



**Western Health
and Social Care Trust**

**WESTERN HEALTH AND SOCIAL CARE TRUST
HOSPITAL AT NIGHT (H@N) OPERATIONAL POLICY**

**Operational Policy for Hospital at Night
Reviewed December 2010**

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WESTERN HEALTH AND SOCIAL CARE TRUST

HOSPITAL AT NIGHT (H@N) OPERATIONAL POLICY

1.0 POLICY STATEMENT

The purpose of this policy is to achieve effective clinical care during out-of-hours by introducing one or more multidisciplinary teams who, between them, have the full range of skills and competences to meet the immediate needs of patients. This policy applies to the Medical and Surgical Divisions and the specialty teams within.

2.0 BACKGROUND TO HOSPITAL AT NIGHT

H@N is a new model of working in hospital during the out-of-hours period. It was initiated in England in 2004 via the DOH and was piloted in NI (Daisyhill Hospital) in 2006. It was implemented in WHSCT in May 2009.

The H@N model was born as a result of the significant number of clinical incidents during out-of-hours (some due to poor communication and errors as a result of doctor fatigue) and as part of the solution to meeting requirements of EWTD (European Working Time Directive) where junior doctors hours will be reduced to 48 hours a week in 2009.

3.0 CLINICAL GOVERNANCE

The Trust's Clinical and Social Care Governance Framework will be applied to the [H@N](#) model. A key feature of the [H@N](#) model is to improve the safety and effectiveness of care and treatment delivered to patients during the out-of hours period. All Trust policies and procedures relating to clinical and social care governance must be adhered to at all times.

The success of the [H@N](#) model is dependent on the competence of various members of the team and the appropriate delegation of clinical duties to the appropriately skilled member.

Due to new working of teams clinical supervision arrangements will be put in place for each of the new roles and differing roles introduced.

A risk management framework has been developed to identify risks and associated actions and monitoring required to ensure the delivery of high quality patient care provided by the [H@N](#) model.

4.0 AUDIT OF COMPLIANCE

There will be a number of regular audit opportunities providing evidence of compliance and care improvement resulting from Hospital At Night implementation. Regular audit, undertaken by the Clinical Coordinators, will include Handover Attendance, OOH ICU/HDU transfers and CCU transfers.

In addition, a number of key performance indicators have been agreed for the WHSCT H@N project that will provide measures of performance in areas such as:

- Patient Outcomes
- Transfers of Care
- Workforce
- Productivity & Efficiency
- Post Implementation Evaluation

Three monthly performance monitoring will be reported to the H@N Project Team meetings and the H@N Project Steering Group.

- Post Implementation Evaluation
- Auditing of clinical skills every 3 months
- Clinical Site Co-ordinators weekly report
- Specific Performance Indicators e.g Cardiac Arrests out of hours.
- Evaluation of Performance

Section 5 of this document will cover Altnagelvin Area Hospital.

Section 6 of this document will cover the Erne Hospital.

Section 5

Altnagelvin Area Hospital

5.0 ALTNAGELVIN AREA HOSPITAL

5.1 Hospital at Night Team

Medical SpR – Clinical Lead
Clinical Co-ordinator (CC) – Operational Lead
Surgical SpR
Medical FY2 x 2
Surgical FY2
Surgical FY1
Orthopaedic/Trauma FY2
Maxillofacial FY2
ENT/Ophthalmology FY2 / SpR
Medical FY1
Hospital Services Manager
Healthcare Assistant (HCA) –Band 3 x 2

5.2 Responsibility and Accountability (Appendix 1)

Individuals and organisations have a shared responsibility to minimise the “out of hours workload” by changing current ways of working and moving non-urgent work from the night time to the extended day.

5.3 Clinical Leadership

The SpR for Medicine will lead the clinical team. The Clinical Co-ordinator (CC) will work in partnership with the Medical SpR and will be the operational lead for the H@N team.

5.4 Responsibilities

5.4.1 SpR Medicine

- Leads the evening handover with the CC and allocates tasks to the most appropriate member of H@N team.
- Directs the H@N team in partnership with CC.
- Directs initial patient management for critically ill patients on wards and in the A&E Department.
- Informs medical consultant on call of any ICU referrals /admissions, and potential transfers of critically ill patients and areas of concern, e.g bed capacity.
- SpR within General Surgery and sub specialities will also inform the on call consultant of critically ill patient’s who are admitted to ICU/HDU

5.4.2 Clinical co-ordinator – BLEEP 8500 (see Appendix 3)

- Coordinate bleeps from wards (as per Bleep filtering policy)
- Review ward referrals and, if required, refer patients to the most appropriate member of the team.

- Support unstable/ acutely unwell patients identified for admission to ICU until they are able to access HDU/ICU.
- Provide clinical support for Level 1 & 2 patients around the various wards/departments
- Support and supervise ward staff and junior doctors by assisting with appropriate clinical skills.
- Manage and supervise the H@N Healthcare Assistants.
- Liaise with
 - And support nursing staff and junior doctors by visiting wards/departments throughout the night on a regular basis.
 - Liaise closely with the Hospital Services Manager regarding emergency and elective admissions from A&E or the GP Out of Hours Base.
 - Assist with ward patients who need to transfer to, HDU, ICU and CCU and maintain safe and rapid transfer during out-of-hours.

5.4.3 Healthcare Assistant - BLEEP 8502

Healthcare Assistants will work under the guidance of the Clinical Co-ordinator and will undertake tasks delegated by the Clinical Co-ordinator. Healthcare Assistants clinical tasks will include:

- Measurement of vital signs i.e.- pulse rate, blood pressure, temperature, respiratory rate
- Measurement of Oxygen saturation
- Measurement of BMI
- Venepuncture - No routine bloods will be performed unless specifically requested by Doctor including Group & Holds unless in an emergency
- Venflon insertion
- Performing 12 lead ECGs
- Blood Glucose
- Urinalysis

5.5 HANDOVER

All members of the H@N team will attend the multidisciplinary Handover meeting each evening at 2100 hours **in the Seminar Room at the entrance of the Acute Medical Unit, South Block Building.** The CC will bleep all members of the H@N team 15 minutes before the start of the Handover.

All members of the H@N team must attend and sign the attendance register.

This is mandatory for all doctors in the out of hours period.

Only urgent bleeps will be sent during the Handover i.e. 2100 – 2130 hours. The operating principles will be as per the Trust's Handover Policy.

The clinical leads within the Medical and Surgical Directorates must ensure that the medical staff covering the out-of-hours period attend the H@N Handover at the designated time and remain contactable while on duty until the end of their shift. Regular audit of attendance will be provided on a monthly basis to these leads to disseminate within their Directorate.

5.5.1 Process at Handover Meeting

Handover will take place every night in the AMU Seminar room between 2100 hrs – 2130hrs. Attendance at this handover is mandatory for all specialties.

The Clinical Co-ordinator and Medical SpR will coordinate the Handover meeting and prioritise and allocate work.

- General introductions and sign attendance sheet.
- Handover of acutely ill, unstable and newly admitted patient.
- When patients are handed over, if specific doctor is required this should be noted on the handover sheet and prioritized.
- Surgical patients (including sub -specialties) should be handed over first followed by medical patients.
- Outstanding tasks/duties should be written onto the board and handover sheet and prioritized. Medical SpR /CC will allocate these tasks accordingly i.e. to the Healthcare Assistant if appropriate
- The Hospital Services Manager and CC will provide an overview of admissions – to include patients in A&E awaiting ward beds.
- If there is a priority call during handover, all clinical covering the crash calls staff should attend as usual and the CC will continue the handover with remaining doctors.

5.5.2 Handover Attendees

Medical SpR (Night) – Clinical Lead
Medical SpR (Day)
Clinical Co-ordinator – Operational Lead
Medical FY2 X 2 (Night)
Medical FY2 X 2 (Day)
Medical FY1 (Night)
Medical FY1 (Day)
Surgical SpR or F2 (Night)
Surgical FY1 (Night)
Surgical FY1 (Day)
Orthopaedic/Trauma FY2 (Night)
Maxillofacial FY2 (Night)
ENT/Ophthalmology FY2 (Night)
Nurse practitioner will up- date the H@N on AMU admissions
Outreach team will up-date the H@N team through the shared drive
Hospital Services Manager

5.5.3 Use of Handover Room

The handover room is available as a base for the team during the night for further reviews as necessary. This room must be kept tidy at all times as it is used for teaching sessions during the day.

5.6 DELEGATION OF DUTIES

The Clinical Co-ordinator and medical SpR will delegate duties post handover to members of the H@N team according to who is available and has the competency to carry out the duty. There may therefore be occasions when team members are asked to work outside their individual specialty.

Clinical Co-ordinator will liaise with Medical Staff during the night regarding outstanding tasks and ensure appropriate allocation.

The Nurse in Charge of A&E and Hospital Service Manager will liaise with the Clinical Co-ordinator of acutely ill patient's who are being transferred to the ward, so that follow up investigations are performed on a timely basis.

5.7 ON-CALL PHARMACIST

An on-call pharmacist will be available outside normal working hours to deal with emergency / urgent requests for information and/ or drugs. Contact with the on-call pharmacist must be made through the night services management structures. Please note 3 separate on-call pharmacist teams cover the following areas:

- Altnagelvin / Gransha and surrounding area = Altnagelvin switchboard.
- Omagh / T&F and surrounding area = TCH switchboard
- Erne & surrounding area = Erne switchboard

A pharmacist will be available to attend the H@N morning handover in the Erne and Altnagelvin.

5.8 REVIEW OF SPECIALTY ACCEPTED OR REFERRED

Members of the H@N team may need to see patients outside of their specialty but working within their level of competence, if asked to do so by the Medical SpR / CC. Patients seen in A&E by non-specialty team members will need review by the relevant FY2 or SpR subsequently. The time frame for this will depend on:

- The clinical state of the patient
- Self awareness of the limits of the non-specialty FY2 own knowledge and ability to recognise critical illness
- Availability and knowledge base of the senior doctor on duty in A&E to give advice for the patient in A&E prior to transfer to a ward bed

5.9 Early Warning Scores EWS (see Appendix 4)

After 21:00hrs

Patient scoring 1-3 (or 3 for 1 parameter) on the EWS – Nurse should inform the Nurse in charge and if appropriate contact the Bleep Clinical Co-ordinator on 8500 for advice. Re-calculate the score within one hour. The Staff Nurse must clearly document in the action plan who has been informed and the outcome.

Patient who scores (4-6) the nurse first must contact the Senior Doctor on duty (FY2 or SpR) for immediate review. The Clinical Co-ordinator should also be made aware of the ill patient who will also review the patient in conjunction with the Doctor. Time frame for this will be within 15-30 minutes. Staff Nurse must document clearly in the action plan of the EWS chart.

Patients scoring 7 or greater on the EWS: - Bleep SpR for urgent review. Clinical Co-ordinator must be made aware of this ill patient. Staff Nurse must clearly document in the action plan of the EWS chart

All **non-urgent** calls from the wards should go to the Clinical Co-ordinator in accordance with the bleep policy. Any doctor receiving inappropriate calls from the wards after this time should redirect them to the CC, unless in the event of an emergency. Refer to appendix 3 for H@N EWS Chart.

SBAR (Situation, Background, Assessment and Recognition) Tool (see Appendix 5).

When staff communicate with the H@N team, they will be expected to use the SBAR tool after they have received the appropriate training. Using this tool, ensures that accurate and relevant information is transmitted to the appropriate person regarding patients whom nursing and medical staff are concerned about. The SBAR tool will also be used in the handover process during the H@N period.

5.10 CRITICAL CARE OUTREACH SERVICES (CCOS)

Sub optimal care in the acutely ill adult in-patient (level 1) has been addressed in several documents. Deficits have been identified in the assessment of patients and their subsequent communication and treatment. CCOS has been established to provide education, clinical support and audit focused on enhancing the skills and knowledge of clinical staff in relation to the identified deficits. Clinical support will take the form of assessing patients to highlight deterioration, developing staff's clinical skills and assisting them with the care of pre Critical Care patients.

As soon as staffing permits a service will be maintained to enable CCOS to update the H@N Clinical Co-ordinator about those patients with which it is involved. When up to complement it is envisaged that initially a twilight and subsequently a whole night service will be provided. CCOS will keep the H@N Clinical Co-ordinator informed of its activities and work with them in a manner that reduces duplication.

5.11 BLEEP POLICY

Between 1900hrs and 0700hrs, calls from the wards will be directed to the designated CC via dedicated bleep (8500). The CC will advise and assess the situation/patient and contact the relevant member of H@N team as necessary. Any doctors receiving non-urgent calls from the wards should redirect the call to the CC.

Nursing staff can contact the doctor directly in an emergency situation at any time e.g. urgent calls/fast bleeps.

Cardiac Arrest calls – NO CHANGE IN PRACTICE. Ext 6666

Departments and Wards should avoid bleeping medical staff during the handover meeting as this leads to disruption.

Internal referrals between medical staff will go directly to referring specialty from referrer and NOT pass through the Clinical Co-ordinator.

External referrals between medical staff will go directly to referring specialty from referrer and NOT pass through the Clinical Co-ordinator.

Section 6

Erne Hospital

6.0 ERNE HOSPITAL

6.1 Hospital at Night (H@N) Team

Consultant Physician on Call – Clinical Lead
Clinical Co-ordinator (CC) – Operational Lead
Surgical Staff Grade
Medical F2/CMT/ST on call
Surgical F2 /CMT/ST on call
FY1 – Cross cover
Healthcare Assistant (HCA) – Band 3

6.2 Responsibility and Accountability (Appendix 2)

Individuals and organisations have a shared responsibility to minimise the “out of hours workload” by changing current ways of working and moving non-urgent work from the night time to the extended day.

6.3 Clinical Leadership

On Call Physician will lead the clinical team. The Clinical Co-ordinator (CC) will work in partnership with the On Call Physician and will be the operational lead for the H@N team.

6.4 Responsibilities

6.4.1 On Call Consultant Physician

- Leads the evening handover with the CC and allocates tasks to the most appropriate member of H@N team.
- Directs the H@N team in partnership with CC.
- Directs initial patient management for critically ill patients on wards and in the Medical and Surgical Assessment Unit.
- Reviews information on medical patients in A&E
- Informs senior colleagues on call of any ICU/HDU referrals /admissions, and potential transfers of critically ill patients and areas of concern, e.g. capacity.

6.4.2 Clinical Coordinator – Bleep 0140. (see Appendix 3)

- Coordinate bleeps from wards (Bleep filtering)
- Review ward referrals and, if required, refer patients to the most appropriate member of the team.
- Support unstable/acutely unwell patients identified for admission to ICU/HDU until they are able to access ICU/HDU.
- Provide clinical support for Level 1 & 2 patients around the Trust/ Wards.
- Support ward staff and junior doctors by assisting with appropriate clinical skills.
- Will manage the H@N Healthcare Assistants.
- Liaise with

- And support nursing staff and junior doctors by visiting wards/departments throughout the night on a regular basis.
- Bleep 0057 regarding emergency and elective admissions from A&E or Medical and Surgical Assessment Unit.
- Wards, HDU, ICU, CCU, Stroke Unit, Wards 8,9, 10, MASU and Surgical to ensure safe and rapid transfer of patients during out-of-hours.

6.4.3 Healthcare Assistant

Healthcare Assistants will work under the guidance of the Clinical Co-ordinator and will undertake tasks delegated by the Clinical Co-ordinator. Healthcare Assistants clinical tasks will include:

- Measurement of vital signs i.e.- pulse rate, blood pressure, temperature, respiratory rate, EWS score
- Measurement of Oxygen saturation
- Measurement of BMI
- Venepuncture
- Venflon insertion - No routine bloods will be performed unless specifically requested by Doctor including Group & Holds unless in an emergency
- Performing 12 Lead ECGs
- Blood Glucose monitoring
- Urinalysis

6.5 HANDOVER

All members of the H@N team will attend the multidisciplinary Handover meeting each evening at 2100 hours in the Boardroom. Please note the Boardroom will be the interim location for handover. The CC will bleep all members of the H@N team 15 minutes before the start of the Handover.

All members of the H@N team must attend.

Only urgent bleeps will be sent during the Handover i.e. 21:00 – 21:30 hours. The operating principles will be as per the Trust's Handover Policy.

The clinical leads within the Medicine and Surgery Directorates must ensure that the medical staff covering the out-of-hours period attend the H@N Handover at the designated time and remain contactable and on duty until the end of their shift.

6.5.1 Process at Handover Meeting

Handover will take place every night in the Hospital At Night Handover room between 21:00 hrs – 21:30hrs.

The Medical On Call Consultant Physician will prioritise and allocate work. The Clinical Co-ordinator and the On Call Consultant Physician will coordinate the handover meeting.

- General Introductions and sign attendance sheet.
- Handover of acutely ill, unstable and newly admitted patients together with allocation of outstanding tasks.

- When sick patients are handed over, if specific doctor is required this should be noted on the handover sheet and prioritized.
- Outstanding tasks/duties should be written onto the board and handover sheet and prioritized. The Clinical Co-ordinator will allocate these tasks accordingly i.e. To the Healthcare Assistant if appropriate
- The CC will provide an overview of admissions – to include patients in A&E awaiting ward beds.
- If there is a priority call during handover, all critical staff should attend as usual and the CC will continue the handover with remaining doctors.

6.5.2 Handover Attendees

Clinical Co-ordinator – Operational Lead
Surgical Staff Grade
Medical F2/CMT/ST on call
Surgical F2/CMT/ST on call
FY1 – Cross Cover (Medical & Surgical).
Link support Consultant Physician
Link support Consultant Surgeon

6.6 DELEGATION OF DUTIES

The Clinical Co-ordinator and medical lead will delegate duties post handover to members of the H@N team according to who is available and has the competency to carry out the duty. There may therefore be occasions when team members are asked to work outside their individual specialty.

Clinical Co-ordinator will liaise with Medical Staff during the night (17:00 – 01:00) regarding outstanding tasks and ensure appropriate allocation. Before going off duty the Clinical Co-ordinator will liaise with the FY1 @ 00:45.

6.7 ON-CALL PHARMACIST

An on-call pharmacist will be available outside normal working hours to deal with emergency / urgent requests for information and/ or drugs. Contact with the on-call pharmacist must be made through the night services management structures. Please note 3 separate on-call pharmacist teams cover the following areas:

Altnagelvin / Gransha and surrounding area = Altnagelvin switchboard.

Omagh / T&F and surrounding area = TCH switchboard

Erne & surrounding area = Erne switchboard

6.8 REVIEW OF SPECIALITY ACCEPTED OR DEFERRED

Members of the H@N team may need to see patients outside of their specialty but working within their level of competence, if asked to do so by the Clinical co-ordinator / Clinical Lead.

Patients seen in A&E by non-specialty team members will need review by the relevant F2/CMT/ST. The time frame for this will depend on:

- The clinical state of the patient
- Self awareness of the limits of the non-specialty F2/CMT/ST own knowledge and ability to recognise critical illness
- Availability and knowledge base of the doctor on duty in A&E to give advice for the patient in A&E prior to transfer to a ward bed.

6.9 Early Warning Scores - EWS SCORES (Appendix 4). After 21:00hrs

Patient scoring 1-3 (or 3 for 1 parameter) on the EWS – Nurse should inform the Nurse in charge and if appropriate contact the Bleep Clinical Co-ordinator on Bleep 0140 for advice. Re-calculate the score within one hour. The Staff Nurse must clearly document in the action plan who has been informed and the outcome.

Patient who scores (4-6) the nurse first must contact the Senior Doctor on duty (FY2 or SpR) for immediate review. The Clinical Co-ordinator should also be made aware of the ill patient who will also review the patient in conjunction with the Doctor. Time frame for this will be within 15-30 minutes. Staff Nurse must document clearly in the action plan of the EWS chart.

Patients scoring 7 or greater on the EWS: - Bleep SpR for urgent review. Clinical Co-ordinator must be made aware of this ill patient. Staff Nurse must clearly document in the action plan of the EWS chart

All **non-urgent** calls from the wards should go to the Clinical Co-ordinator in accordance with the bleep policy. Any doctor receiving inappropriate calls from the wards after this time should redirect them to the CC, unless in the event of an emergency. Refer to appendix 3 for H@N EWS Chart.

SBAR (Situation, Background, Assessment and Recognition) Tool (see Appendix 5)

When staff communicate with the H@N team, they will be expected to use the SBAR tool after they have received the appropriate training. Using this tool, ensures that accurate and relevant information is transmitted to the appropriate person regarding patients whom nursing and medical staff are concerned about. The SBAR tool will also be used in the handover process during the H@N period.

6.10 BLEEP POLICY

Between 2100 - 0900hrs, calls from the wards will be directed to the designated CC via dedicated bleep 0140. The CC will advise and assess the situation/patient and contact

the relevant member of H@N team as necessary. Any doctors receiving non-urgent calls from the wards should redirect them to the CC. Healthcare Assistants can be contacted via Bleep number 0191 for Medical Directorate and Bleep number 0192 for Surgical Directorate & MASU.

Nursing staff can contact the doctor directly in an emergency situation at any time e.g. urgent calls/fast bleeps.

Cardiac Arrest calls – NO CHANGE IN PRACTICE.

Departments/Wards should avoid bleeping medical staff during the handover meeting (21:00 – 21:30hrs.).***

Internal referrals between medical staff will go directly to referring specialty from referrer and NOT pass through the Clinical Co-ordinator.

External referrals between medical staff especially from GP out of hours will go through the Clinical Co-ordinator who will then pass them unto the appropriate speciality.

Appendices

APPENDIX 1

TIMETABLE FOR ALTNAGELVIN HOSPITAL

H@N commences at
19:00

Arrive on duty. Attend relevant wards and record list of new admissions unstable patients and clarify management plans including DNAR status.

Meet the Hospital Services Manager and the Bed Manager to receive accurate information of emergency admissions and throughput issues.

- 19.45 Attend the Night Managers handover report where the bleep sister will provide information on patient flows and clinical problems. The Clinical Co-ordinator should ensure they have an accurate list of patients who have been admitted during the hospital day, especially those after 5pm. This information should include diagnosis and their location. Also establish a list of impending new admissions within A&E department that have been accepted by the speciality teams. This information should then be shared with the SpR and H@N team during handover period. It is important that all patients are handed over to ensure management plans are in place for the out of hours period.
- 20.45 CC to call/bleep necessary staff members to attend handover.
- 21.00 Multidisciplinary handover meeting commences at 9pm in handover room Seminar Room (AMU).
- 21.25 Night Medical SpR/FY2/CMT on call and CC prioritise work and allocate outstanding tasks to appropriate members of the HaN team
- 21.30 Medical SpR/ F2/CMT and CC to assess the needs of ill/unstable patients handed over and ensure there is a plan of care for the night. Team to provide care as per 'priority' and competency and reassess patients as necessary. All Trust policies and protocols will be adhered to.
- 12 Midnight CC, Hospital Services Manager and Medical SpR/ F2/CMT to meet or communicate by phone to discuss the work of the H@N team.
- 03.00 CC and Medical SpR/ F2/CMT meet and assess work of HaN Team
- 06.45 CC to ensure handover sheets are updated for the morning Medical handover. CC and Medical SpR/FY2/CMT meet to handover before the CC goes off call.
- 08.45 Medical SpR/ FY2/CMT to attend morning handover meeting to handover all new admissions overnight and all ill patients to the appropriate medical teams. Consultants from the various specialties to be in attendance.

APPENDIX 2

TIMETABLE FOR ERNE HOSPITAL

H@N commences at 17:00

Arrive on duty. Attend relevant wards and record list of new admissions unstable patients and clarify management plans including DNAR status.

Meet the Patient Flow Manager to receive accurate information of emergency admissions and throughput issues.

20.45 CC to call / bleep necessary staff members to attend handover.

21.00 Multidisciplinary handover meeting commences at 9pm in the Board Room.

21.25 Night Medical Cons/FY2/CMT/FY1 on call and CC prioritise work and allocate outstanding tasks to appropriate members of the HaN team

21.31 Medical SpR/ F2/CMT and CC to assess the needs of ill/unstable patients handed over and ensure there is a plan of care for the night. Team to provide care as per 'priority' and competency and reassess patients as necessary. All Trust policies and protocols will be adhered to.

00:30 CC meets with the FY1 to discuss any outstanding clinical tasks as well as handing over a list of ill patient's that needs to be reviewed before the morning.

01.00 CC completes documentation and reports of duty.

APPENDIX 3

Acquisition of Skills for Clinical Co-ordinators

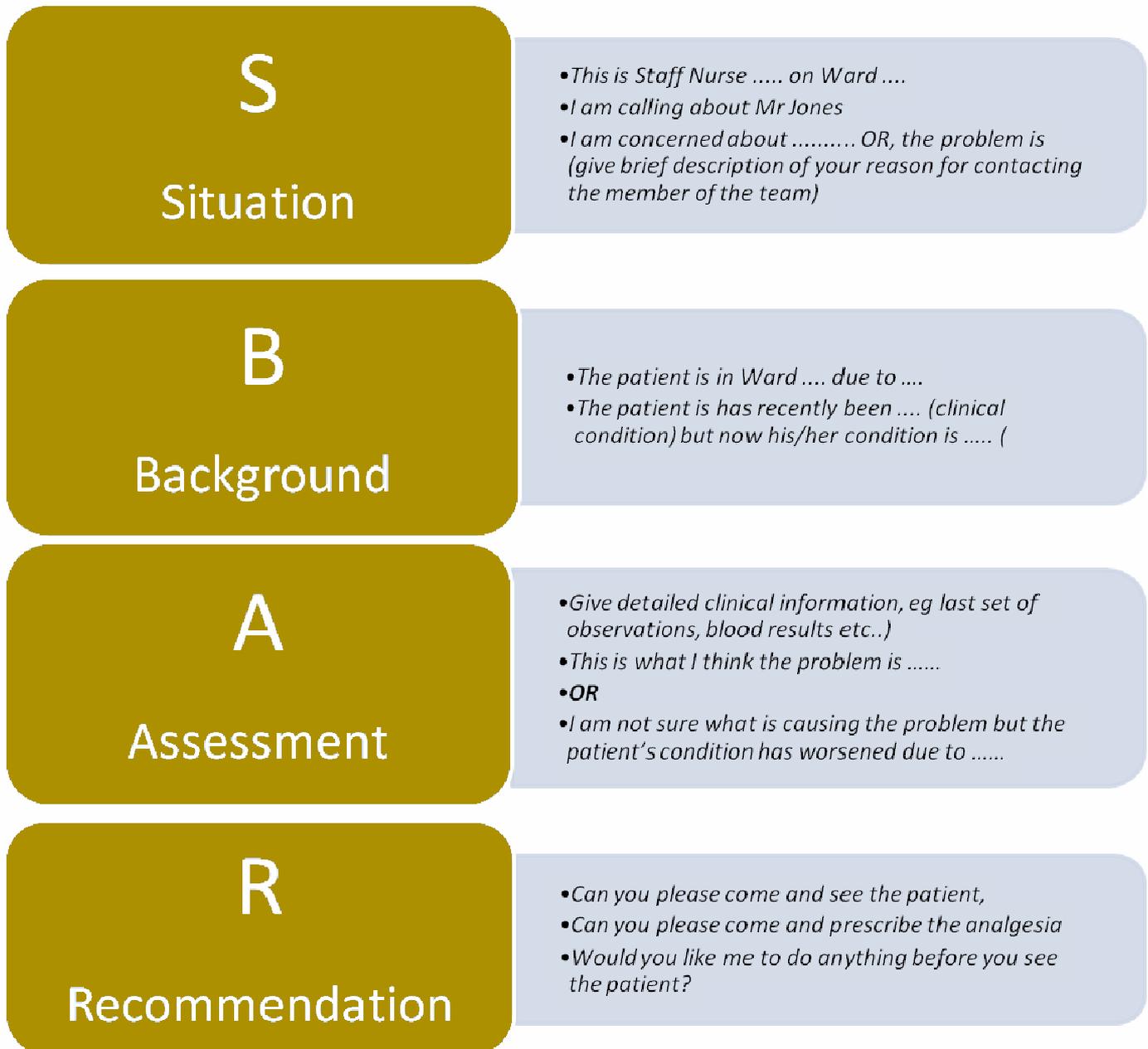
- Venepuncture
- IV cannulation
- Assessment of Ill patient's.
- Insertion of nasal gastric tubes.
- Tracheotomy care
- Arterial blood gas sampling
- 1st dose IV antibiotics and IV Drugs
- Care of Central lines and HICC/ PICC lines
- ECG interpretation
- Urinary catheterisation for male and female patients
- Assessment of patients following a fall
- Radiology requesting as per protocol. Chest, Abdominal and Skull X-Rays
- Review X-Rays
- NIV Management
- Administration of medicines under Patient Group Directions (PGDs)
- Verification of Life Extinct for expected death.
- Clinical Supervision in clinical skills.

Hospital at Night – Early Warning Scoring (EWS) action chart

TOTAL SCORE	ACTION TO TAKE
0 – 1	Continue observation as before
2 – 3 AGGREGATE SCORE OF 2 NUMBERS I.E 2+1	Inform nurse in charge re-calculate 1 hour later (or sooner as patients condition dictates) and consider BM
4 – 6 (OR 3 FOR 1 PARAMETER)	<p>Airway, Breathing, Circulation, Disability and Exposure assessment Inform nurse in charge & contact CLINICAL CO-ORDINATOR– WHO WILL ASSESS PATIENT WITHIN 15MINS AND CALL F2/CMT/ST IMMEDIATELY Consider high flow oxygen, IV Access +/- IV Sodium Chloride 0.9% appropriate bloods. (Consider 12 lead ECG/CXR/ABG)</p> <p>If no response to interventions, consider: Request attendance of Senior Medical staff/ On call consultant After talking to senior medical staff/consultant consider transfer to critical care.</p> <p>Resuscitation status to be reviewed by SpR or Consultant on- call</p>
7 OR GREATER	As above with immediate senior medical staff/ consultant bedside review from the particular speciality
NB	If patients normal observations fall into action score, record below and observe for deterioration outside patients normal range

Staff Nurse must clearly document in the Action Plan what events occurred during the episode of acute illness according to the score.

All non-urgent calls from the wards should go to the Clinical – Co-ordinator in accordance with the bleep policy. Any doctors receiving calls from the wards after this should redirect them to the CC unless in the event of an emergency.



Always document your SBAR communication in the patient's Nursing Evaluation Booklet.

Your documentation of the SBAR report should;

- Be concise and reflective of what you communicated. (S)
- Include date and time recorded (S)
- Identify name of staff member you communicated with (S)
- Clearly state reason for contacting staff member (B)

