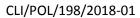




BARTS HEALTH TRUST CORPORATE POLICY OBSERVATION AND ESCALATION POLICY - ADULT PATIENTS [Excluding Pregnant Women]

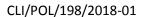
APPROVING COMMITTEE(S)	Trust Policies Committee	Date approved:	13 December 2018		
EFFECTIVE FROM	Date of approval				
DISTRIBUTION	Policy Liaison Officers for distribution to all Clinical Staff				
	Adverse Incident Policy				
	BH Critical Care Tran	sfer Guidelines.			
	Communicating With	Doctors Out Of Hou	rs (Bleep Filtering)		
	Duty of candour follow	wing adverse events			
	Do Not Attempt Card Policy	iopulmonary Resusc	itation (DNACPR)		
	End Of Life Care Deli	ivery			
	Mandatory Training -	Acute Care Skills			
RELATED DOCUMENTS	Neurological Observa	ation Policy			
	Oxygen Delivery Poli	су			
	High Flow Oxygen Po	olicy			
	PCA / Epidural Pain I	Management Policy			
	Resuscitation / Resus	scitation Training			
	Safeguarding vulnerable adults				
	Sepsis Policy				
	Tracheostomy Guidelines Treatment Escalation Plans				
	National Patient Safety Agency [2007] Recognising a responding appropriately to the early signs of deterioration hospitalised patients.				
	NICE [2007] Clinical Hospital	l Guideline 50 - Ad	cutely III Patients in		
	National Early Warning Score: Standardising the assessment of acute-illness severity in the NHS [2012]				
STANDARDS	Care Quality Commission Report 2015 for NUH; WXUH and RLH				
	National Early Warning Score [NEWS] 2: Standardising the assessment of acute-illness severity in the NHS [2017]				
	NHS England [2018] Patient Safety Alert – Resources to Support the safe adoption of the revised National Early Warning Score [NEWS2].				





OWNER	We Prevent Group		
AUTHOR/FURTHER INFORMATION	Nurse Consultant Critical Care Outreach Critical Care Outreach Service		
	Practice Facilitators Critical Care Outreach		
SUPERCEDED DOCUMENTS	All previous existing Observation and Escalation Policies in Adult Care		
REVIEW DUE	3 years after approval		
KEYWORDS	Early warning score; escalation pathway; trigger threshold; sepsis; Acute Kidney Injury [AKI]; NEWS 2		

INTRANE	T LOCATION(S)			
IIIII	LOGATION(O)	Critical Care [Adult patients]		
z	7	We Prevent Group		
CONSULTATION		Accident and Emergency Department		
LTA	Barts Health	Neurosurgeons		
Isn	20.10 7.00.17	Pain Service		
00		Learning Difficulties Nurse Specialist		
		Risk Management Unit / Healthcare Governance Clinical Standards Committee		
SCOPE OF APPLICATION AND EXEMPTIONS	Included in policy: For the groups listed below, failure to follow the policy may result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees, and other action in relation to organisations contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement. All Trust staff, working in adult areas excluding Maternity Services			
) LC	Excluded from the policy:	<u> </u>		
= APF XEMI	Patients under 16 years old [national guidance]			
PE OI	NB Local Guidance - Adolescents who are placed on non-paediatric wards e.g.Trauma Ward can with the agreement of their Paediatric Team use NEWS2 if deemed appropriate			
သဒ	Pregnant women [> 17 weeks gestation]			
	Patients who are receiving end of life care			
	Caution if high spinal cord patients are assessed with NEWS 2			



REFERENCES/BIBLIOGRAPHY



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TITLE: OBSERVATION AND ESCALATION POLICY – ADULT PATIENTS

1 INTRODUCTION

Definitions

ACCU	Adult Critical Care Unit
AKI	Acute Kidney Injury
Autonomic Dysreflexia	Is a potentially life threatening complication that can occur in spinal cord injured patients [usually T6 and above] where there is unopposed sympathetic outflow to a noxious stimulus. Uncontrolled hypertension, bradycardia, headache and facial flushing are common signs of the condition.
Cauda Equina Syndrome [CES]	Cauda equina syndrome is a rare disorder where there is compression of the bundle of nerve roots at the lumbar end of the spinal cord. It is a surgical emergency.
CREWS	Chronic Respiratory Early Warning Score
COPD	Chronic Obstructive Pulmonary Disease
CRT	Capillary Refill Time - A rapid clinical test for assessing blood flow through peripheral tissues.
Critical Care Outreach Team	A team of critically care trained practitioners who are able to oversee the care and management of level 1 patients with the wider multi-professional team and assist in the management of level 2 [HDU patients] and level 3 [intensive care patients] with other ACCU staff during treatment escalation and admission to critical care.
CVAPU	A rapid initial way of assessing level of consciousness. Any patient who is not alert should have a formal GCS performed.
Cyanosis	The appearance of blue/purple colouration in the skin or mucus membranes due to poor oxygenation of the tissues.
DVT	Deep vein thrombosis.
Early Warning Score [EWS]	Early Warning Score standardises the assessment of acute illness whilst determining the overall patient acuity from normal bedside observations.
ECG	Electrocardiogram – trace of the heart rhythm
Escalation	The process of highlighting a concern and engaging other senior clinicians in the process of reviewing and treating a patient
FAST	FAST is a mnemonic used to identify and respond to stroke victims - Facial drooping, A rm weakness, S peech difficulties and T ime to seek urgent medical help.
GCS	Glasgow Coma Scale assesses conscious level in response to a defined stimulus.
HDU / Level 2	High Dependency Unit is a specialised unit that admits patients with single organ failure
Hospital At Night Team	A team of senior practitioners who review sick/deteriorating patients or those patients relocating from ACCU
Hypercapnic Respiratory Failure	Hypercapnic Respiratory Failure (type 2 respiratory failure) is hypoxia with an arterial partial pressure of carbon dioxide (PaCO ₂) of >6.5kPa on room air at sea level.
ICU / Level 3	Intensive Care Unit is a specialised unit that admits patients requiring advanced respiratory support and or requiring multiple organ support.
Medical Outlier	A patient nursed outside the specialty area
NEWS	National Early Warning Score – aggregated score to determine patient acuity. NEWS2 is an amended version of the score which was published by the Royal College of Physicians in December 2017



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- 1 - 1 1				
NICE	National Institute for Clinical Excellence – provides national guidance and advice to improve health and social care.			
NPSA	National Patient Safety Agency – a national forum that monitors patient safety incidents.			
SBAR	SBAR is a structure communication tool that describes the S ituation; B ackground; A ssessment and makes R ecommendations on what should happen next.			
SCI	Spinal Cord Injury			
Sepsis	Sepsis is a life threatening organ dysfunction caused by a dysregulation host response to infection.			
Sepsis Six	Care bundle delivered in caring for a septic patient to reduce morbidity and mortality.			
SpO ₂	Measured using pulse oximetry and determines the peripheral capillary oxygen saturation			
SpR	Special Practice Registrar – A senior doctor who is completing their specialty training.			

SUMMARY OF THE POLICY

The policy provides a framework for the safe clinical care of patients within the Trust. This includes type and frequency of physiological observations, use of National Early Warning Score 2 (NEWS2) [Table 1], escalation protocol and best practice advice on the movement of patients into and out of critical care areas [Intensive Care Unit (ICU) or High Dependency Care Unit (HDU)]. This policy particularly applies to patients that deteriorate and require escalation of their care in order to reduce the risk of morbidity and mortality.

Treatment Escalation Plan – This denotes ceilings of therapy where appropriate.

1. PURPOSE

TEP

1.1 This policy outlines the minimum standard of care regarding physiological observations and escalation of care expected from clinical staff for adult patients [> 16 years] within the Trust excluding pregnant women 17 weeks gestation or more. The policy has been written in accordance with guidelines from the National Institute of Clinical Excellence (NICE) the Royal College of Physicians, the National Patient Safety Agency (NPSA) and the results from root cause analysis of serious incidents in the Trust.

1.2 The policy details:

- a. Physiological observations that should be measured
- b. Resetting trigger thresholds for patients with comorbid disease
- c. Determining the frequency of observations
- d. Establishing a monitoring plan.
- e. Responding to clinical deterioration.
- f. How to escalate the care of a patient for a senior review.
- g. Establish treatment limitations.
- h. How to make a referral to the critical care team
- i. Transferring to and from High Dependency Unit [HDU] and Intensive Care Unit [ICU]

NEWS2 is NOT SUITABLE FOR PATIENTS LESS THAN 16 YEARS OR PREGNANT WOMEN > 17 WEEKS GESTATION.

CAUTION WHEN EVALUATING HIGH SPINAL CORD INJURED PATIENTS WITH NEWS 2

THESE PATIENTS MAY DEVELOP AUTONOMIC DYSREFLEXIA

NB In Bart's Health NHS Trust Pregnant women and children have their own early warning scores [EWS] and escalation policies to address their clinical need for monitoring and escalation in care.



2. APPLICATION

2.1 This policy applies to all those working in the Trust in whatever capacity. A failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement.

3. THE POLICY

- 3.1 Adult patients in acute hospital settings, including patients in the Accident and Emergency Department for whom a clinical decision to admit has been made must have:
 - a) **Physiological observations** recorded at the time of their initial assessment or admission that incorporates a **NEWS2**.
 - b) All patients are admitted under SpO₂ Scale 1 **unless** documented by a competent clinical decision maker to commence Scale 2. <u>Only</u> patients with pre-existing or newly diagnosed with hypercapnic respiratory failure should use Scale 2 for SpO₂ monitoring [See Section 5]. The decision to commence Scale 2 must be reviewed by the patient's parent medical team SpR or Consultant within 24 hours.
 - c) A clear written monitoring plan that specifies which physiological observations must be recorded and how frequently. The patient's plan of care must take account of the patient's diagnosis and presence of co-morbidities.
- 3.2 **NB**: The team that is responsible for the patient's medical management should also be recorded on the front of the observation chart with the contact bleep number.

4. OBSERVATION MONITORING

4.1 As a minimum the following physiological observations must be recorded at the initial assessment of the patient and as part of routine monitoring:

Physiological parameters included in the NEWS

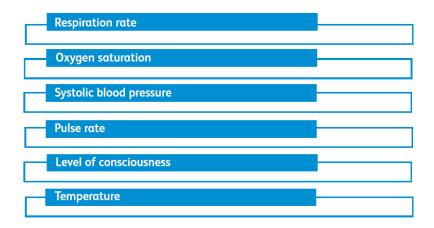
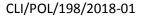
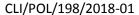


Figure 1: Physiological Parameters Recorded in NEWS2





- **NB** [i] Oxygen saturation the use of Scale 2 must be verified by the competent clinical decision maker caring for the patient
 - [ii] Supplemental oxygen Add 2 NEWS points
- 4.2 The physiological observations listed above constitute a full set of basic observations [Appendix I]. These observations must be RECORDED 12 HOURLY AS AN ABSOLUTE MINIMUM, unless the nurse responsible for the patient has used their clinical judgment and has discussed this within the multidisciplinary team at senior level. Any additional elements that need to be included in each set of observations must be identified and agreed locally.
- 4.3 The NEWS2 must be used to monitor all adult patients except pregnant women over 17 week gestation and be performed as an integral part of each observation. Total the score for each component in accordance to the patient's observations. All seven parameters must be included in the calculation for accuracy.
- 4.4 Observation trends should be interpreted in line with the patient's normal baseline values. Any deviation should be escalated to the nurse in charge to allow a timely review.
- 4.5 If systolic blood pressure (SBP) falls greater than 20mmHg from their normal baseline a repeat blood pressure is required in 30 minutes. If a patient's SBP falls greater than 40mmHg from their normal baseline this must be escalated to medical staff for an immediate review, as this is a high risk marker for sepsis. A Sepsis Proforma should be completed to ensure that they are not septic. Staff should with-hold any antihypertensive medication until the patient is reviewed and 30 minute observations should be recorded.
- 4.6 For patient's not requiring close monitoring of their urinary output, staff must ascertain whether the patient has voided urine in the last 6 hours. Commence a fluid balance chart when clinically indicated and for those patients within medium and high risk score [see Section 6].
- 4.7 All responses other than alert now scores 3 in NEWS 2. Patients who have a chronically altered level of consciousness should have their baseline level of consciousness recorded on the front of the chart. Once verified this is the patient's normal state of alertness this should score 0. Any deviation from this should score 3 and be commenced on a GCS and a urgent medical review. NB new onset confusion now scores 3 in NEWS2.





Physiological Score 3 2 1 2 3 parameter 0 Respiration rate 9-11 12-20 21-24 ≥25 ≤8 (per minute) 94-95 SpO₂ Scale 1 (%) ≤91 92-93 ≤96 88-92 93-94 on 95–96 on ≥97 on SpO₂ Scale 2 (%) 84-85 86-87 <83 ≤93 on air oxygen oxygen oxvaen Air or oxygen? Air Oxygen Systolic blood 101-110 111-219 91-100 ≥220 ≤90 pressure (mmHg) 51-90 91-110 Pulse (per minute) ≤40 41-50 111-130 ≥131 Alert **CVPU** Consciousness Temperature (°C) ≤35.0 35.1-36.0 36.1-38.0 38.1-39.0 ≥39.1

Table 1: National Early Warning Score [NEWS]2

- The front of the observation chart allows pre-assigned trigger thresholds to be changed in line with the patient's chronic abnormal physiology caused by their co-morbidities i.e. their physiological norm may be different from that pre-assigned values. The Parent Medical team who have a clear understanding of the patient's baseline physiology may complete this section of the chart. The patient's frequency of observations can also be documented on the front of the chart in conjunction with escalation parameters.
- 4.9 The general Trust observation chart will be used to monitor all patients **EXCEPT** patients who require additional monitoring of their Glasgow Coma Scale or who have patient controlled analgesia or epidural in situ. In this case the relevant chart is selected and NEWS2 is calculated and recorded on the appropriate chart.
- 4.10 The NEWS2 chart will be used [Appendix II]. This chart is arranged in an A E format is colour coded to alert staff when the patient's observations are triggering on the NEWS2 parameters.

NEWS2 should aid clinical assessment but must NEVER REPLACE COMPETENT CLINICAL JUDGEMENT.

Some patients may exhibit <u>RED FLAG SYMPTOMS</u> but not trigger NEWS2. These patients are still at risk and need urgent attention and escalation in care:

Cardiac chest pain at rest lasting longer than 20 minutes

Headache of dramatically sudden onset

Palpitations associated with syncope

Cauda equina syndrome

Painful swollen calf

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- 4.11 VULNERABLE ADULTS and patients with learning difficulties should have their baseline function assessed using additional information from a carer or family member who knows them well and their Learning Disabilities Hospital Passport. When patients have difficulty in engaging with basic observations consider reasonable adjustments e.g. requesting the support from the carer to ensure the observations are being recorded and advise the Lead Nurse Learning Disabilities. Alterations in their behaviour e.g. increasing agitation or drowsiness should be seen as an adverse sign and the patient should be reviewed by medical staff to determine its significance. If a patient is refusing and unable to engage with basic observations consider the patients capacity to consent to treatment and best interest decision making. This guidance similarly applies to patients with dementia or mental health disorders.
- 4.12 Patients who may require more comprehensive and frequent observations include:
 - New admissions
 - Post procedure patients in the first 48 hours after their intervention
 - Patients requiring additional monitoring secondary to specialist treatment or blood product transfusion
 - Patients recently discharged from ICU or HDU care
 - Patients who are giving cause for concern
 - Patient who are septic
 - Neutropenic patients

These patients will require more frequent observation as determined by the most senior qualified healthcare professional overseeing their management.

- 4.13 MEDICAL OUTLIERS [i.e. those patients who are nursed in a different specialist ward to their care needs] should be monitored closely with clearly documented parameters on when the team should be alerted regarding any physiological change. Such patient's must be reviewed daily by their medical teams [FY2 or above] and relocated to the specialist ward as soon as is practical. Higher acuity patients should be nursed in an appropriate ward where staff can meet their clinical needs.
- 4.14 Any decision to change the frequency of observations must have a clearly documented rationale recorded on the front of the patients' observation chart and/or in their healthcare record. PATIENTS RECEIVING END OF LIFE CARE ARE EXEMPT FROM THIS POLICY.
- 4.15 The frequency of monitoring must increase if abnormal physiology is detected as outlined in the section on graded response strategy [Section 6].
- 4.16 Observations which show a significant change should be repeated immediately. Check blood pressure using a manual sphygmomanometer, reposition the cuff and ensure it is the correct size, take a manual pulse, count the respiratory rate and ask the patient how he/she feels.
- 4.17 All communications between health professionals regarding patients at risk of deterioration should be carried out using the SBAR communication tool [Appendix IV and V].

Explain: The patients current **Situation**

Relevant medical Background

Your **Assessment** of the patient's condition



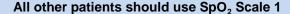
What your Recommendations to the health professional are regarding their assistance

5. SpO₂ MONITORING & OXYGEN DELIVERY

NEWS2 now differentiates patients with Hypercapnic Respiratory Failure to ensure that they do not incorrectly trigger the NEWS2 but more importantly they are not given excessive supplemental oxygen.

SpO₂ scale 2 is used for patients with hypercapnic respiratory failure with a target saturation of 88-92%. This should be signed for by a competent clinical decision maker on the front of the chart. A SpR or consultant must review this decision within 24 hours and document. SpO₂ scale 1 should be crossed out on the patient's observation chart.

This system is similar to the CREWS previously used within the Trust but is now integral to NEWS2.



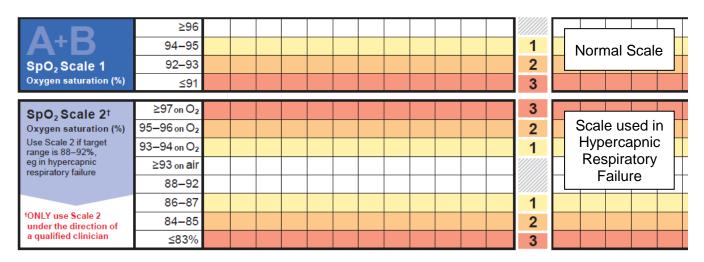


Figure 2: SpO₂ monitoring scales incorporated in NEWS2

How oxygen delivery is recorded and the administration device has also been standardised within NEWS2 in line with the guidance from the British Thoracic Society. Each oxygen device has a code and the overall percentage of oxygen delivered and or the flow rate is now recorded.

Codes for recording oxygen delivery on the NEWS2 observations chart				
A—AIR	RM—Reservoir mask			
N— Nasal Cannula	TM—Tracheostomy mask			
SM— Simple Face Mask	CP—Continuous positive airway pressure			
V—Venturi mask and percentage (eg V24, V28, V35, V40, V60)	NIV — Non-invasive ventilation			
H—Humidified oxygen and percentage (H28, H35, H40, H60)	OTH— Other, specify			
HFO—High-flow humidified oxygen via nasal cannulae/tracheostomy				



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Figure 3: Oxygen Delivery Device Codes

Air or	A=Air				
	%/L/min O ₂				2
Oxygen?	Device				

Figure 4: Recording of Supplemental Oxygen Delivery

Flow (L/min)

6. GRADED RESPONSE STRATEGY

The response to patients at risk of clinical deterioration should consist of 4 levels as outlined below:

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low-medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

Figure 5: NEWS2 thresholds and triggers

All healthcare staff recording data or responding to the NEWS2 should be trained in its use. The staff must understand the significance of the scores and trigger thresholds and escalate care timely and appropriately

Low – Medium Scores Respo

Response by a Clinician or Clinical team who is competent in the assessment and treatment of acutely ill patient and determines if any escalation is required.

Medium - High Scores

The response team must include staff with critical care skills including airway management.



LOW RISK			
Score	Frequency of Observations	Patient Escalation	Clinical Response
0	Minimum 12 hourly	Registered Nurse [RN]	 Continue routine NEWS2 monitoring Escalate patient if concerned about the patient's clinical condition irrespective of NEWS
1-4	Minimum 4 – 6 hourly	RN Nurse in Charge [NIC]	Any deterioration: Nurse in Charge to review patient Increase observation frequency Check for other adverse signs ENSURE NO PARAMETER SCORES 3

MEDIUM R	ISK		
Score	Frequency of Observations	Patient Escalation	Clinical Response
Single parameter scores 3	Minimum 1 hourly	Nurse in Charge [NIC] Parent Medical Team	 Medical review and escalation plan
5-6 URGENT RESPONSE	Repeat observations within 30 minutes & then 1 Hourly minimum [until the patient is reviewed]	Parent Medical Team CCOT/H@NT PATIENT MUST BE REVIEWED BY A CLINICIAN WITH COMPETENCIES TO ASSESS & TREAT ACUTELY ILL PATIENTS	 Immediate review Commence Sepsis Proforma & fluid balance chart Ensure Senior Registrar or Consultant aware of patient's condition/treatment plan Consider Critical Care Review if appropriate NEW score of 5 or more? Think sepsis! COMPLETE SEPSIS PRO FORMA & PROVIDE SEPSIS 6

^{&#}x27;Sepsis is life-threatening organ dysfunction caused by a dysregulated host response to infection.'

CLARIFY THE ESCALATION PLAN OR LIMITATIONS OF THERAPY IF FURTHER DETERIORATION OCCURS



HIGH RISK

If the patient has a LIFE THREATENING CHANGE in their

Airway [including tracheostomy/laryngectomy emergencies]

Breathing

Circulation

FAST +ve / Reduced Glasgow Coma Scale

Call the Cardiac Arrest Team 2222 and commence resuscitation

Score	Frequency of Observations	Patient Escalation	Clinical Response
>7 NOT LIFE THREATENING	Continuous Monitoring	Nurse in Charge [NIC] Registrar/Consultant Parent Medical Team CCOT/H@NT REVIEW BY A CLINICIAN WITH CRITICAL CARE COMPETENCIES WHICH INCLUDES ADVANCED AIRWAY SKILLS	 Immediate review Ceilings of therapy clarified Consider transferring to Level 2 [HDU] or Level 3 [ICU]

If the patient fails to respond to initial therapy and/or continues to deteriorate call CCOT/H@NT or the ICU Registrar

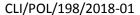
ENSURE THE CONSULTANT RESPONSBILE FOR THE PATIENT'S CARE IS AWARE OF THEIR CONDITION

IF THERE IS ANY DELAY IN DIAGNOSTIC WORK UP OF A DETERIORATING PATIENT INVOLVE THE CONSULTANT

For Medium to High Risk patients ascertain:

When patients trigger their NEWS2 and escalation is required this must be documented within the Escalation Log. The responding team needs to sign, date and time once the patient has been reviewed [Figure 6].

An appropriate medical response MUST occur. If there is no reply from the team member being contacted, contact the next most senior member of the team until advice/assistance is received e.g. If no response from SHO, contact SpR, if no response form SpR contact consultant. Contact the Site Manager for assistance if there are on-going problems getting medical advice or assistance.

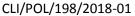




	Escalation Log							
Date	Time		Escalated to Med/ CCOT/H@N/RN	Action Plan	Signature (RN/AHP/ HCSW)	Responding team Signature	Date	Time

Figure 6: Escalation Log Barts Health NHS Trust

- 6.2 Initiate appropriate interventions to address the patient's deterioration [Appendix III]
- 6.3 Ward staff must stay with the patient to **monitor** the patient's condition **continuously**, liaise with and assist other health professionals that have been called to review the patient.
- 6.4 Clarify and document overall treatment plan including treatment limitations where appropriate in the patient's healthcare record.
- 6.5 Outcomes of all referrals and reviews must be clearly documented in the patient's healthcare record.
- 6.6 The patient's fluid balance must be assessed and a fluid balance chart commenced.
- 6.7 Ensure that the nursing team are fully aware of any plan made and are able to action it.
- Reassess the patient's response to therapy. If the patient fails to improve call other clinicians of an appropriate senior grade and specialty to assist.





7. ADMISSION TO CRITICAL CARE

- 7.1 If the team caring for the patient considers that admission to a critical care area is clinically indicated, the decision to admit the patient must involve both the Consultant caring for the patient on the ward and the Critical Care Consultant.
- 7.2 The patient should be moved to ICU or HDU as soon as possible after the decision to admit has been made. Acute interventions and monitoring instigated must be maintained whilst the patient awaits transfer to a higher level of care.
- 7.3 Where a delay is incurred the patient should be appropriately supervised and receive the **correct level of care irrespective of their geographic location**. A monitoring and escalation plan must be agreed between the parent medical team, outreach and critical care medical team.
- 7.4 Staff accompanying the patient to critical care should have the required competencies to care for a critically sick patient and adhere to the critical care transfer guidelines.

8. DISCHARGE FROM CRITICAL CARE

- 8.1 After the decision to transfer a patient from a critical care area to a ward has been made they should be transferred as early as possible.
- 8.2 Transfers from critical care areas to wards between 22:00hrs and 07:00hrs should be avoided whenever possible and should be documented as an adverse clinical incident if they occur.

9. CARE ON THE WARD FOLLOWING TRANSFER FROM CRITICAL CARE

- 9.1 The critical care team and the ward team must jointly ensure that:
 - Continuity of care through a formal structured handover from critical care to ward staff (both medical and nursing).
 - There is a written plan of care post critical care discharge which covers the first 24-48 hours that includes details of on-going therapy and monitoring needs.
 - That the receiving ward can deliver the plan of care.
 - The physiological and emotional needs of the patients transferred from critical care must be considered as part of the care plan.
 - An agreed plan of care for high risk patients who may have a further clinical deterioration regarding further escalation in care is documented.
- 9.2 CCOT will provide early follow up of patients discharged from critical care and consideration will be given to their on-going healthcare and rehabilitation needs and rehabilitation will continue as guided by the patient's multidisciplinary team. Hospital at Night should be informed of out of hours follow up to ensure a smooth transition in care.



Appendix I - Observation Recording

Respiratory rate

Must be counted and not estimated.

Count for 1 minute.

Note depth, pattern, equal chest expansion, increased work of breathing.

Blood Pressure

Bladder of cuff must encircle at least 80% of arm

Apply cuff to bare skin, not over clothing

Use a manual sphygmomanometer in all **medium** (Amber) and **high risk** (Red) patients

NB if SBP drops greater than 40mmHg from patient's baseline escalate patient for an immediate review and withhold antihypertensive[s] until patient reviewed.

If SBP drops greater than 20mmHg from patients baseline repeat SBP in 30 minutes.

Also screen the patient for Sepsis

DO NOT apply cuff to limb with:

- Dialysis fistula or shunt
- Implants
- Trauma, burn, fracture
- Mastectomy on that side

Pulse

Manually count pulse at radial artery for 1 minute – assess rate, rhythm and volume.

If unable to palpate radially suspect hypotension, feel for brachial or carotid pulse.

In addition, assess Capillary Refill Time by applying pressure at nail bed for 5 seconds. Once released the colour should return in < 2 seconds. Ensure arm is level with the patient's heart level.

SpO₂

Aim for \geq 95% for patients with normal respiratory function.

Competent clinical decision makers can select SpO₂ Scale 2 for patients with Hypercapnic Respiratory Failure - aim for saturations 88%-92%.

Do not use Dynamap monitor to measure pulse – the pulse should be performed manually.

Use assessment skills – examine for pale mucous membranes, peripheral and/or central cyanosis.

SpO₂ does not monitor ventilation.

DO NOT TAKE O₂ OFF WHEN TAKING A BLOOD GAS

Inaccurate readings are given due to:

- Poor perfusion (cold hands)
- Nail varnish
- Jaundice
- Carbon monoxide poisoning
- · Faulty machine



Oxygen Delivery

Follow the British Thoracic Society Guidelines for Oxygen Delivery Devices [see Section 5].

Record:

- [i] The amount of oxygen administered [oxygen percentage or litres per minute depending on the device used]
- [ii] For high flow oxygen delivery record percentage of oxygen administered and flow rate of the device
- [iii] For Hypercapnic Respiratory Failure Patients will trigger NEWS2 and will indicates oxygen is to be weaned

Temperature

Normal levels between 36-37.4°C

To get an accurate reading, pull the ear up and back to straighten ear canal when using tympanic/ear thermometers.

Escalate immediately if temperature is un-recordable.

Neurology (CAVPU)

C: Confused Refers to new onset confusion - patient not orientated to one or more: person/place or time

A: Alert, appropriate, orientated to person, place and time

V: Responding to **Voice** only, drowsy

P: Responding to central Pain only, by localizing or flexion, obtunded

U: Unresponsive to painful stimuli

Check blood sugars, check pupils, protect and provide an airway for patients if \mathbf{P} or \mathbf{U} – consider putting the patient in recovery position – caution for trauma patients who have not had their C spine cleared. Call for help with any change in level of consciousness and commence Glasgow Coma Scale.

2222 if patient found unresponsive

Urine Output

Calculate according to patient's weight

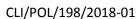
Acceptable amount is between 0.5 mls to 3 mls/kg/hour for patients who have normal renal function

Consider Acute Kidney Injury (AKI) if urine output <0.5ml/kg/hr and Creatinine is elevated from patients baseline

Example: if patient weighs 80 kgs

Minimum urine output = $0.5 \text{ mls/kg/hour} = 0.5 \times 80 = 40 \text{ mls/hour}$

Maximum urine output = 3mls/kg/hour = 3 x 80 = 240 mls/hour





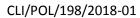
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Appendix II - NEWS2 Observation Chart

A + B 223										_						
A + B	Year	DATE														DATE
Respirations 19-20 Breaths/min 19-21 Scale 1 286 Sp02 (8) 99-99 Sp02 (8) 99-99 Scale 2 275 0.0. 33 Scale 2 275 0.0. 32 Sp02 (8) 99-99 Scale 3 1 99-99 Scale 3 1 99-99 Scale 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month	TIME														TIME
Respirations 19-20 Breaths/min 19-21 Scale 1 286 Sp02 (8) 99-99 Sp02 (8) 99-99 Scale 2 275 0.0. 33 Scale 2 275 0.0. 32 Sp02 (8) 99-99 Scale 3 1 99-99 Scale 3 1 99-99 Scale 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		≥25							3							≥25
18-20 18-2	A + B															21-24
Scale 1																18-20
Scale 1 9-11																15-17
Scale 1 296 5902 (8) 9-293 1 9-295 1 9-295 9-295 1 9-295 9-295 1 9-295 9-295 1 9-295	Breaths/min															12-14
Scale 1 396									1							9-11
Scale 1 296 590 1 1 94-95 92-93 1 1 94-95 92-93																≤8
Scale 2 94-95 92-93 2 93-95 92-93 92-95 92-93 92-95 92-93 92-95 92-93 92-95		<u> </u>					•									
SpC2 8 92-93 9	Scale 1															
Scale 2 S7 on 0, 0 S8 S8 S8 S8 S8 S8 S8	SpO2 (%)															
Scale 2 SP7 on O.	/															
Sept						-			3							
Spo, 88-92% 99-94 on O ₂ 99-94 on O ₂	Scale 2	≥97 on O ₂														≥97 on O ₂
299 on Air 88-92 88-98		96-95 on O ₂							2							96-95 on O₂
Select 2 under the Select 7 Select 1	SpO₂ 88-92%	93-94 on O ₂							1							93-94 on O ₂
Scale 2 under the direction of S4-45 3-4		≥93 on Air														≥93 on Air
Medical Team S83		88-92														88-92
Act		86-87							1							86-87
Air or		84-85							2							84-85
Air or	Medical Team	≤83							3							≤83
Air or		A=Air		Ī		T										A=Air
Device Flow (Limits) Flow (Limits) Flow (Limits)	Air or								2							
Capitage Flow (L/min) Flow (L/min) Flow (L/min)																Device
C 201219 181200 18120	Oxygen?					1										
SBP mmHg 181-200 18														-		
SBP mmHg 181-200 18									3							≥220
161-180 161-			 	<u> </u>	-	-	-			-	-	-				201-219
Sep drops 20mmlg 141-160 141-	SBP mmHg					-										
The past Part at 2 141-160 14																
Minutes 111-120 58P drops 101-110 101-111 1 101-111 1 101-111 1 101-111 1 1 101-111 1 1 101-111 1 1 101-111 1 1 1 101-111 1 1 1 1 1 1 1 1						-										141-160
Sept drops 101-110 1																
Description																111-120
Description																101-110
Medical review S1-90									2							91-100
L Lying 123 61-70 51-6		81-90										ļ				81-90
S-Standing		71-80														71-80
SSO SS MAPS MAP		61-70							3							61-70
MAPs		51-60														51-60
MAPs 2131 3 2131 2131 3 2131 3 2131 3 3 3 3 3 3 3 3 3	78	≤50														≤50
Pulse		MAPs														MAPs
Pulse		≥131							3							≥131
Beats/min	Dulco															121-130
101-110									_		i	i	i	i	i	
91-100 81-90 81-	Beats/min								1							
Since Sinc									_							
1																
61-70 51-60 1	89 87															
S1-60	- 07															
A1-50 31-40 3 3 3 3 3 3 3 3 3	? •															
New Confusion New Confusio	\ /								1							
S S S S S S S S S S	V															21.40
Reg/Irreg	- 75								3							
Alert New Confusion New																
New Confusion			 	<u> </u>	<u> </u>			-		-		-				
Verbal	Р															Alert
Pain Unresponsive Pain	U															New Confusion
NEW anset contraion (no score if chronic) Pain Unresponsive	Consciousness								3							Verbal
E 239.1 239. 23	NEW onset confusion (no	Pain														Pain
Temperature °C 38.1-39.0 36.1-38.0 36.1-38.0 35.1-36.0	score if chronic)	Unresponsive														Unresponsive
Temperature °C 38.1-39.0 36.1-38.0 36.1-38.0 35.1-36.0	_	≥39.1							2							≥39.1
Temperature °C 36.1-38.0 35.1-36.0 1 35.1	E															38.1-39.0
1 35.1-36.0	_															36.1-38.0
≤35.0 3 ≤35.0 3 ≤35.0 3 ≤35.0 3 ≤35.0	Temperature °C								1			İ				35.1-36.0
NEWS Total																≤35.0
Pain (0-10)** At rest 0 = no pain 1	NEW CT			i												
0 = no pain			 <u> </u>	<u> </u>		<u> </u>		Ļ		<u> </u>	<u> </u>	<u> </u>	 			Total
Capillary Blood Glucose mmol/L Monitoring frequency (hrly/mins) Escalation of Care Y/N/NA Contacted (RN/Med/CCOT/H@N) Movement Capillary Blood Glucose mmol/L CBG mmol/ Frequency Escalation Contacted (RN/Med/CCOT/H@N)		At rest														At Rest
Capillary Blood Glucose mmol/L Monitoring frequency (hrly/mins) Escalation of Care Y/N/NA Contacted (RN/Med/CCOT/H@N) Contacted (RN/Med/CCOT/H@N)	0 = no pain 10 = worst pain imaginable															Movement
Monitoring frequency (hrly/mins) Escalation of Care Y/N/NA Contacted (RN/Med/CCOT/H@N) Frequency Escalation Contacted (RN/Med/CCOT/H@N)			i	i	i	†	Ì			 		i -		 		
Escalation of Care Y/N/NA Escalation Contacted (RN/Med/CCOT/H@N) Contacte	Capillary Blood	Glucose mmol/L	 <u> </u>	<u> </u>	<u> </u>	<u> </u>		Ļ		ļ		-	ļ	<u> </u>		cBG mmol/L
Contacted (RN/Med/CCOT/H@N) Contacte	Monitoring freque	ency (hrly/mins)														Frequency
	Escalation	of Care Y/N/NA														Escalation
	Contacted (RN/M	ed/CCOT/H@N)														Contacted
																Initials

** Use PainAD for patients with communication impairment and/or dementia

¹⁸





Appendix III - The A-E of Managing a Deteriorating Patient

PATIENT ASSESSMENT	LOOK, LISTEN, FEEL & MEASURE	INTERVENTIONS
AIRWAY & O ₂	 ♦ Reduced GCS ♦ Increased facial / airway swelling ♦ Abnormal noises—Stridor, gurgling ♦ See-saw breathing TRACHEOSTOMY/LARYNGECTOMY PROBLEMS 	Call 2222 ◆ Positioning [head-tilt & chin lift or jaw-thrust] CAUTION PATIENTS WITH SPINE CORD INJURY [SCI] ◆ Airway adjunct / suctioning AIRWAY EMERGENCY ALGORITHM FOR ARTIFICAL AIRWAY
BREATHING	Respiratory Rate, Depth, Pattern Symmetry and Work of Breathing SpO₂ Auscultation	Oxygen ◆ Positioning ◆ Aid sputum clearance/Physiotherapy ◆ Nebulised therapy if prescribed
CIRCULATION (Compared to baseline)	 ◆ Pulse [Rate, regularity , volume] ◆ Blood Pressure ◆ CRT / Extremities warmth / coolness ◆ Urine Output / AKI CONSIDER SEPSIS 	 ♦ IV access & Bloods ♦ Sepsis 6 [Proforma] ♦ AKI - Fluid Resus, Review Drug Chart, Bladder Scan ♦ Fluid Balance Chart / Urinary Catheter ♦ ECG
DISABILITY	 CAVPU or GCS [If GCS <8 review airway] Pupil Reaction Capillary Blood Glucose Pain Assessment FAST Assessment 	Recovery position [except SCI patient] & GCS chart Treat hypoglycaemia Check Drug Chart / Analgesia / Pain Team Review **[See Acute Pain Management Policy—PainAD] FAST +ve 2222 & immediate Medical SpR review
EXPOSURE	 ✦ Head-to-toe, Front and Back ✦ Rashes, Oedema, Bleeding, Trauma, Abdomen Distension, DVT & Wounds ✦ Temperature 	 Maintain dignity during "exposure" Medical Devices ◆ Prevent and manage hypo / hyperthermia







SBAR Communication Tool

Before calling:

- Assess the patient yourself
- Have all the information to hand
- Know what you want to happen at the end of the phone call

When calling:

- Use SBAR
- Communicate exactly what is concerning you
- Agree a plan with a timeframe
- If you do not get the help you need continue to escalate until you do!

In a Medical Emergency call 2222

- Loss of airway
- Unconscious
- Un recordable BP
- Cardio Respiratory Arrest
- FAST +ve

Situation Clearly state the purpose of

your call from the start

Background Know the patient's relevant

medical history and current

treatment

Have this information to hand

Assessment Full set of recent observations

Calculate NEWS

Your assessment of the situation

Have the charts to hand

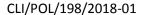
Recommendation Discuss what needs to happen

next

Confirm a time frame for any

actions

Always document your call in the healthcare record



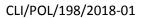


Appendix V - CALLING FOR HELP

If there is no reply from the team/team member being contacted, contact the next most senior member of the team until advice/assistance is received e.g. If no response from SHO, contact SpR, if no response form SpR contact Consultant. You should also contact the Site Manager for assistance if you continue to have problems getting medical advice or assistance. When using the bleep system follow the instructions before you hang up.

	RLH	SBH	NUH	WXUH
Site Manager	Bleep 1111 DEC 45678	Bleep 0287	Bleep 4339	Bleep 2131 or 2003
ССОТ	Bleep 1294 Office 40339 7 days a week 08:00 – 20.30	Bleep 0264	Bleep 4118	CCOT 2673
Hospital At Night	Bleep 1572 or 1573 [Non urgent calls] Or DEC 45681 or 45682	Hospital at Night Team Bleep 1945	CSM Bleep 4339	Bleep 2003 CSM Or CCOT 2673
Adult Critical Care Unit	Bleep 1113 [ACCU SpR] DEC 45715	Bleep 0007	Bleep 4087 ITU SpR	Bleep 2018
Medical Registrar	Bleep 1112 DEC 45645	Cardiology SpR via Mobile on Switchboard QEII SHO Bleep 0034 HAC Bleep Bleep 0358 /0359 HaemOnc via Mobile on Switchboard	Bleep 4627	Bleep 2001 [Acute Take] Bleep 2111 Ward Cover OOH only
Surgical Registrar	Bleep 1676 SHO 1188	Cardiothoracic SpR via Mobile on Switchboard CT SHO Bleep: 0087 Day or Bleep: 0090 Night Haem Onc Bleep 0065 / 0158 Max Fax Bleep: 0267	Bleep 4634	Bleep 2938 [Night]

All communications between health professionals regarding patients at risk of deterioration should be carried out using the **SBAR** communication tool.

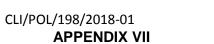




Appendix VI

1. DUTIES AND RESPONSIBILITIES

All staff working in the Trust	CLINICAL STAFF must adhere to the policy. All staff should be able to calculate or interpret a NEWS2 and realise the significance for the patient.
	NURSING STAFF must accurately record the patient's observations as determined by their overall acuity or additional instructions from the medical team.
	MEDICAL STAFF must consider ceilings of therapy; determine what additional observation is required beyond the basic NEWS2 observations and respond appropriately and review deteriorating patients. Doctors should realise their limitations in practice and realise if they need to seek additional help from a more senior or specialised colleague e.g. Critical Care.
	If a patient is placed in an outlying area relevant to their clinical need the medical team must ensure that the patient is reviewed daily by a FY2 Doctor or above and clear guidance is given to the nursing team on how to detect early deterioration should it occur.
Managers	WARD MANAGERS must ensure their team [qualified and unqualified staff] are competent to undertake a set of observations; use the NEWS2 and escalate concerns. Ward Managers will also complete compliance audits on a monthly basis and upload the relevant information on the Quality Improvement Dashboard.
	CLINICAL SITE MANAGERS must ensure that patients are allocated an appropriate bed according to their acuity and clinical need. Sick Level 1 patients should be nursed within the specialty bed base.
Other posts	RESUSCITATION OFFICERS AND RISK MANAGERS must audit compliance with this policy and raise concerns if patients have deteriorated without due process being adhered to.
	CRITICAL CARE OUTREACH PRACTITIONERS/HOSPITAL AT NIGHT TEAM These practitioners should respond timely to ward based referrals from the multidisciplinary team and augment/assist in the care of deteriorating patients on the wards. Moreover these teams must share acute care skills with their ward based colleagues. CCOT/H@NT must escalate concerns to Adult Critical Care or other specialist services as appropriate.
Committees	GOVERNANCE MEETING & DETERIORATING PATIENT GROUP peer review moderate – serious incidents relating to the deteriorating patients and ensure that this policy remains fit for purpose and incorporates national guidance and or safety alerts.





MONITORING THE EFFECTIVENESS OF THIS POLICY

[See Appendix VI]

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Completeness/accuracy of observations and	Audit	Ward Managers and Senior Nurses	Monthly	Patient Safety Forum
escalation of sick patients				Deteriorating Patient Group
				DON/ADON/
				Senior Nurses
Adverse incidents relating to the deteriorating patient where the NEWS2 policy has not been used	Case by case review	Clinical Risk Advisors/Managers	As the incidents occur	Clinical Risk Managers
effectively			Quarterly thematic analysis of	CAG DON and Clinical Directors
			the deteriorating	Senior Nurses
			patient incidents	Governance Review Meeting
Review of events leading up to cardiac arrest calls to determine if there were	Case by case review	Resuscitation Officers	RCA of each CA call	Resuscitation Officers
any missed opportunities to intervene earlier	Resuscitation Audit		Monthly Audit	Deteriorating Patient Group
				CAG DON and Clinical Directors
				Senior Nurses

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Appendix VIII – Impact assessments

Equalities impact checklist - must be completed for all new policies

EQUALITIES IMPACT CHECKLIST

Which groups All groups with the exception of weeks gestation will be covered by this policy Other groups:	
minority ethnic people (including gipsy/travellers, refugees & asylum seekers	people of low income
women and men	 people with mental health problems
 people in religious/faith groups 	homeless people
disabled people	 people involved in criminal justice system
 older people, children & young people 	• staff
 lesbian, gay, bisexual & transgender people 	any other groups
N.B. The word proposal is used below as shorthand for any policy, procedure,	What positive & negative impacts do you think there might be?
strategy or proposal that might be assessed.	Which groups will be affected by these impacts?
What impact will the proposal have on lifestyles?	For example, will the changes affect:
Diet and nutrition?	Should not be affected by this policy for acute ward based patients
Exercise and physical activity?	Patients requiring closer monitoring may be restricted to their bed area to allow this to occur. These patients are normally too sick to mobilise anyway.
 Substance use: tobacco, alcohol or drugs? 	Discouraged particularly during acute illness. Each patient will be considered on an individual basis to determine that they do not require additional treatment to counteract any withdrawal symptoms.
Risk taking behaviour?	Not applicable. All interventions with patients should be risk assessed and consent obtained prior to recording observations where possible.
Education and learning or skills?	Staff will be trained on how to use the NEWS2 and escalate care. Ward Managers must ensure that all nursing staff in their ward/department can accurately record a set of observations and calculate NEWS2.
Will the proposal have any impact on the social e include:	
Social status	Not applicable



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Employment (paid or unpaid)	
Social/family support	
Stress	
Income	
Will the proposal have any impact on:	
Discrimination?	Not applicable.
Equality of opportunity?	
Relations between groups?	
Will the proposal have any impact on the physica impacts on:	I environment? For example, will there be
Living conditions?	Patients may be hospitalised or in outpatient departments or A&E during observation recording.
Working conditions?	Staff from across BH will be realigned to using the NEWS2 and this will replace all legacy warning scores for adult patients excluding midwifery.
 Pollution or climate change? 	Not applicable
Accidental injuries or public safety?	The use of the NEWS2 should allow earlier recognition and escalation of sick and deteriorating patients and therefore promote patient safety.
Transmission of infectious disease?	Dynamaps; pulse oximeters and tympanic thermometers need to be adequately decontaminated between patients.
Will the proposal affect access to and experience	of services? For example:
Health care	Not applicable
Transport	
Social Services	
Housing services	
Education	
Equalities Impact Che	ecklist: Summary Sheet
Positive Impacts (Note the groups affected) Earlier recognition and treatment of deteriorating patients. NEWS2 will allow common language to be used across healthcare when discussing the overall score	2. Negative Impacts (Note the groups affected) The scoring system has its limitations and is sensitive and will be easily triggered. Trigger fatigue is a real risk but trigger thresholds can be revised for individual patients where chronic disease triggers the NEWS2 erroneously.
	Moreover some patients may not trigger NEWS2 but may need an urgent review e.g. a patient with chest pain. SCI patients at risk of autonomic dysreflexia should be monitored with caution if NEWS2 used
Race Equality Does the policy take account of race equality legislation and the Trust's Race Equality	See: Race Equality Scheme, Equal Opportunities Policy



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Scheme?

Not applicable

Disability discrimination

Does the policy take account of DDA

legislation?

Considers how to assess patients with learning disabilities or poor historians when

assessing a patient
Age discrimination

Not for under 16 year old patients.

Does the policy take account of relevant

legislation?

Gender discrimination

Does the policy take account of relevant

legislation?

See: Equal Opportunities Policy, Working beyond Retirement Age

See: Equal Opportunities Policy, Employment of People with

Disabilities Policy

Policy

See: Equal Opportunities Policy

Yes

3. Additional Information and Evidence Required

Royal College of Physicians published the NEWS2 [December 2017] to develop a common language when discussing patient acuity across all of healthcare including the acute Trust. This allows other healthcare providers to understand the condition of the patient in the same way that the Glasgow Coma Scale talks a universal language with head injured patients or patients with an altered level of consciousness.

NHS England has mandated that the NEWS2 is adopted by all acute Trusts by March 2019.

4. Recommendations

5. From the outcome of the Equalities Impact Assessment, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

Manager's Signature: Date:



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Appendix IV : Organisational Impact Assessment

Name of policy	OBSERVATION AND ESCALATION POLICY – ADULT PATIENTS						
	[Excluding Pregnant Women]						
Date of impact	18/10/18 Completed by: A McGinley Position Nurse						
assessment					Consultant		

Area for consideration	Description of issue	Trust contact	Policy author description of how issue has been taken into account in the policy/guideline
Financial impact on Trust	Does the policy impose an additional direct or indirect financial cost on the Trust and how will this be managed?	Potentially	Identifying patients who require an escalation in care and admission to L2 or L3 critical care — including potential inter-hospital transfers
Impact on PFI Service Providers:	How will the policy impact on the volume/cost of services provided by the Trust's PFI partner and how has this been addressed?	TBC	NA
Impact on other partner organisations	How will the policy impact on other partners?	TBC	May identify patients who require a specialist service and transfer of care.



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