Trust Policy

Essential Adult Inpatient Observations, Reporting and Escalation Policy

Issue Date	Review Date	Version
8 July 2016	July 2021	1.0

Purpose

This policy sets out the criteria for performing consistent and safe essential adult inpatient observations. In addition it describes the action that must be taken in line with the Adult Inpatient Observation Chart and Escalation Procedure.

Who should read this document?

All clinical staff involved in measuring, recording, escalating and assessing physiological observations (vital signs) for adult inpatients at PHNT.

Key Messages

All adult patients in acute hospital settings must have regular comprehensive physiological observations as a minimum standard. The identification of abnormal observations or those causing concern must be followed by a prompt and appropriate level of escalation to the medical team and/or Acute Care Team (ACT). This will ensure that any deterioration in a patient's condition will be recognised early, treated promptly by qualified and suitably trained staff.

Core accountabilities	
Owner	Ed Cox
Review	Matrons and key Trust personnel
Ratification	Nursing and Midwifery Operational Committee (NMOC) – September 2016
Dissemination	Heads of Nursing, Matrons and Senior Nurses
Compliance	Nursing and Midwifery Operational Committee (NMOC)

Links to other policies and procedures
Consent to Examination or Treatment Policy TRW.HGV.POL.216.8 Hand Hygiene Guidelines CLI.INF.GUI.55.9. Mental Capacity 2005.

Version History		
1.0	August 2016	Ed Cox

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

Physiological observations are fundamental to ensuring that patients in hospital are safe and that healthcare professionals are aware of the health status of patients (NICE, 2007;NPSA 2007).
All patients in acute hospital settings must have regular comprehensive physiological observations as a minimum standard. The identification of abnormal observations or those causing concern must be followed by a prompt and appropriate level of escalation to the medical team and/or Acute Care Team (ACT). This will ensure that any deterioration in a patient's condition will be recognised early, treated promptly by qualified and suitably trained staff.
The essential observations to be recorded are:

- Respiratory rate
- Oxygen saturation
- Temperature
- Blood pressure
- Heart rate
- Temperature

2 Purpose

This policy sets out the criteria for performing essential adult inpatient observations to a consistent and safe standard. In addition it describes the action that must be taken in line with the Adult Inpatient Observation Chart and Escalation Procedure.

The policy does not cover advanced monitoring of cardiopulmonary observations such as continuous electrocardiogram (ECG) monitoring, invasive arterial blood pressure measurement, or central venous pressure (CVP) monitoring.

This policy applies to all adult patients admitted to the Hospital as inpatients, including the Emergency Department but excluding Critical Care areas. Please refer to separate guidance for these patient groups. Staff in these areas must adhere to specialist practice as instructed through their local induction and development programmes

3 Duties

Plymouth Hospitals NHS Trust is an established teaching Trust and has a range of undergraduate students in medicine, nursing, midwifery and allied health professions. In addition the Trust has an active programme of support worker development. Where it is appropriate to their role, students/trainees should be able to observe and practice as part of the learning process under the direct supervision of the registered practitioner or competent healthcare professional.
Plymouth Hospitals NHS Trust has an established Early Warning Scoring (EWS) chart.
The Trust has a duty to patients to ensure that there is adequately trained staff to ensure that the procedure of taking and recording vital signs is undertaken completely every time and they are done at a frequency that is determined by the patient's presenting condition. The trust also has a duty to ensure that staff know the correct reporting; and escalation procedures in accordance with this policy 24 hours a day.

<u>Service Line Management Team</u>

It is the responsibility of the Service Line Management team to ensure that staff are released for training and aware of the changes highlighted in the policy

<u>Matrons</u>

It is the responsibility of the Matrons to ensure that their staff have attended, and are up to date with relevant training for their role; and accurate records are kept and recorded on Oracle Learning Management (OLM) system.

<u>Ward Manager</u>

It is the responsibility of the Ward Manager to follow up reports regarding staff that Did Not Attend relevant training and to take appropriate action to ensure staff meet the trust's mandatory requirements.

Medical Educational Supervisors

It is the role of the Medical Educational Supervisors to ensure that their medical trainees have completed the relevant EWS training/ awareness programmes

Learning and Development Team

Learning and Development can be commissioned to support the delivery of education / training related to essential adult inpatient observations.

It is the responsibility of the Learning and Development Department to ensure that all relevant training registers are uploaded onto the OLM within 3 weeks of the course / learning being undertaken.

All Clinical Staff

Individual staff members undertaking clinical observations are responsible for ensuring they are suitably trained and competent to undertake the skill.

4 Main Body of Policy

This policy refers to the following essential adult inpatient observations, which must be undertaken as a minimum. These observations must be recorded on the Trust's EWS chart which will indicate the appropriate level of escalation based on the degree of abnormality of physiological parameters. The following physiological parameters are the essential observations and these will be recorded in the following priority order at each set of observations taken:

- Respiratory rate
- Oxygen saturation
- Blood pressure
- Heart rate
- Temperature
- Neuro Response – AVPU / Glasgow Coma Score (GCS)

In addition to this, patient's pain score must be assessed and recorded at each set of observations. In specific clinical circumstances, additional physiological monitoring should be considered; this will depend on the clinical area and the condition of the patient.

Examples are:

Blood loss via drains or wounds

Peripheral sensation and/or movement

Capillary refill – pressure points

Urine output.

Consent

Every time a set of observations is to be taken, the practitioner must gain consent from the patient. Where the patient lacks capacity to consent, the practitioner can undertake observations if this is in the patient's best interests in line with Best Interest Policy/Procedure this must be documented in the patients notes.

Equipment

All clinical areas must have:

- Manual blood pressure sphygmomanometers and stethoscopes.
- Tympanic thermometers
- Pulse oximeters

All equipment must be checked prior to each use or as a minimum daily if not in use, and be in clean working order.

Any equipment that is damaged or not working must be sent to the medical equipment management team for repair.

Regular Observations

- All patients must have a set of manual essential observations recorded on admission to hospital. Manual observations must be identified as 'M' on the observation chart
- Each patient must have at least one set of manual observations each day
- Any patient with an irregular and/or fast heart rate **must always** have their blood pressure and heart rate recorded manually.
- Any observation that lies on a scoring border must be counted as the higher score.
- Any observation that is un-recordable must be scored as RED and escalated immediately.
- All observations must be recorded as directed on the observation chart (e.g. solid dots and join the dots with **straight solid** lines)

Oxygen Saturations

Target oxygen saturations need to be documented on the PHNT Adult Prescription Chart by the admitting medical staff. If oxygen is required this must be prescribed prior to administration. ONLY in an emergency can oxygen be prescribed after administration starts. Nursing staff are required to check the oxygen flow rate and device in use at every drug round and document this in the appropriate section in oxygen section of the inpatient prescription chart.

Frequency of Observations

The required frequency of essential physiological observations must be recorded on the observation chart, by the Registered Nurse or Doctor. Every patient must have all observations recorded every time at the prescribed frequency unless they have a clearly documented plan that specifies which physiological observations should be recorded and how often.

All inpatients will have their essential physiological observations recorded **every 12 hours** as a minimum. This frequency may be reduced so long as this is documented in the patient's record by a senior member of the medical team.

The frequency of essential physiological observations will be guided by the current level of escalation. Where a patient is displaying signs of deterioration, the frequency of observations will be increased as per instructions on the observation chart.

On admission the admitting medical team must document the frequency of observations required for each individual patient in the patient's clinical record. This frequency must be reviewed as part of the patient's medical review.

The medical team must consider revising the trigger point depending on the patient's condition. The revised trigger point can be adjusted, therefore increasing or decreasing the threshold for

triggering a medical review. The trigger point can be adjusted by a Foundation Year doctor, however this must first be discussed with a Specialty Registrar (ST3+ or above) or Consultant and documented on the observation chart and within the patient notes. The revised trigger must be reviewed during the next Consultant review of that patient.

For emergency admissions, acutely unwell patients and patients stepping down from designated critical care areas, observations must be taken at least every 4 hours until a senior medical review has occurred. This should continue until the patient is seen by the medical team and agreed frequency of observations has been documented

This does not apply to patients on the End of Life care where a decision has been made to stop observations.

For patients where the minimum observation frequency has been significantly reduced, a set of observations must be performed within 24 hours of discharge, to ensure that there have been no significant changes to the patient's condition.

Post general/spinal anaesthesia observations

For inpatients who have undergone general or spinal anaesthesia, observations will be performed at the following minimum frequencies post-procedure, unless a decision is made at a senior medical level to reduce this frequency.

Specific post-operative pathways may also necessitate observations at more or less frequent intervals. Please refer to locally agreed guidelines/pathways for more information.

- Every 30 minutes for two hours
- Hourly for four hours
- Two hourly for six hours
- Four hourly for twelve hours

For the purposes of this policy, the patient's arrival on the ward indicates the start of the post-operative period.

This will make a total of 24 hours monitoring post procedure. An increased frequency of observations may be necessary depending on triggers/concerns raised during the post-operative period.

Observations MUST be recorded overnight, where there is a clinical indication to do so. There is no qualifiable evidence to omit post-operative observations because a patient is asleep.

Documentation

All documentation must be clear and legible, using consistent methods of charting as illustrated in Appendix.

All documentation must be completed in black ink.

Manual observations must be identified on the observation charts with 'M'.

The time recorded on the observation chart must be the exact time the observations were recorded.

Apical heart beat deficits should be noted to indicate 'apex' and 'radial' rates.

It is acceptable to identify lying and standing blood pressure with 'Ly' or 'St', but both recordings must be with black ink.

It is good practice to identify which arm has been used for blood pressure measurement (Left or Right). Or when indicated, which leg.

All observations causing concern and the action taken must be documented in the patient record and also on the observation chart if a trigger is identified.

Reporting and Escalation

Unregistered practitioners must report any change in the patient's observations to the registered practitioner who delegated the task to them. This must be done verbally and the action taken recorded on the back of the observation chart

All action taken by Registered and Non-Registered staff in response to the observations must be recorded on the reverse of the observation chart.

The Situation, Background, Assessment, Recommendation (SBAR) format must be used to formally escalate a patient who is presenting with deterioration in their physiological status or is a cause for concern, in every event a full set of observations must be available when reporting deterioration of a patient's condition.

All medical staff of grade FY2 and above and Hospital at Night clinical staff must assess, manage and escalate patients using an ABCDE approach. Assessment should include consideration and documentation of:

- The cause of deterioration
- The management plan with guidance to nursing staff in relation to fluid therapy and Oxygen.
- The timing of the next medical review
- The frequency of observations
- The ceiling of treatment including Cardiopulmonary Resuscitation decisions (discussion with SpR or above)
- Adjusting the trigger if appropriate (discussion with ST3+ or above).
- Removing the patient from the EWS trigger system if appropriate (discussion with ST3+ or above)
- Escalation to senior medical teams if patient continues to deteriorate
- If nursing staff any concerns about the escalation or the timeliness of review then they must contact Acute Care Team

Training

Clinical observations and SBAR training is essential for all clinical staff who undertake essential observations.

Staff can access classroom, ward based or e-learning training materials to undertake this.

All training including essential observations must be based on this policy and training staff will refer to it for guidance.

Ensuring that staff are competent in performing essential observations must be included in all ward/department induction programmes.

Training records for all staff must be kept by the ward/department manager and entered on to OLM for compliance, governance and audit purposes.

Infection Control

Clinical practice covered within this policy must adhere to the standards set out in the Trust's Infection Prevention and Control policies and procedures.

Maternal Essential Observations

The Maternal Obstetric Early Warning (MOEW) Chart utilises a different trigger system for summoning medical assistance based on the Confidential Enquiry into Maternal and Child Health (2007) recommendations.

Guidance and instructions for using this trigger system are printed on the back of each MOEW chart.

For further information and a copy of the Maternal Obstetric Early Warning Chart relating to this please refer to the following Maternity Guidelines. These can be found on the Maternal Intranet page

- Recognition of the severely ill Obstetric Patient
- Maternity Services Training Needs Analysis
- Maternal Perioperative Record of Care

Training in the use of the Maternal Obstetric Early Warning chart will be included within the Maternity mandatory training programmes as identified in the Maternity Training Needs Analysis.

Any Obstetric patient on a non-maternity ward must be referred to the midwife in charge of the Central Delivery Suite (CDS) by the ward staff. Either a Midwife or Obstetric medical staff will then review the patient as necessary, recording any maternal observations on a Maternal Obstetric Early warning chart, which is to be stored in the patient's hand held maternity notes. All observations undertaken by nursing staff will continue to be recorded on the National Early Warning Score Chart.

ICU, CDU, and Theatres

All Patients who are going to be transferred to the wards must already be on the Early Warning Score Chart.

Any patient who triggers a response must first be medically assessed prior to transfer.

ICU

All patients who are ready to return to the ward must have observations recorded on the Early Warning Score Chart. Escalation should be made to the ICU medical staff in the event of any patient triggering a response.

Any trigger and subsequent intervention must be clearly documented and the receiving ward informed.

Clinical Decision Unit

All staff within Clinical Decisions Unit (CDU) must record patient observations on the Early Warning Score Chart.

Escalation must be made to the Emergency Department doctors in the event of any patient triggering a response.

Any trigger and subsequent intervention must be clearly documented and the receiving ward informed.

Emergency Department

ED staff will complete a EWS chart at triage and at the point of patient handover to the ward. Observations on a EWS chart will be recorded whilst the patient is in the department and the local escalation process will be followed in the event of deterioration.

The acute care team must be notified of any patient transferring to an inpatient ward from the ED's Resus area.

Theatres

All Patients must have regular observations recorded on the Early Warning Score Chart prior to discharge back to a clinical area post operatively. Escalation must be made to the Theatre doctors in the event of any patient triggering a response prior to discharge.

Maintenance of Equipment

Where applicable calibration and accuracy of equipment should be regularly checked based on the manufacturer's recommendation or annually as per Trust policy.

5 Overall Responsibility for the Document

This policy will be overseen, monitored and updated via the Nursing & Midwifery Operational Committee (NMOC), chaired by the Chief Nurse.

6 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Nursing & Midwifery Operational Committee (NMOC) and ratified by the Director of Nursing.

Non-significant amendments to this document may be made, under delegated authority from the Director, by the nominated owner. These must be ratified by the Director.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

7 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

8 Monitoring Compliance and Effectiveness

Auditing of compliance with this policy and to ensure that essential observations are undertaken as per the policy will take place in all clinical areas (where the chart is used) by the ward staff using the agreed audit collection tool on Meridian. Overarching audit data arising from this audit will be reported to the Nursing and Midwifery Operational Committee on a 6-monthly basis for assurance.
Compliance will also be reported to Director of Nursing, Heads of Nursing and should be reviewed regularly at ward and service line level. Action plans for any identified deficiencies will be developed and monitored at Service Line level, reported through Service Line Governance meetings.

9 References and Associated Documentation

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Mackay CA, Burke DP, Burke, JA, Porter, KM, Bowden, D, Gorman D (2000) Association between the assessment of conscious level using the AVPU system and the Glasgow coma scale, Pre-Hospital Immediate Care, 4, 17-19

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Moulton C, Yates, D (1999 2nd Edition), The Principles of Emergency Medicine (Chapter 1), Lecture Notes on Emergency Medicine, Blackwell Science

National Confidential Enquiry into Patient Outcome and Death (2005) An Acute Problem?: A report of the National Confidential Enquiry into Patient Outcome and Death, www.ncepod.org.uk (accessed 2006)

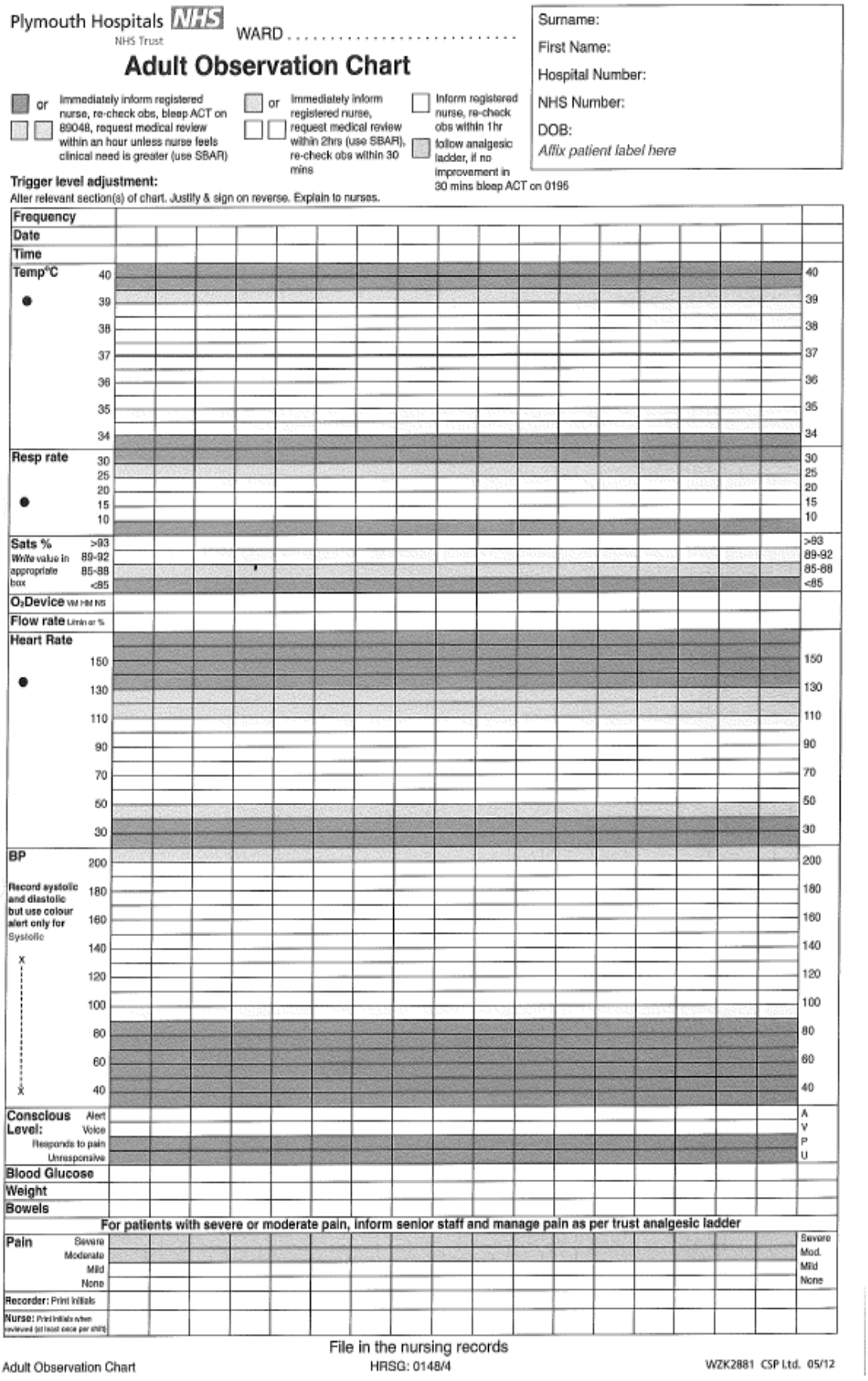
National Institute for Health and Clinical Excellence (2007) Acutely ill patients in hospital: Clinical guideline 50, www.nice.org.uk

National Patient Safety Agency (2007) Recognising and responding appropriately to early signs of deterioration in hospital patients, www.npsa.nhs.uk/corporate/nNEWS/deterioration-in-hospitalised-patients

National Patient Safety Agency (2007) Safer care for the acutely ill patient: learning from serious incidents, www.npsa.nhs.uk/corporate/nNEWS/deterioration-in-hospitalised-patients
Stanford University Medical Centre, Cardiovascular Diseases: Vital Signs, www**.stanfordhospital.com/healthLib/atoz/cardiac/vital.html (accessed 2006)**

Appendices

General EWS chart



Plymouth Hospitals NHS
NHS Trust

WARD .....

Adult Observation Chart

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Affix patient label here

or Immediately inform registered nurse, re-check obs, bleep ACT on 89048, request medical review within an hour unless nurse feels clinical need is greater (use SBAR)

or Immediately inform registered nurse, request medical review within 2hrs (use SBAR), re-check obs within 30 mins

Inform registered nurse, re-check obs within 1hr

follow analgesic ladder, if no improvement in 30 mins bleep ACT on 0195

Trigger level adjustment:
Alter relevant section(s) of chart. Justify & sign on reverse. Explain to nurses.

Frequency
Date
Time
Temp°C 40 39 38 37 36 35 34
Resp rate 30 25 20 15 10
Sats % >93 / 89-92 / 85-88 / <85 — Write value in appropriate box
O_2 Device VM HM NS
Flow rate L/min or %
Heart Rate 150 130 110 90 70 50 30
BP 200 180 160 140 120 100 80 60 40 — Record systolic and diastolic but use colour alert only for Systolic
Conscious Level: Alert / Voice / Responds to pain / Unresponsive — A V P U
Blood Glucose
Weight
Bowels

For patients with severe or moderate pain, inform senior staff and manage pain as per trust analgesic ladder

Pain: Severe / Moderate / Mild / None — Severe / Mod. / Mild / None
Recorder: Print Initials
Nurse: Print Initials when reviewed (at least once per shift)

File in the nursing records

Adult Observation Chart HRSG: 0148/4 WZK2881 CSP Ltd. 05/12

General EWS chart

Urinalysis																		
Date																		
Time																		
Leucocytes																		
Nitrate																		
Urobilinogen																		
Protein																		
pH																		
Blood																		
Specific Gravity																		
Ketones																		
Bilirubin																		
Glucose																		
Sent for MSU																		

Use SBAR when requesting medical review or calling outreach.

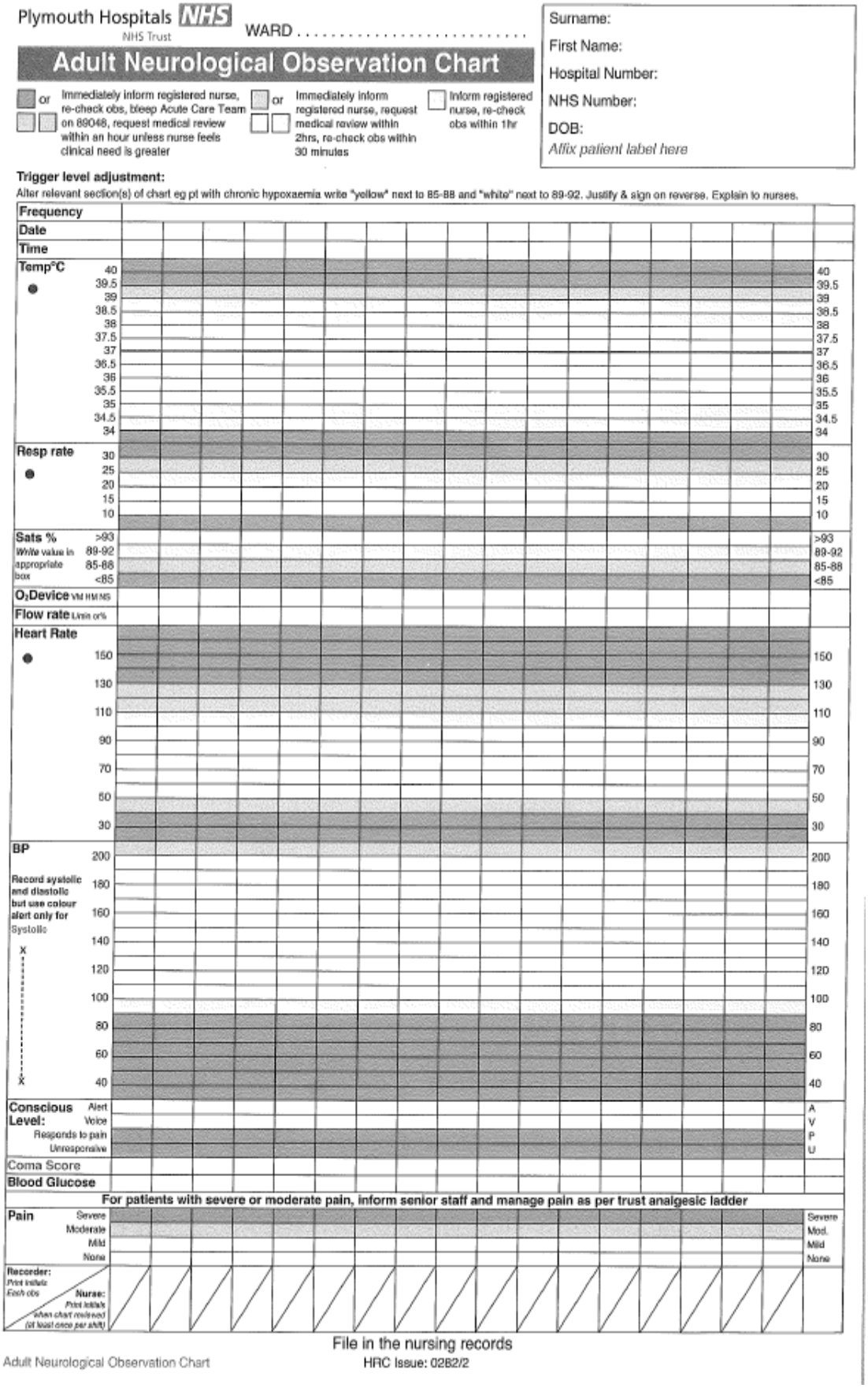
Pre-call preparation: Gather the following information: Patient's name; age; obs chart, fluid chart & drug chart.
Use the checklist below to gather your thoughts and prepare.

S	**Situation:** I am (name), a nurse on ward (X) I am calling about (patient X) I am calling because I am concerned that . . . . . (e.g. BP of low/high, pulse is XX temperature is XX, Early Warning is XX)
B	**Background:** Patient (X) was admitted on (XX date) with . . . . . (e.g. MI/chest infection) They have had (X operation/procedure/investigation) Patient (X)'s condition has changed in the last (XX mins) Their last set of obs were (XX) Patient (X)'s normal condition is . . . . (e.g. alert/drowsy/confused/pain free)
A	**Assessment:** I think the problem is (XXX) and I have . . . (e.g. given O2/analgesia, stopped the infusion) OR I am not sure what the problem is but patient (X) is deteriorating OR I don't know what's wrong but I am really worried
R	**Recommendation:** I need you to . . . . (e.g. come to see the patient in the next XX mins) AND Is there anything I need to do in the meantime? (e.g. stop the fluid/repeat the obs)

Date/Time	Observation / Trigger (R) (A) (Y) (P)	ACTION taken *(tick box)*				Print Name
		Nurse Informed	Obs Re-done	Dr review Requested	ACT called	

Adult Observation Chart HRSG: 0148/4

Neurological EWS chart



Plymouth Hospitals NHS
NHS Trust

WARD . . . . . .

Adult Neurological Observation Chart

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Affix patient label here

or Immediately inform registered nurse, re-check obs, bleep Acute Care Team on 89048, request medical review within an hour unless nurse feels clinical need is greater

or Immediately inform registered nurse, request medical review within 2hrs, re-check obs within 30 minutes

Inform registered nurse, re-check obs within 1hr

Trigger level adjustment:
After relevant section(s) of chart eg pt with chronic hypoxaemia write "yellow" next to 85-88 and "white" next to 89-92. Justify & sign on reverse. Explain to nurses.

Frequency																			
Date																			
Time																			
Temp°C ●	40																		40
	39.5																		39.5
	39																		39
	38.5																		38.5
	38																		38
	37.5																		37.5
	37																		37
	36.5																		36.5
	36																		36
	35.5																		35.5
	35																		35
	34.5																		34.5
	34																		34
Resp rate ●	30																		30
	25																		25
	20																		20
	15																		15
	10																		10
Sats % *White value in appropriate box*	>93																		>93
	89-92																		89-92
	85-88																		85-88
	<85																		<85
O_2Device VM HM NS																			
Flow rate L/min or%																			
Heart Rate ●	150																		150
	130																		130
	110																		110
	90																		90
	70																		70
	50																		50
	30																		30
BP *Record systolic and diastolic but use colour alert only for Systolic* X ⋮ X	200																		200
	180																		180
	160																		160
	140																		140
	120																		120
	100																		100
	80																		80
	60																		60
	40																		40
Conscious Level:	Alert																		A
	Voice																		V
	Responds to pain																		P
	Unresponsive																		U
Coma Score																			
Blood Glucose																			
For patients with severe or moderate pain, inform senior staff and manage pain as per trust analgesic ladder																			
Pain	Severe																		Severe
	Moderate																		Mod.
	Mild																		Mild
	None																		None
Recorder: *Print initials Each obs* / **Nurse:** *Print initials when chart reviewed (at least once per shift)*																			

File in the nursing records

Adult Neurological Observation Chart HRC Issue: 0282/2

Neurological EWS chart

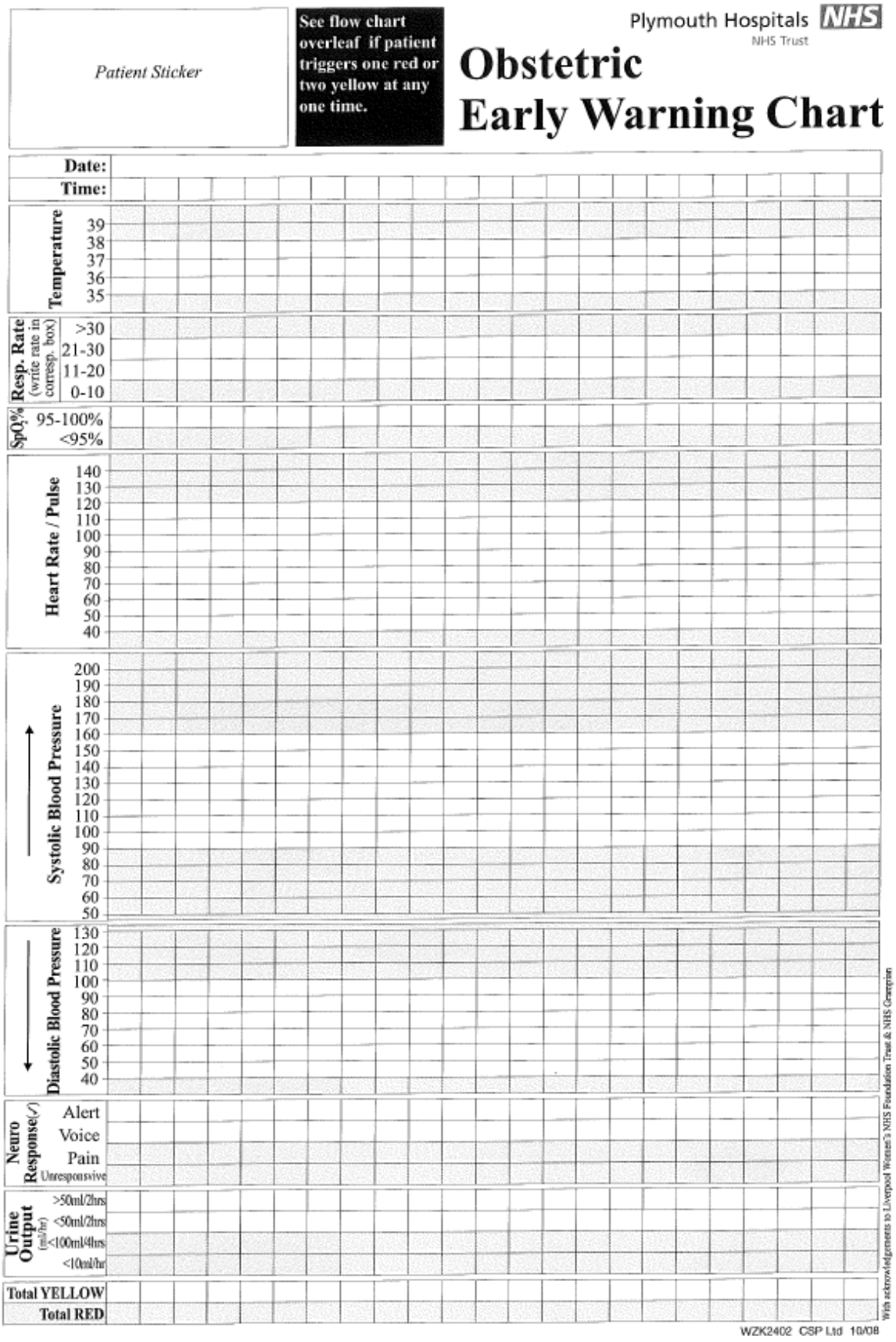
		Date																		Pupil Scale (mm)
		Time																		1 2 3 4 5 6 7 8
1 point drop in GCS = ☐			If no improvement at 30 minutes or 2 point drop = ☐										3 point drop in GCS = ☐							
Coma Score	eyes open	Spontaneously	4																	
		To speech	3																	
		To pain	2																	
		None	1																	
	best verbal response	Orientated	5																	
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	best motor response	Obey commands	6																	
		Localise pain	5																	
		Flexion to pain	4																	
		Abnormal flexion	3																	
		Extension to pain	2																	
		None	1																	
Coma Score																				
Pupils	Right	Size																		+ reacts - no reaction c eyes closed by swelling
		Reaction																		
	Left	Size																		
		Reaction																		
Limb movement	Arms	Normal power																		If there is a difference between two sides record right (R) and left (L) separately
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	Legs	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
Weight																				
Bowels																				
Urinalysis		Date Time			Leuk Nit			Pro pH			βHCG SG			Blood Ket			Glu Sent for MSU ☐			

If a patient suffers a new head injury in hospital

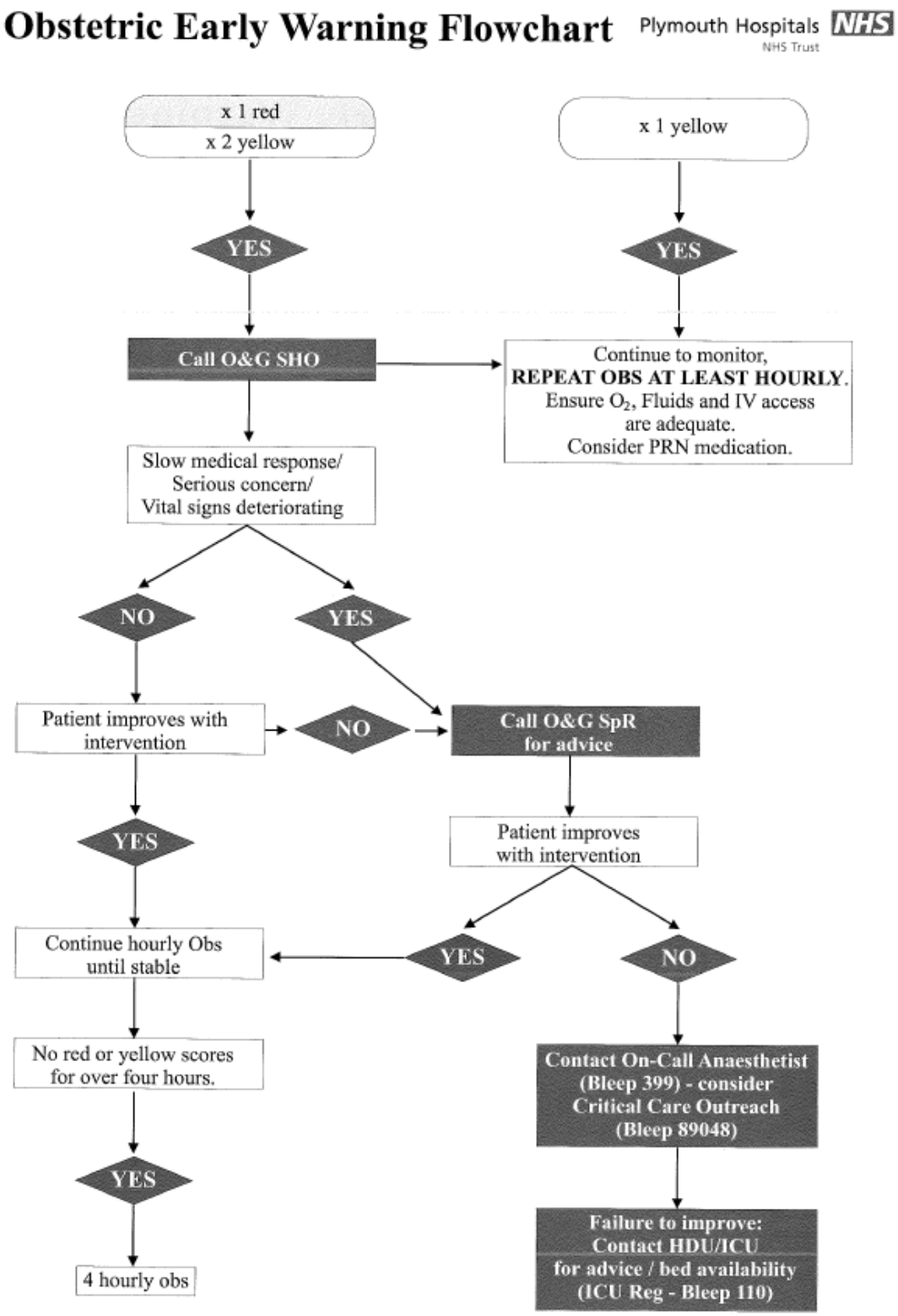
- Perform and record observations on a half-hourly basis until GCS = 15
- When GCS = 15, minimum frequency of observations is:
  - half hourly for 2 hours
  - then 1 hourly for 4 hours
  - then 2 hourly thereafter
- If patient deteriorates to GCS < 15 after initial 2 hr period, revert to half-hourly observations & follow original schedule

Date/Time	Observation / Trigger (Red, Amber, Yellow)	ACTION taken *(tick box)*				Print Name
		Nurse informed	Obs re-done	Dr review requested	Acute Care Team called	

Maternal EWS chart



Maternal EWS chart



Date Finalised	July 2017
Previous Documents	
Action to retrieve old copies	N/A

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff	May 2017	Vital Signs	Information Governance Team
Ward Nursing Staff	June 2017	Team Review	Matrons & Senior Sisters

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes

	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	25/5/17
Title	**Essential Adult Inpatient** **Observations, Reporting and Escalation Policy**
What are the aims, objectives & projected outcomes?	**This policy sets out the criteria for performing consistent and safe essential adult inpatient observations. In addition it describes the action that must be taken in line with the Adult Inpatient Observation Chart and Escalation Procedure.**

Scope of the assessment
The assessment covers all protected characteristics The EIA was produced by the Trust's Equality & Diversity Lead Incidents are monitored via datix and reported as necessary

Collecting data	
Race	There is no evidence to suggest there is disproportionate impact on race regarding this policy. Consideration will be made for patients with English as a second language to ensure they are able to provide consent to the procedure Data collected from Datix incident reporting will ensure this is monitored.
Religion	There is no evidence to suggest there is a disproportionate impact on religion or belief and non-belief regarding this policy. Consideration will be made for patients who have specific religious requirements. This will be monitored through complaints and incidents. Data collected from Datix incident reporting will ensure this is monitored.
Disability	There is no evidence to suggest there is a disproportionate impact on disability regarding this policy. However, data collected from Datix incident reporting will ensure this is monitored. Consideration will be made for patients who have special requirements. This will be monitored through complaints and incidents.

Sex	There is no evidence to suggest there is a disproportionate impact on sex regarding this policy. However, data collected from Datix incident reporting will ensure this is monitored.
Gender Identity	There is currently no data collected for this area. However, data collected from Datix incident reporting will ensure this is monitored
Sexual Orientation	There is no evidence to suggest there is disproportionate impact on sexual orientation regarding this policy. However, data collected from Datix incident reporting will ensure this is monitored.
Age	There is no evidence to suggest there is a disproportionate impact on age regarding this policy. However, data collected from Datix incident reporting will ensure this is monitored.
Socio-Economic	There is currently no data collected for this area. However, data collected from Datix incident reporting will ensure this is monitored.
Human Rights	Data collected from Datix incident reporting will ensure this is monitored
What are the overall trends/patterns in the above data?	No comparative data has been used to date which means that no trends or patterns have been identified.
Specific issues and data gaps that may need to be addressed through consultation or further research	No gaps have been identified at this stage but this will be monitored via data collected from Datix incident reporting.

Involving and consulting stakeholders	
Internal involvement and consultation	All Senior Nurse via NMOC Equality and Diversity Lead
External involvement and consultation	N/A
Impact Assessment	
Overall assessment and analysis of the evidence	

Action Plan

Action	Owner	Risks	Completion Date	Progress update
Monitor incidents linked to this policy via Datix			ongoing	