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DOCUMENT TITLE:	Clinical Observation Policy
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DOCUMENT REPLACES Which Version	Version 1.3
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TARGET AUDIENCE:	**All Health Care Professionals**
DOCUMENT PURPOSE:	**To ensure patient safety, quality of care and early recognition of the deteriorating patient**

To be read in conjunction with (identify which internal documents)	**Fluid SOP** **ELHT Measuring Adult Fluid Status SOP017** **ELHT Fluid Balance Audit SOP63** **ELHT National Early Warning Score Audit** **ELHT Sepsis in Obstetrics and Gynaecology G75** **ELHT Severely Ill Woman G40** **ELHT Do Not Attempt To Resuscitate C116** **ELHT C074 Transfer Policy** **ELHT Paediatric SOP N1ELHT Acute Pain Guidelines / Anaesthetics** **Plasmalyte PGDs 098** **ELHT 003 PGD Oxygen** **ELHT C087 Guidelines for the Care of Adults with Learning Disabilities** **ELHT Adult Sepsis Bundle**
SUPPORTING REFERENCES	**Royal College of Physicians** **National Early Warning Score (NEWS2)** **Mental capacity Act 2005**

CONSULTATION		
	Committee/Group	**Date**
Consultation	**Deteriorating Patient Steering Group**	**November 2018**
Approval Committee	**Deteriorating Patient Steering Group**	**December 2018**
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AMENDMENTS:		

Table of contents

1. Introduction

The close monitoring of patients physiological parameters is the most effective form of early detection of the deteriorating patient. However, research suggests that early changes in patient observations are often not detected or communicated appropriately leading to significant delays in patient's interventions. Morgan et al (1997) developed the EWS tool, in the aim of providing a simple scoring system that could be readily nurses and doctors to help identify patients deteriorating. The Critical Care Outreach forum and NICE CG50, suggest these tools are enhancing care by ensuring timely recognition of all patients with potential or established critical illness, are seen and treated effectively.

2. Policy Statement

East Lancashire Hospitals NHS Trust is committed to ensuring that patients at risk of clinical deterioration are promptly identified and managed according to their clinical need, providing safe, personal and effective care.

Patients admitted to East Lancashire Hospitals NHS Trust are entitled to the best possible care and need to be confident that should their condition deteriorate that they will receive prompt and effective treatment.

The purpose of this policy is to ensure a standardised approach to the use of a combined physiological observation and track and trigger system. Utilising the EWS/NEWS escalation protocol.

All healthcare staff must apply the EWS/NEWS system using parameters, as outlined in the policy for **ALL** hospital settings.

3. Purpose

To improve patient outcomes by recognising and responding upon early signs of deterioration in patients by:

- Identifying trends in patient vital signs/observations
- Ensuring that timely patient reviews and appropriate treatment occur
- Improving the documentation and communication of patient observations
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4. Roles and Responsibilities

All healthcare staff **must** comply with this policy

NEWS2 is a physiological 'track and trigger' clinical assessment tool and cannot replace the clinical judgement of a qualified member of staff. If a patient condition raises concerns, nursing/therapy professionals/medical staff should not hesitate

to contact a senior member of the patient's Medical Team to review the patient, irrespective of the EWS.

5. "Vital signs" Assessment

5.1 The minimum vital signs to be recorded with each set of observations are:

- Respiratory Rate
- Pulse (manual)
- Systolic Blood pressure
- Temperature
- Oxygen saturations
- Inspired oxygen
- Level of consciousness (Alert, Voice, Pain, Unresponsive, New Confusion)

A full set of observations should be documented on all patients at the following times:

- On admission and time of initial assessment
- Post procedure as directed
- A minimum of 4hourly observations in a 24hour period on any patient admitted from the Emergency Department, Acute Medical Unit (AMU), Surgical Triage Unit (STU), who has been transferred from a critical care area such as Critical Care or Coronary Care (ICU/CCU) or following an inter hospital transfer
- A minimum of 8hourly observations on all other patients unless specified otherwise
- Every patient transferring to another ward/area needs to have a full set of observations completed prior to transfer

In addition, a full set of observations need to be completed:

- If the patient's condition deteriorates
- As per EWS policy
- Family member or carer concern, as appropriate
- As per Standard Operating Procedures (blood transfusion, PCA, IV/Subcutaneous opioid infusions)
- Following administration of medications, that will affect vital signs, including IV Morphine, a full set of observations must be completed within 30 minutes of administration

If a single parameter is rechecked to assess the effect of an intervention (i.e. Paracetamol given for temperature) a full set of vital signs should be completed within 30minutes of the administration of the medication.

Any decrease in the frequency of vital signs must only be done on the direction of the Nurse-in-charge or in consultation with the medical practitioner and **must** be documented in the patient's medical records.

All observations should be measured by an appropriately trained and competent member of staff. (NMC Code of Conduct 2015, point 11, 11.1, 11.2,11.3)

EWS observations for patients deemed as end of life may be stopped, however this **must** be documented in the medical records by an ST3 or above. Observations taken after this time **must** be taken by a registered nurse and only to responded to for symptom control and documented in the plan of care. Escalation along track and trigger is **not** mandated.

5.2 Refusal to have Clinical Observations taken

Every adult has the right to make his or her own decisions. The patient is always central to their own healthcare and health needs. A patient may refuse to have clinical observations due to agitation, fear or a lack of understanding. Every effort must be made to provide patients with the information to make an informed choice. Any reason for refusal to have clinical observations should be documented in the patient record.

There are groups of patients who decline having their observations undertaken for a variety of reasons. These patients **must** have a capacity assessment undertaken; **those that are deemed to have capacity are the only ones able to decline having their observations taken**. Only in this patient group is it appropriate to write: refused observations.

Patients, who are deemed to lack capacity, should where possible have a complete set of observations completed. This may take time and ingenuity but in most cases should be possible.

There may be times that this is not possible due to patient agitation and risk to staff safety, in these cases observations that are achievable should be undertaken.

These should include but aren't limited to a:

- Respiratory Rate
- AVPU
- Temperature
- Heart Rate

Apart from the Heart Rate these observation can be undertaken often without distressing the patient.

A score of 3 or above in one parameter and a score of 3 collectively in an incomplete set of observations should be escalated. An incomplete set of observations does not stop the person undertaking them escalating any concerns they have to the appropriate person be that a Doctor or the Acute Care Team.

For patients who lack capacity to consent to physical observations can present some ethical dilemmas. The use of restrictive physical interventions maybe required to enable staff to effectively assess or deliver essential care and treatment to individuals who lack capacity when required to carry out diagnostic examinations and tests.

The Mental capacity Act 2005 clearly outlines the healthcare professionals' responsibility, in relation to clinical holding and restraint stating:

'Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so they can do something more easily. If a restraint is necessary to prevent harm to the person that lacks capacity, it must be the minimum amount of force for the shortest possible time' (MCA 2005)

'A 'proportionate response' means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity. On occasions when the use of force may be necessary, carers and healthcare and social staff should use the minimum amount of force for the shortest possible time' (MCA 2005)

Use of clinical holding must be clearly documented as part of the care planning and best interest process.'

For patients with Learning Difficulties please refer to C087 for guidance on the Care of Adults with Learning Disabilities.

6. Early Warning Score

6.1 Adult Patients

An Early Warning Score is to be calculated each time a set of observations is taken.

Observations to be scored are:

- Systolic Blood pressure
- Pulse (manual)
- Temperature
- Respiratory rate
- Oxygen saturations
- Inspired oxygen
- Level of consciousness (Alert, Voice, Pain, Unresponsive, New Confusion)

EWS patients may score higher because of their individual pre-existing conditions (i.e. chronic lung disease, dialysis, cardiac patients). This should be noted within

the patient management plan and an escalation plan formulated; that outlines specific triggers for concern should they deteriorate.

Scoring criteria may only be changed following a full medical assessment by a senior doctor. This **must** be documented with a clear rationale for the decisions made within the patients' medical records.

Observation frequency should be clearly documented on the observation chart; unless a patient has a EWS ≥5, when observations will be recorded hourly as a minimum for the first hour, then altered as per EWS score "frequency monitoring".

If a patient has triggered an EWS >3 and the score has reduced to EWS <3, one hour later, then subsequent observations should be a minimum of 4hourly for 48 hours.

6.2 Post-operative Patients

All post-operative patients' should have frequency as stated below, unless medical staff document alternative requests, or patients have PCA/Epidural in place, then refer to local guidelines:

- 30 minutes for 2 hours
- Hourly for 2 hours
- As patient need dictates, minimum 4hourly for 12 hours, reverting back to the EWS escalation protocol **(Appendix 1)**

6.3 Community Hospital Patients

All patients in the Community Hospitals will have their clinical observations completed, minimum 12hourly. This can **only** be changed if it has been clearly documented by the medical professional.

Please refer to:

- Community Patient Observation SOP

6.4 Obstetrics and Maternity patients

All women who are pregnant or up to 6 weeks postpartum (or after the end of pregnancy did not end in a birth) need to have observations recorded on the Modified Early Obstetric Warning Score (MEOWS) chart.

At **RBH** these will be centrally located in the Emergency Department, Acute Medical Units A & B, Surgical Triage Unit and Acute Care Team.

At BGH they are available from the postnatal wards at the Lancashire Woman and Newborn Centre.

Please refer to:

- ELHT G40a The Deteriorating Maternity Patient
- ELHT G40b Close Observation Unit and Transfer of Patients

6.5 Paediatric patients

Please refer to:

- ELHT PEWS (Paediatric Early Warning Score) Clinical Observation Procedure. SOP N1

7. EWS Protocol for Escalation of Treatment

EWS is to support clinical staff in monitoring the condition of the patient, to improve communication with the medical team, ensuring an appropriate treatment plan can be promptly implemented for the patient.

Once a patient has triggered a EWS of 3 in any parameter or an aggregate score of 3 or greater than 3, the EWS escalation protocol must be adhered to. **(Appendix 1)**

8. Communication in relation to the deteriorating patient:

SBAR (Situation, Background, Assessment, Recommendation)

- **S**ituation – what is the current situation, concerns, observations etc... (EWS/NEWS)
- **B**ackground – What is the relevant background?
- **A**ssessment – What do you think the problem is? Interpretation of the situation and background information to make educated conclusion about what is going on
- **R**ecommendations – What do you need them to do? What do you recommend should be done to correct the current situation?
- Clearly document in patients notes

This does not exclude escalating to the appropriate medical professional should the trigger score of 3 or greater than 3 remain following interventions and subsequent set of observations.

Please refer to the:

- Escalation protocol **(Appendix 1)**
- Fluid Balance SOP

Please note that there are PGDs in place for:

- Oxygen **(ELHT 003)**
- Fluids

9. Appendix 1 - Escalation Protocol

EARLY WARNING SCORE (EWS)	FREQUENCY OF OBSERVATIONS	ESCALATION PROTOCOL
0	Minimum 12 hourly in NON-ACUTE areas (COMMUNITY HOSPITALS ONLY)	
0 - 2	Minimum 8 hourly in all ACUTE areas (RBH & BGH)	
0 - 4	Minimum 1 hourly (ED/UCC ONLY)	If EWS > 4 Escalate to Nurse in Charge
3 - 4	Observations to be recorded minimum 4 hourly	Action Nurse Led Algorithm and escalate to nurse in charge, escalate to Doctor if required
5 – 6 or scoring 3 in any one parameter	Repeat observations hourly and within 30 minutes initially	Contact Acute Care Team (Bleep 113) and appropriate Doctor, to attend within 1 hour of receiving the call
7 or above	Repeat observations every 15 minutes	Contact Acute Care Team (Bleep 113) and ST3+ Doctor, to attend the ward within 15 minutes of receiving the call