East Cheshire NHS Trust

Minimum Standards for Monitoring and Recording Adult Physiological Vital Signs

(Maternity and non-inpatient areas ONLY)

Policy :	Minimum Standards for Monitoring and Recording Adult Physiological Vital Signs (Maternity and non-inpatient areas ONLY)
Executive Summary:	Although the close monitoring and recording of patients physiological vital signs is paramount in the early detection of acute illness, this basic skill is often neglected by health care workers. The National Institute for Health and Clinical Excellence (NICE CG50 2007) has produced evidence which suggests that patients who are, or become acutely unwell in hospital may receive suboptimal care. This may be due to their deterioration not being recognised, or despite patients exhibiting signs of clinical deterioration it is sometimes not appreciated, or prioritised. This Policy will dictate the minimum standard required to recognise and respond to the deteriorating patient utilising physiological observations in an effort to improve outcome. This policy should be read in conjunction with the Policy Schedule and the compliance monitoring tool.
Supersedes:	New Policy
Description of Amendment(s):	N/A
This policy will impact on: All Trust Staff	
Financial Implications:	

Policy Area:	Urgent Care	**Document Reference:**	
Version Number:	2	**Effective Date:**	October 2013
Issued By:	Lesley Petrie	**Review Date:**	June 2015
Author: **(Full Job title)**	Consultant Nurse Critical Care	**Impact Assessment Date:**	October 2013

APPROVAL RECORD

	Committees / Group	Date
Consultation:	Managers, Ward sisters, senior Specialist Nurses, Matrons, Clinical Leads	September 2013
Approval Committee	Executives Medical Director & Director of Nursing , Performance and Quality	September 2013
Ratified by Committee/ **Executive Director:**	Executives Medical Director & Director of Nursing , Performance and Quality	September 2013

1.0 Policy Statement

1.1 The increasing complexity of healthcare, the ageing population and shorter length of stay, means that patients in hospital today need a higher level of care than ever before. Although the close monitoring and recording of patients physiological vital signs is paramount in the early detection of acute illness, this basic skill is often neglected by health care workers. The National Institute for Health and Clinical Excellence (NICE CG50 2007) has produced evidence which suggests that patients who are, or become acutely unwell in hospital may receive suboptimal care. This may be due to their deterioration not being recognised, or despite patients exhibiting signs of clinical deterioration it is sometimes not appreciated, or acted upon quickly enough.

1.2 NICE highlights that communication and documentation between the multi-disciplinary team is often poor, experience of critical care expertise sparse and admission to critical care areas often delayed.

1.3 The purpose of this document is to provide staff tasked with the recognition, response and intervention of physiological observations and fluid balance monitoring clear guidance to deliver best practice when the clinical decision to admit has been made. Patients admitted to East Cheshire Trust will feel confident that if they are acutely unwell or their condition deteriorates, they are in the best place to receive prompt, safe, effective care.

2.0 Organisational Responsibilities

2.1 Chief Executive and Board of Directors
The Chief Executive and Board of Directors have overall responsibility for ensuring the requirements within this policy are fulfilled and that all operational responsibilities are in place. In addition appropriate equipment must be provided to enable clinical staff to take and record Adult Physiological Observations.

2.2 The Executive Medical/Nursing Director
The Medical and Nursing director are responsible for ensuring that the requirements set out in this policy are fulfilled.

2.3 Clinical Directors and Associate Directors
The Clinical Director and Associate Director will oversee the application of this Policy into the clinical practices of their services.

2.4 Trust Committees
As a group are responsible for the consultation and approval process required during the development of policies for the Trust. The committees are responsible for the review of policies submitted to them to ensure that policies are appropriate, workable and follow the principles of best practice

2.5 The Primary Consultant
As the professional with the overall clinical responsibility for patients the Consultant will ensure that clinical standards are maintained and that any necessary deviation from this policy is documented and explained in the medical notes.

The Consultant will supervise medical staff in training to ensure that all patients have a documented medical management plan including frequency of observations.

The Consultant will be responsible for setting goals and acceptable parameters to guide other clinical staff in their role of monitoring, interpreting and acting upon abnormal parameters

In the absence of the Consultant (i.e. Leave) the responsibility will lie with their delegated senior

2.6 Heads of Nursing

Heads of Nursing have a responsibility to ensure that this policy is disseminated to Matrons and Ward Senior Sisters/Charge Nurses to inform clinical staff of their responsibilities in the accurate recording of the POTTS (Physiological Observation Track and Trigger System) and to act appropriately when patients begin to trigger.

In collaboration with Matrons and Senior Sisters/Charge Nurses, Heads of Nursing must ensure that adverse clinical incidents in relation to physiological monitoring in their clinical areas are reported and investigated and action plans produced to prevent future occurrence.

2.7 Matrons and Senior Sisters/Charge Nurse

Matrons and Senior Sisters/Charge Nurses have a responsibility to ensure that any staff responsible for taking and recording observations are competent, able to calculate the Physiological Track and Trigger System (POTTS) accurately, suitably trained to recognise acute illness and knowledgeable in the Recognition and Response Escalation Policy, to escalate care when needed to the appropriate people.

Matrons and Senior Sisters/Charge Nurses have a responsibility to monitor compliance with agreed frequency of observations according to recognition and reponse escalation plan and ensure that all clinical staff have access to appropriate monitoring equipment and that it is in working order and that the observation charts are available and located in close proximity to the patient at all times.

2.8 Health Care Professionals

All Clinical Professionals involved in monitoring, recording, interpreting or acting on adult physiological observations have a personal and professional responsibility to;

2.9.1 ensure that they are competent, within their scope of professional practice, to accurately undertake and record physiological vital signs in accordance with this policy

2.9.2 acknowledge any limitations in their knowledge and competence and seek further training as appropriate

2.9.3 report any abnormalities or concerns to a more senior member of the team where appropriate

2.9.4 be competent in the use of equipment necessary for the taking and recording of adult physiological observations

2.9.5 be able to report any malfunctions to the Electrical Medical Engineering Services department (EME)

2.9.6 be aware of the Recognition and Response Escalation Policy when patients begin to trigger on the Track and Trigger Tool (POTTS)

2.9.7 what actions are needed by the range of scores generated, a summary of the Escalation Policy is located on the Adult Observation folder in a RAG (Red Amber Green) rated colours and the full policy is available on the Trust Intranet.

2.9.8 report any untoward incident that occurs by not adhering to this Policy by informing their line manager and using the 'Datix' reporting system.

2.9 Consultant Nurse Critical Care

Has the responsibility to audit this Observation Policy to ensure that clinical practitioners are provided with the Education to support achievement of set competencies

2.10 Electrical Medical Engineering

Have a responsibility to check and maintain physiological measurement equipment in accordance with hospital policy and manufacturers recommendations

3.0 Scope

This policy will cover Maternity and all non-inpatient areas ONLY

4.0 Minimum Observation Standard

All adult patients admitted into East Cheshire Trust, (including patients in the Emergency and Outpatients Departments when a decision has been made to admit) will have a Physiological Track and Trigger Observation Chart (POTTS) commenced and physiological observations recorded at the time of their admission. Each basic set of observations must include;

4.0.1 Respiratory rate

4.0.2 Oxygen saturation

4.0.3 Pulse – rate and regularity

4.0.4 Blood pressure

4.0.5 Temperature

4.0.6 AVPU score (conscious level)

4.0.7 Urine Output

4.0.8 Pain assessment

4.0.9 Oxygen delivery (reverse of chart)

4.0.10 Track and Trigger score (Refer to Critical Care Outreach Operational Policy)

4.1 In specific clinical circumstances, additional monitoring must be considered and the decision documented clearly within the medical notes. For example;

- Blood sugar
- Fluid balance
- Hourly urine output
- Sepsis screen
- Neurological observation chart (Glasgow Coma Score)

4.2 All adult acute in-patients admitted into the East Cheshire Trust will have their observations undertaken **4 hourly**. The exemption (in addition to 4.7) will be at 02.00hrs if the patient is considered stable and not triggering the POTTS then an uninterrupted period of sleep will be permitted for up to 8 hours. Maternity patients and those deemed medically fit or in a rehabilitation environment, will have observations undertaken **12 hourly as a minimum standard** unless a decision has been made at a senior level (Medical/Outreach/Nurse in Charge) to increase or decrease this frequency for an individual/group of patients. Any alteration to the minimum standard must be documented on the monitoring plan/medical notes.

4.3 Any patients following emergency admission or inpatients who are becoming acutely unwell must have their observations taken within the hour and if required the frequency of observations increased in accordance with the Trust Recognition and Response Escalation Policy for the Management of Acutely ill Adult Patients, (and see section 4.8 and 4.9 of this policy).

4.4 Any patient admitted via the Emergency Department must have their observations recorded a **minimum of 4 hourly** for the first 24 hours of admission unless specified. Any variance to this minimum standard must be documented clearly in the patients' medical notes.

4.5 Patients discharged from a higher level of care, i.e. ICU/HDU, will have their observations recorded **a minimum of 4 hourly** and a strict input output, Fluid Balance Chart (FBC), for the first **48 hours** on a general ward.

4.6 It is considered best practice that a clear monitoring and management plan which specifies frequency and type of observations is recorded, and be completed by the admitting or reviewing medical practitioner. This should be done on initial assessment or admission and written clearly in the patients' medical notes or on the POTTS chart/Monitoring plan. The plan should take into account the patients diagnosis, agreed treatment plan and presence of co-morbidities.

4.7 Exceptions to this minimum standard must be considered at an early stage and established for patients who are acutely ill but will not benefit from an escalation of therapy beyond ward based care, any decisions must be clearly documented in the medical notes. If a decision has been

made that therapy will not be escalated beyond ward based care and, even with maximum medical management, the patient continues to deteriorate then a decision must be made:

- on the patients resuscitation status
- or to commence the Trust's recognised Care of the Dying Pathway

Please refer to the Trust Resuscitation Policy and Do Not Attempt Resuscitation Policy on the Trust Infonet. (If a patient is escalated to a level II/III facility this guidance/policy will not apply).

4.8 The frequency of observations will be guided by the T&T Score in conjunction with the Recognition and Response policy used within the Trust (Refer to Critical Care Outreach Operational Policy)

Therefore if the patient scores a:

No Score 0:	record observations minimum of 4 hourly (unless considered 6-12hourly by Parent Team)
Low Score 1- 2:	record observations minimum of 4 hourly
Medium score 3- 5:	record observations minimum of 1 hourly
High Score 6 or more:	record observations minimum of every 30 minutes

4.9 When a patient begins to trigger on the POTTS, the RAG (Red Amber Green) rated Recognition and Response Escalation Policy (Refer to Critical Care Outreach Operational Policy) **must be followed to escalate care**. A summary of this is located on every Adult Patient Observation Blue folder at the base of the bed and the process can be found in the Critical Care Operational Policy

In some circumstances, patients who are acutely unwell will not trigger on the POTTS. It is therefore important that specified clinical staff use their clinical judgement in deciding the frequency of observations recorded, especially when there is any clinical concern that the patient is becoming unwell. This must be recorded in the monitoring plan found inside the blue folders housing the POTTS chart

4.10 Other scoring systems can also be used within the Trust, for example CURB 65 (refer to Community Acquired Pneumonia pathway) however; these must be used in conjunction with the POTTS and not as an alternative.
All observations recorded on the observation chart at the start of each day will show the date clearly.

5.0 All entries on the observation chart must;

5.1 Have a patient label (if no label available must have Name, Date of Birth Hospital number and it is best practice to use the NHS number

5.2 Must specify primary consultant

5.3 Must specify patient weight

5.4 Specify the actual time and date the observations were undertaken.

5.5 Be initialled by the person carrying out the observations.

5.6 Include the respiratory rate counted over one minute, documented **graphically** and best practice would consider **numerically**

5.7 Include oxygen saturation. (Refer to the Trust Oxygen Policy for appropriate action if not within normal parameters for that patient) Should the patient require oxygen do not remove the source to either record the saturations or to perform any arterial blood gas sampling that maybe required, unless advised by a Senior Clinician

5.8 Include the mode of oxygen delivery when a patient is receiving oxygen therapy. This will be recorded using the key located on the reverse of the POTTS Observation Chart, this reduces any ambiguity in recording the mode of oxygen delivery. Any patient receiving oxygen therapy must have this prescribed and reference should be made to the Target Saturation required in the management plan referred to in section 2.6

5.9 Include the pulse (heart rate) documented in **graph form** and **numerically.**

5.10 This will be a manual pulse taken over one minute to assess the characteristic of the heart rate and rhythm, best practice would be to document as regular (R), or irregular (I) on the observation chart. If continuous ECG monitoring is used document the appropriate rhythm recorded.

5.11 Include systemic blood pressure. In cases of very low blood pressure ($\leq$ 80 Systolic) electronic devises will be inaccurate and a manual blood pressure using a sphygmomanometer must be carried out. Manual sphygmomanometers will be available to all areas and staff should be competent to use them. This must be charted in graph form and not numerically unless the systolic BP is greater than 240mmhg.

5.12 Include temperature. Method of temperature recording will be assumed to be tympanic unless otherwise stated and will be recorded in degrees centigrade.

5.13 Include level of consciousness using the AVPU score, where

A - Alert

V - rousable to voice

P - rousable to pain

U - unrousable

5.13i If a patient has developed **new** confusion or agitation this will be recorded as 1 on the observation chart in line with the POTTS. Patients scoring a P or U must be given medical help immediately if their, **their airway is at risk**. **Consider** calling 2222 if the patient is for Attempted Resuscitation.

5.13ii A Trust Neurological Observation Chart (Glasgow Coma Score (GCS)) must be commenced for patients scoring a P or U on the POTTS and frequency of observations as per NICE CG 56 (see 5.13iv)

5.13iii All patients who have sustained a head injury before or during admission to the East Cheshire Trust must have a neurological observation chart commenced, unless a senior Medical Practitioner has made a decision that this is not required. Any decisions must be documented in the medical notes. The frequency of observation will be determined by the management plan referred to in section 2.6

5.13iv Frequency of neurological observations will be based on NICE guidelines:

http://www.nice.org.uk/nicemedia/pdf/cg56niceguideline.pdfrecommend

Perform and record observations on a half hourly basis until GCS = 15

When GCS = 15, minimum frequency of observations is half- hourly for 2 hours

Then 1 hourly for 4 hours

Then 2 hourly thereafter

5.13v If patient deteriorates to GCS<15 after initial 2 hour period, revert back to half-hourly observations

5.1vi Frequency of observation as per Recognition and Response algorithm when stable

Any deviation from this minimum standard must be decided by a senior medical practitioner and documented in the monitoring plan.

6.0 Fluid Balance Monitoring

6.0 All patients requiring a fluid balance monitoring will have the Trust Fluid balance chart at the bedside

6.1 Indications for completion can be found in **Appendix A**

6.2 Indications for strict fluid balance are described in **Appendix B**

At midday and midnight all fluid balance charts must be totalled to show the fluid balance and it is considered best practice to record the cumulative fluid balance.

7.0 Process for monitoring compliance to the Observation Policy - Minimum Standards for Monitoring and Recording Adult Physiological Vital Signs.

7.1 “Please refer to the compliance monitoring tool for details”

8.0 Standards/key performance indicators and process for monitoring compliance

8.1 “Please refer to the compliance monitoring tool for details”

Key performance indicators for the Observational Policy will be reviewed during audit. The compliance target the Trust is looking to achieve is **100%.**

9.0 Dissemination, Implementation and Access to this Document

9.1 This policy will be disseminated by the policy coordination administrator as per the policy on procedural documents

9.2 The Consultant Nurse will organise awareness sessions for all practice educators within the trust who will then disseminate this to clinical staff on their designated wards. The Outreach Team will provide training to ward managers (for any wards without a practice educator), who will disseminate to staff.

9.3 All Ward managers should allocate time for staff to attend these awareness sessions

9.4 It is the responsibility of individual clinical staff to ensure they attend the awareness sessions, and a record of attendance will be recorded by the practice educators/Outreach Team and logged with the Training Department.

9.5 Awareness sessions will be held in various locations around the trust to all clinical staff involved in taking, recording and analysing Adult physiological observations and Fluid balance including ward sessions,

9.6 Global email will be sent Trust wide

9.7 Presented by Outreach Team at all Trust Inductions and statutory and Mandatory training

10. Implementation

The policy will be implemented on October 2013

11 Access

11.1 The policy will be available on the Trust’s Infonet

11.2 Observation charts (POTTS), Monitoring Plans, Escalation policy, Fluid Balance Charts and Neurological Observation Charts, which will be kept at the patient’s bedside at all, times for ease of access.

12 Review, Updating and Archiving of this Document

12.1 This policy will be formally reviewed every 3 years. The review will be initiated by the author of this policy

12.2 This policy will be updated if any new evidence is produced or by any substantial change in national policy.

13 Expert and Stakeholder Involvement

The following people have been involved in the adaption/development of this policy;

- Acknowledgements to University Hospitals South Manchester foundation Trust
- Mid Cheshire Trust
- Heather Cooper Consultant Nurse Critical Care
- Critical Care Outreach Team
- Infection control Jackie Devaney

The following staff have reviewed this policy

- Resuscitation Team:
- Heads of Nursing
- Matrons
- Ward Managers
- Practice Based Educators
- Risk Manager
- Clinical Leads

14.0 Appendices

Appendix A
Fluid balance charts must be completed for the following patients, unless a medical practitioner or a registered nurse has made a decision otherwise. The rational for this variance must be documented in the patients medical/nursing notes and monitoring plan;

- Scoring 3 or more on the T & T
- All emergency hospital admissions
- Post operative patients.
  - **Post op exceptions may include;**
    Day case patients, having minor surgical/medical procedures,
    Short stay patients
  - However, in these cases a fluid balance chart must be commenced if clinical staffs feel there is a clinical need.
- Temperature is greater than 38C
- Experiencing any excessive fluid loss (ie total volume out exceeds volume taken in) from, for example, surgical drains/cavity drains, naso-gastric tubes, underwater seal drains, ascitic drains, ileostomy, nephrostomy
- On a restricted fluid intake
- Nil by mouth more than 8 hours
- With vomiting and or diarrhoea
- Receiving Intravenous fluid therapy, IV medications or parenteral nutrition
- With known or suspected renal impairment or cardiac conditions i.e. those with an upward trend in urea and creatinine, with an electrolyte imbalance etc
- With urinary catheters, except for those patients with long-term catheters who do not have an acute onset of illness
- Who are not catheterised and it is documented on the observation chart that they have not passed urine in the last 6 hours
- Discharged from ICU/ HDU for a minimum of 48 hours post discharge.
- Those patients with known sickle cell disease patients should have a carefully maintained fluid balance chart for the duration of their admission. (NCEPOD 2008)
- Patients who are demonstrating Sepsis
- Charts should be filed in notes after 48hours
- This is not an exhaustive list and there may be other indications for commencing a fluid balance chart.

Appendix B
Guidance for completing fluid balance monitoring

- It is considered best practice that the fluid balance chart should have a patient identification preferably a patient label attached for each day (please ensure patient address is not on public display)
- All entries will be made in millilitres (mls)
- A fluid balance chart will assess all fluid **input**. (i.e. Oral, Intravenous, Nasogastric (NG), PEG, bladder washout, subcutaneous, via any drains etc) and all fluid **output** (i.e. micturition, catheter, stools, stoma, NG, wounds (vac) faecal collectors etc). Insensible loss (average 500mls /day) should be considered by the clinician when assessing fluid balance
- There will be a running total
- Best practice will be to administer intravenous (IV) fluids through an infusion pump. However if no pump available drip rate must be calculated to achieve prescribed parameters
- Fluids will only be recorded if the patient has been given the fluid (i.e. IV fluids will be recorded as the hourly rate, not the total of the bag commenced
- If no fluid intake or output write ‘NIL’
- It will be completed four hourly to coincide with the POTTS
- Catheter bag will be emptied at least 6 hourly (EPIC II)
- Output for all patients on FBC will be measured and not recorded as ‘PUT’ – (‘passed urine toilet’) or CBD – (‘catheter bag draining’) If the patient has PUT then staff must review, if fluid balance monitoring is required. Should the patient require monitoring then patient education regarding monitoring must given and be recorded on fluid chart as ‘Pt educated’
- It will identify patients who have not passed urine for 6 hours (without a catheter and who may then trigger on the POTTS)
- If urine and liquid stools are passed together, estimate a total volume and chart under liquid stool and ensure this is recorded on stool chart
- If urine and formed stools are passed together, estimate the value of the urine and chart in urine column
- Incontinence: Best practice would be to weigh pads to assess the volume loss and record under urine.

15.0 Compliance Monitoring Tool

Policy	Minimum Standards Policy					
Author	Heather Cooper		**Date of Approval**	2012	**Date for review**	2015
NHSLA Criterion Number (as applicable)		4.8	**Approving Committee/Group**	Risk Management sub Committee		
Requirement to be monitored	**Process to be used for monitoring e.g. audit**	**Responsible individual/ committee for carrying out monitoring**	**Frequency of monitoring**	**Responsible individual/committee for reviewing the results**	**Responsible individual for developing an action plan**	**Responsible Committee/group monitoring the action plan**
Requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured including the frequency of measurement	Audit via Safety thermometer	Matron	Twelve times a year	Matrons Forum	Heads of Nursing	Professional Forum
Use of an early warning system within the organisation to recognise patients at risk of deterioration	Yearly Point prevalence audit 12 times a year ward documentation audit	Consultant Nurse	Yearly point prevalence 12 times year	Consultant Nurse	Consultant Nurse	Business Unit SQS's
Actions to be taken to minimise or prevent further deterioration in patients.	Audit	Clinical Lead Outreach team	12 times per year	Outreach team	Consultant Nurse	Business Unit SQS's Professional Forum

16.0 References

National Patient Safety Agency (2007). Recognising and responding to early signs of deterioration in hospitalised patients.

NCEPOD (2005) An Acute Problem? A report of the National Confidential Enquiry into Patient Outcome and Death.

NCEPOD (2009) Caring to the end? A review of the care of patients who died in hospital within four days of admission

NICE (2007) Acutely Ill Patients in Hospital: Recognition of and response to acute illness in adults in hospital. NICE guideline 50

NICE (2007) Head Injury – triage, assessment, investigation and early management of head injury in infants, children and adults. NICE guideline 56

NMC (2002) Guidelines for records and record keeping

NPSA (2007) Safer Care for the Acutely Ill Patient: learning from serious incidents

O'Driscoll et al (2008) Guideline for emergency oxygen use in adult patients. British Thoracic Society

Patient Safety First Campaign (2008) www.patientsafetyfirst.nhs.uk

Survive Sepsis Campaign www.survivingsepsis.org

Andrews, T., Waterman, H. (2005) Packaging: a grounded theory of how to report physiological deterioration effectively. Journal of Advanced Nursing; 52: 5, 473-481.

Buist, M.D. et al (1999) Recognising clinical instability in hospital patients before cardiac arrest or unplanned admission to intensive care. A pilot study in a tertiary-care hospital. The Medical Journal of Australia; 171: 1, 8-9.

Butler-Williams, C. et al (2005) Increasing staff awareness of respiratory rate significance. Nursing Times; 101: 27, 35-37.

Chellel, A. et al (2002) Nursing observations on ward patients at risk of critical illness. Nursing Times; 98: 46, 36-38.

Critical Care Stakeholder's Forum and National Outreach Forum (2007) Clinical Indicators for Critical Care Outreach Services. www.dh.gov.uk

Cuthbertson BH, Bourjerdi M, Aucott L, Prescott G. Can physiological variables and early warning scoring systems allow early recognition of the deteriorating surgical patient? Crit Care Med (2007) 35:402–9.

Department of Health (2005) Quality Critical Care - Beyond 'Comprehensive

Critical Care'. www.dh.gov.uk

Department of Health (2004a) National Standards, Local Action: Health and Social Care Standards Planning Framework 2005/6-2007/8).www.dh.gov.uk

Department of Health (2004b) Standards for Better Health. www.dh.gov.uk

Department of Health (2004c) The NHS Improvement Plan: Putting People at the Heart of Public Services. www.dh.gov.uk

Department of Health (2003) Critical Care Outreach: Progress in Developing Services. www.dh.gov.uk

Department of Health (2000) Comprehensive Critical Care: A Review of Adult Critical Care Services.www.ics.ac.uk

Gao H, McDonnell A, Harrison DA, et al. Systematic review and evaluation of physiological track and trigger warning systems for identifying at-risk patients on the ward. Intensive Care Med (2007) 33:667–79.

Esmonde L, McDonnell A, Ball C, et al. Investigating the effectiveness of critical care outreach services: a systematic review. Intensive Care Med (2006) 32:1713–21.

Goldhill, D.R., Sumner, A. (1998) Outcome of intensive care patients in a group of British intensive care units. Critical Care Medicine; 26: 8, 1337-1345.

Goldhill, D.R. et al (1999) Physiological values and procedures in the 24 hours before ICU admission from the ward. Anaesthesia; 54: 6, 529-534.

Goldhill, D.R., McNarry, A. (2002) Intensive care outreach services. Current Anaesthesia and Critical Care; 13: 6, 356-361.

Hillman, K.M. et al (2001) Antecedents to hospital deaths. Internal Medicine Journal; 31:6, 343-348.

Hillman, K.M. et al (1996) Identifying the general ward patient at risk of cardiac arrest. Clinical Intensive Care; 7: 242-243.

Intensive Care Society (2002) Guidelines for the Introduction of Outreach Services.www.ics.ac.uk

McGloin, H. et al (1999) Unexpected deaths and referrals to intensive care of patients on general wards. Are some cases potentially avoidable? Journal of The Royal College of Physicians of London; 33: 3, 255-259.

McQuillan, P. et al (1998) Confidential inquiry into quality of care before admission to intensive care. British Medical Journal; 316: 7148, 1853-1858.

NCEPOD (2005) An Acute Problem? www.ncepod.org.uk

NCEPOD (2008) A Sickle Crisis? www.ncepod.org.uk

NICE (2007) Acutely Ill Patients in Hospital: Recognition and Response to Acute Illness in Adults in Hospital. www.nice.org.uk

National Patient Safety Agency (2007a) Safer Care for the Acutely Ill Patient: Learning from Serious Incidents. 5th Report from the Patient Safety Observatory. www.npsa.nhs.uk

National Patient Safety Agency (2007b) Nutritional Screening: Structured Investigation Project. www.npsa.nhs.uk

O'Riordan, B. et al (2003) Implementing a critical care course for ward nurses. Nursing Standard; 17: 20; 41-44.

Parissopoulos, S., Kotzabassaki, S. Critical Care Outreach And The Use Of Early Warning Scoring Systems; A Literature Review ICUS NURS WEB J issue 21January – march 2005

Patient Safety First Campaign (2008) The 'how to guide' for Reducing Harm From Deterioration. www.patientsafetyfirst.nhs.uk

Schein, R. et al (1990) Clinical antecedents to in-hospital cardiopulmonary arrest. Chest; 98: 6, 1388-1392.

Sherman, F.T. (2002) Vital signs are still- well, vital. Geriatrics; 57: 3, 9.

Smith, G. et al (2006) Hospital-wide physiological surveillance - a new approach to the early identification and management of the sick patient. Resuscitation; 71: 1, 19-28.

Smith, G. (2000) Alert Life-threatening Events. Recognition and Treatment: A Multi-professional Course in Care of the Acutely Ill Patient: Course Manual. Portsmouth: Portsmouth Institute of Medicine, Health and Social Care Faculty of Science.

Tarassenko L, Hann A, Young D. (2006) Integrated monitoring and analysis for early warning of patient deterioration. Br J Anaesth 97:64–8.

East Cheshire NHS
NHS Trust

Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. **Use it to help you develop fair and equal services.**
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

ients vital signs

Details of person responsible for completing the assessment:

Heather Cooper *Consultant Nurse* *Critical Care Outreach:*

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(*usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)*

e purpose of this document is to provide staff that are tasked with the recognition, response and rvention of physiological observations and fluid balance monitoring, clear guidance to deliver best ctice when the clinical decision to admit has been made. Patients admitted to East Cheshire Trust feel confident that if they are acutely unwell or their condition deteriorates, they are in the best ce to receive prompt, safe, effective care.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

The population of Cheshire as at the 2005 mid year figures (Cohesia Report 2008) is 684,400.

Age:

17.8% (30,500) of the population in Cheshire East is over 65 compared with 15.9% nationally. This results in a high "old age" dependency ratio, i.e. low numbers of working-age people supporting a high non-working dependant older population. The percentage of "older" or "frail" old is also considerably higher, with 2.3% (8,200) persons 85 and over compared to 2.1% nationally.

Cheshire East has the fastest growing older population in the North West. By 2016, the population aged 65+ will increase by 29.0% (8,845) and the population aged 85+ by 41.5% (3,403).

This will have an impact on the number of patients being managed by ECT and the complexity of the health and social care issues that the older person is experiencing. In addition the staffing profile of ECT will change to include an increasing number of staff over 65 in the workforce.

Race:

The 2005 mid year estimate (Cohesia Report 2008) show that the majority of the population in Cheshire
(94.6%) is White British, with 5.4% non White British. The Cheshire 2007-10 Local Area Agreement
identified that minority ethnic communities account for around 3% of the population. Issues for BME communities include lack of knowledge of services, access to services, access to translation/interpretation, cultural differences, family values. Many people from BME communities experience poverty, poor housing and unemployment which make it difficult for them to lead healthier lives. 4180 migrant workers registered in Cheshire in 2006/07 and comparison to the mid-

year population estimates for Cheshire in 2005 strongly suggests that Cheshire's migrant worker population is larger than every individual BME group other than the White-Other White group.

Gypsies and travellers – at the last count (July 2006) the highest number was recorded in the Borough of Congleton (125). 42% of gypsies and travellers report limiting long term illness compared to 18% of the settled population, with an average life expectancy 10-12 years less than settled population. 18% of gypsy and traveller mothers have experienced the death of a child compared to 1% in the settled population.

Disability:
There are over 10 million disabled people in Britain, of whom 5 million are over state pension age. Nearly 1 in 5 people of working age (7 million, or 18.6%) in Great Britain have a disability.
Hearing loss: 1 in 4 has a hearing problem.
Sight problems: There are 2 million people with sight problems in the UK.
Learning disabilities: There is quite a high proportion of people with learning disabilities in the local area due to there being a number of residential homes/institutions in the area.
Problems encountered can be lack of staff awareness, communication issues, information requirements.

Dementia
Approximately six in 100 people aged over 65 develop dementia and this rises to around 20 in 100 people aged 85 or over. Dementia affects 750,000 people in the UK.

Carers
Around 6 million people (11 per cent of the population aged 5+) provided unpaid care in the UK in April 2001. While 45% of carers were aged between 45 and 64, a number of the very young and very old also provided care. By 2037, it is anticipated that the number of carers will increase to 9 million.

Gender
On average in Cheshire, 49% of the population are male and 51% are female
Transgender: No local data available, national trends show:
1/12,000 males, transgender from male to female
1/33,000 females, transgender from female to male

Specific issues around access to services, specific services for men or women, and 'single sex' facilities. In terms of the transgender population, GIRES (Gender Identity Research and Education Society) gives an estimate of 600 per 100,000. If these figures were applied to the Cheshire East community based on the 2005 mid year estimates, there may be around 2,100 trans people in the area.

Religion/Belief

In the Cheshire East area:

Christian	- 80%	Sikh	- 0.05%
Buddhists	- 0.16%	Other religion	- 0.15%
Hindu	- 0.15%	No religion	- 11.84%
Jewish	- 0.12%	Not stated	- 6.67%
Muslim	- 0.36%		

The Muslim population has the highest levels of ill health amongst faith groups – this includes higher smoking rates amongst men and higher rates of coronary heart disease and diabetes.

Sexual Orientation

Lesbians, gay men and bi sexual people (LGB) make up to 5-7% of the UK population (Dept of Trade and Industry, 2003). 13% of Gay men and 31% Lesbian women are parents (Morgan and Bell, First Out: Report of the findings of Beyond the Barriers national survey of LGB people)

The experience and health needs of gay men and women will differ. However, both groups are likely to experience discrimination, higher levels of mental ill health and barriers to accessing health care
National Health Inequalities data shows that lesbian, gay, bisexual and transgender (LGBT) people are e 2001 census showed:
significantly more likely to smoke, to have higher levels of alcohol use and to have used a range of recreational drugs than heterosexual people. They are also at greater risk of deliberate self-harm. Although most LGBT people do not experience poor mental health, research suggests that some are at higher risk of mental health disorder, suicidal behaviour and substance misuse

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the

NO

policy, procedure, proposal, strategy or service or its effects on different groups?)

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

NO

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the **policy, procedure, proposal, strategy or service** (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the **policy, procedure, proposal, strategy or service** on each of the strands listed below.

RACE:

From the evidence available does the **policy**, **procedure, proposal, strategy or service** affect, or have the potential to affect, racial groups differently?
Yes ☐ No ✔
Explain your response:
All patients treated equally according to their needs. Staff know how to access interpreting services for patients whose first language is not English.

GENDER (INCLUDING TRANSGENDER):

From the evidence available does the **policy**, **procedure, proposal, strategy or service** affect, or have the potential to affect, different gender groups differently?
Yes ☐ No ✔
Explain your response:
All patients treated equally according to their needs. The Trust has a transgender policy covering both staff and service users and provides training in LGBT issues. It is important that staff are aware of the policy and treat all people with dignity and respect.

DISABILITY

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, disabled people differently? Yes ☐ No ✔

Explain your response: All patients treated equally according to their needs. **:** Staff need to know how to

access interpreting for patients with hearing and/or sight problems and they should implement/continue with the reasonable adjustments care plan for all patients with a learning disability.

AGE:

From the evidence available does the **policy**, **procedure, proposal, strategy or service,** affect, or have the potential to affect, age groups differently?
Yes ☐ No ✔
Explain your response: No adverse impact, applies to all ages.

LESBIAN, GAY, BISEXUAL:

From the evidence available does the **policy**, **procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☐ No ✔
Explain your response: All patients treated equally according to their needs. All staff have access to equality and diversity training, specialised LGB sessions have been provided and the Trust was 13th in the 2012 Healthcare Equality Index. An LGB staff network has been established and there is growing openness about sexuality in the Trust.

RELIGION/BELIEF:

From the evidence available does the **policy**, **procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?
Yes ☐ No ✔

Explain your response: All patients treated equally according to their needs. Staff have access to the Opening the Spiritual Gate website and training, and there is a privacy, dignity, religious and cultural beliefs booklet.

CARERS:

From the evidence available does the **policy**, **procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently? Yes ☐ No ✔

Explain your response: All patients treated equally according to their needs. Carers would be involved as appropriate.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.

From the evidence available does the **policy**, **procedure, proposal, strategy or service** affect, or have the potential to affect any other groups differently? Yes ☐ No ✔

Explain your response: No adverse impact - all patients treated equally according to their needs.

4. Safeguarding Assessment - CHILDREN This is an Adult only policy

a. Is there a direct or indirect impact upon children? Yes ☐ No ✔ ☐
b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:
c. If no please describe why there is considered to be no impact / significant impact on children **This is an adult only policy.**

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the **policy**, **procedure, proposal, strategy or service** *will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?*

6. Date completed: October 2013 Review Date: June 2015

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

Action	Lead	Date to be Achieved
Nil of note		

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: Lyn Bailey

Date: 6 March 2014