BSUH Observations Policy

Brighton and Sussex University Hospitals NHS Trust

MONITORING

This physiological track and trigger system attributes a score to each physiological observation and can improve the recognition of unstable and potentially critically ill patients.

4 hourly for first 24 hrs of admission.

Respiration Rate

- Increasing tachypnoea – **early marker** of deterioration – rise in RR commences up to 3 days prior to acute deterioration
- Affected by metabolic neurological and cardiac changes

Spo2 – Target range/scale documented by medics

Oxygen Use – Prescribed as medication

Pulse – **Always taken manually** – never via bedside monitors/ probes

- Allows assessment skin **tone, turgour, temperature**

Temperature Tempadots: 3 mins sub axillary, 1 min orally.

- Do not carry in pockets/leave in sunlight

Blood Pressure – **Late marker** deterioration

- Mechanical devices unsuitable for patients with arrhythmias, hyper/hypotension – use manual sphygmomanometer

ACVPU

- New Confusion? (no score if chronic) Neurological observations: GCS + Bld Sugar

Pain Score 1-10

- Abbey Pain Scoring for non-verbal patients

Fluid Balance – Urine dip for all patients on admission. Monitored for first 24 hrs. consider risk of AKI?

DETERIORATION

IS THERE:

- **Active deterioration?**
- **Risk of deterioration?**
- **Opportunity to discuss treatment escalation plan e.g. DNACPR?**

Decision to use scale 2 Signed:	Designation	Date

NEW Score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of obs • If patient within first 24 hours of admission or step-down from ITU/HDU, 4 hourly observations are required regardless of the NEWS score
Total: 1- 4	Minimum 4 - 6 hourly	• Inform registered nurse • Registered nurse decides whether increased frequency of monitoring and / or escalation of treatment is necessary
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient who will review and decide whether escalation of treatment is necessary (this should be 4 hourly if first 24 hours of admission or step-down from ITU)
Total: 5 or more Urgent response threshold	Increased frequency to minimum of 1 hourly	• Registered nurse to inform nurse in charge of ward/unit • Registered nurse to **immediately** inform medical team caring for the patient (using SBAR) on call team for out of hours • Registered nurse to request urgent assessment by clinical team caring for patient who should plan goals of care and appropriate treatment escalation • Registered nurse to request urgent assessment by clinician or team with core competencies in the care of acutely ill patients. (Critical care outreach team (CCOT) or Clinical Site Manager (CSM) out of hours • Could this be sepsis; Complete sepsis screen
Total: 7 or more Emergency response threshold	Continuous monitoring of vital signs (using DASH monitor)	• Registered nurse to **immediately** inform medical team caring for the patient (using SBAR)- this should be at least at specialist registrar level. • Emergency assessment by a team with critical care competencies (Critical Care Outreach Team CCOT or CSM out of hours) Consider involving practitioners with advanced airway management skills • Inform CCOT (or CSM out of hours) • **Consider MET call 2222** for rapid response team – emergency assessment undertaken by MET team • Consider transfer of clinical care (for level 2/3 care) • Clinical care in an environment with monitoring facilities
Contacts: CCOT: **RSCH** Bleep 8495 0730-2000 7 days week **PRH** Bleep 6331 24 hours /day CSM: **RSCH** 8152 **PRH** 6014		

Only a registrar or consultant may alter the trigger or change choice of scale. This must be clearly documented in the patient's health records with rationale for decision or confirmed diagnosis and sign below.

- However if you are concerned about the patient do not wait for the patient to 'trigger', escalate your concerns to the nurse in charge and medical team without delay.
- If you require a rapid response for a sudden acute change in the patient's condition use the MET team on 2222.
- Any changes to the above recommended frequency of monitoring must be clearly documented in the patients nursing care plan with rationale.

ESCALATION

Use SBAR tool to convey your concerns to team.

Reverse side for medical team to document response.


CALLING A DOCTOR TO REVIEW YOUR PATIENT

Brighton and Sussex NHS University Hospitals NHS Trust

IF YOU NEED IMMEDIATE RAPID RESPONSE CALL 2222 TO PUT OUT A MEDICAL EMERGENCY CALL

BEFORE YOU CALL • Have you done your ABCDE assessment • Have you got the relevant observation chart / fluid chart / patient nursing notes / health records in front of you? • Consider the response time that you are expecting • Inform the nurse in charge or night practitioner (state who):

Name

Attach PAS label here

Trust ID number

Date of birth

S SITUATION

My name is ____ from ____ ward

And your name is ____ Bleep no. ____

Date / time of call ____

Patients name ____

Consultant ____

I am calling because I am concerned about ____

B BACKGROUND

The patient was admitted on / / with/has had ____

Condition changed in the last ____ minutes Resp rate ____

Oxygen sats ____ Delivered oxygen ____ % Temp ____

Pulse ____ regular / irregular BP ____/____ AVPU / GCS ____

Mental state ____ Capillary refill time ____

Urine output ____ MEWS ____ Sweating: Yes / No

A ASSESSMENT

☐ I think the problem is ____

and I have ____ (eg given oxygen / analgesia) OR

☐ I am not sure what the problem is but the patient is deteriorating OR

☐ I don't know what's wrong but I am really worried

R RECOMMENDATION

I need you to come and review the patient in the next ____ minutes

AND is there anything I need to do in the meantime?

- ____
- ____
- ____
- ____

Criteria	MET (2222)
Airway	Upper Airway obstruction / airway. Support required because of loss of consciousness
Breathing	Respiratory Rate: **Acute** change to > 30 / min or < 8 / min Oxygen saturations: **Acute** change to < 90% despite O_2 therapy
Circulation	Systolic BP: **Acute** change to < 90mmHg Heart Rate: **Acute** change to <40 / min or >130 / min
Conscious Level	**Acute** change in conscious state
Urine Output	**Acute** change to < 50mls over last 4 hrs
Other	Staff member worried about the patient despite the above criteria not being met

Consider

Sepsis 60 Minutes to Save a Life

Trigger level – is there a higher parameter? Is there an escalation plan? Are they on the correct SPO2 scale?

Timing – minimum 12 hourly

Teamwork – accountability remains with registered nurse. However HCA deemed competent can calculate score independently

Age of patient and compensation

LOOK... LISTEN... FEEL...

Consider

Sepsis 60 Minutes to Save a Life

TRACK AND TRIGGER

Score 5+ triggers urgent review from medical, outreach and site team as per policy + sepsis screen

Alterations to trigger threshold: – registrar or consultant to document in medical record

Factors that may affect score

Complications to diagnosis – AKI sepsis screening

Lactate – repeat 2 hrs post initial raised result

Escalation Planning

Sepsis 60 Minutes to Save a Life

COMMUNICATION

Ward round – use to push for a plan

NEWS chart – use action summary on reverse of to document timeline of events

Single Clerking Proforma – is the escalation page completed?

Discussion of plan with NOK – has it been documented in notes?

Clodagh Bannerman/Jo Kelly