Understanding How to Audit this Policy

Triggers (with documentation) are:

A score of 1 or above

If on repeated observations measurements the score is the same – this does not constitute a new trigger

If the score increases (even by one) this counts as a new trigger

If the trigger increase to 9 and a cardiac arrest call is put out, this counts as escalation.

Triggers (without documentation) are:

A score of 1 or above of escalation to another nurse or a doctor.

Appendix 2 - SBAR Tool for Escalation

Surname: _____
First Name _____
Hosp no: _____
<i>Or affix patient label</i>



SBAR report to Doctor about a critical situation

S	<p><u>Situation</u></p> <p>The patients name _____ The patient's resuscitation status is <For Resus/Not For Resus> _____ The problem I am calling about is _____ The patient was admitted with _____</p> <p>I am afraid the patient is going to arrest <input type="checkbox"/></p> <p>I have just assessed the patient personally; Observations are: BP _____ Pulse _____ Resps _____ Temp _____ Blood glucose _____ Oral intake _____ Pain = Site/Duration _____</p> <p>I am concerned about the: Observations in the blue on the obs chart <input type="checkbox"/> BP because it is over 180 <input type="checkbox"/> or less than 100 <input type="checkbox"/> <input type="checkbox"/> Pulse because it is over 100 <input type="checkbox"/> or less than 50 <input type="checkbox"/> <input type="checkbox"/> Resps because it is less than 10 <input type="checkbox"/> or over 29 <input type="checkbox"/> <input type="checkbox"/> Temp because it is less than 35.5 <input type="checkbox"/> or over 38 <input type="checkbox"/> <input type="checkbox"/> Urine Output _____ <input type="checkbox"/> Patient refusing to have obs _____</p>		
B	<p><u>Background</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>The patients mental status is: <input type="checkbox"/> Confused <input type="checkbox"/> Alert <input type="checkbox"/> Voice (respond to verbal stimuli only) <input type="checkbox"/> Pain (responds to painful stimuli only) <input type="checkbox"/> Unresponsive</p> </td> <td style="width: 50%; vertical-align: top;"> <p>The skin is: <input type="checkbox"/> Warm and dry <input type="checkbox"/> Pale / Clammy <input type="checkbox"/> Sweaty <input type="checkbox"/> Extremities are cold <input type="checkbox"/> Extremities are warm</p> </td> </tr> </table> <p>The patient is not on oxygen <input type="checkbox"/> or is on oxygen <input type="checkbox"/> <input type="checkbox"/> The patient has been on _____ (l/min) or (%) oxygen for _____ (hours) <input type="checkbox"/> The oximeter is reading _____ % <input type="checkbox"/> The oximeter does not detect a good pulse and is giving erratic reading _____</p>	<p>The patients mental status is: <input type="checkbox"/> Confused <input type="checkbox"/> Alert <input type="checkbox"/> Voice (respond to verbal stimuli only) <input type="checkbox"/> Pain (responds to painful stimuli only) <input type="checkbox"/> Unresponsive</p>	<p>The skin is: <input type="checkbox"/> Warm and dry <input type="checkbox"/> Pale / Clammy <input type="checkbox"/> Sweaty <input type="checkbox"/> Extremities are cold <input type="checkbox"/> Extremities are warm</p>
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A	<p><u>Assessment</u></p> <p><input type="checkbox"/> I think the problem is _____ <input type="checkbox"/> I don't know what the problem is but the patient is deteriorating <input type="checkbox"/> The patient has fallen on the ward</p>		
R	<p><u>Recommendation</u></p> <p><input type="checkbox"/> I would like you to see the patient within the next 20 minutes <input type="checkbox"/> I would like you to see the patient now <input type="checkbox"/> I would like approval of my course of action which is _____</p> <p>Are any tests needed? Yes / No Please specify _____</p> <p>Is it appropriate to reset the Patients Trigger parameters? Yes / No If yes, to what? _____</p>		

Call initiated by Nurse: _____ To: _____
 Date/Time: _____ Ward: _____

