Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Bassetlaw@ Operational Policy

This is a new procedural document – please read in full

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	Karen Barnard, Director of People & OD
Author/reviewer: (this version)	Joanne Sayles, Lead Advanced Clinical Practitioner for Bassetlaw@
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Approved by:	Policy Approval and Compliance Group
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Date issued:	8 October 2018
Next review date:	September 2019 – **(extended to October 2020)**
Target audience:	All clinical staff, Trust wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1	8 October 2018	This is a New procedural document - please read in full	Joanne Sayles

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1 PURPOSE

This policy describes the working principles and practices for staff who work outside normal working hours with the guiding and underlying principles of ensuring that patients are treated and cared for in a timely manner by the most appropriate professional.

2 INTRODUCTION

Outside normal working hours NHS hospitals have traditionally relied on multiple tiers of specialty specific teams as the model for providing medical cover. The Bassetlaw@ model essentially proposes that a multi-disciplinary team provide operational and clinical care across the hospital on the basis of being competent to provide care, rather than by virtue of belonging to a particular profession.

The Bassetlaw@ model provides the best possible care for patients and offers the most efficient method of preserving and even enhancing, doctors' training in the reduced hours available.

The model consists of a multidisciplinary team, which has the competencies to cover a wide range of interventions but has the capacity to call in specialist expertise when necessary. This contrasts with the traditional model of junior doctors working in relative isolation and in specialty-based silos.

The Bassetlaw@ model consists of a centrally coordinated approach to care. All out of hours tasks, operational, NEWS2 (National Early Warning Score 2 (See Appendix 1) and deteriorating patient reviews are relayed to Nervecentre a central task management system. An Advanced Clinical Practitioner (ACP) or Clinical Site Manager (CSM) will act as a clinical co-ordinator and triage, prioritise and allocate workload to the most appropriate person for completion in a timely manner. The Doctor, ACP, CSM or Clinical Support Co-ordinator (CSC) can then perform their allocated workload that has been prioritised for them, enabling them to focus directly on the patient without interruption.

2.1 The Hospital out of Hours Service

The Hospital out of Hours Service advocates:

- Supervised multi-specialty handover in the evenings, night time and mornings.
- Other staff taking on some of the work traditionally undertaken by junior doctors.

- Moving a significant proportion of non-urgent work from the night to the evening or daytime.
- Reducing the unnecessary duplication of work by better co-ordination and reducing multiple clerking and reviews.
- Reducing the isolation of staff working out of hours.
- Support for the out of hours team and junior doctors.
- Having a competent team who have the most appropriate clinical skills to treat the patient.
- Seeing the 'sickest quickest'.

2.2 Scope of the policy

This policy applies to all staff working within the Hospital out of Hours remit:

- Executive director on call
- Senior Manager on call (SMOC)
- Medical staff who are members of the Bassetlaw@ Team
- Medical Staff who are not members of the Bassetlaw@ Team
- ACPs who are members of the Bassetlaw@ Team
- ACPs who are not members of the Bassetlaw@ Team
- Clinical Site Management Team
- Nursing staff who are not members of the Bassetlaw@ Team
- Clinical Support Workers, Patient Flow Co-ordinators who are members of the Bassetlaw@ Team
- Radiologists/Radiographers
- Pathology/Microbiology
- On call Pharmacists
- Service assistants

Although the prime aim of this policy is to ensure quality care for patients during the out of hours' time period, scope also exists to develop the principles more broadly thus ensuring patient care is provided seamlessly.

2.3 Exclusions

The following clinical areas will not be covered by the Bassetlaw@ model:

- Department of Critical Care
- Emergency Department
- Obstetrics & Gynaecology
- Special Care Baby Unit

2.4 Working hours

Bassetlaw:

ACP Monday – Sunday: 20:00 – 08:30hrs

CSM Monday – Sunday: 08:00 – 20:30hrs

- Monday – Friday Between 17:00 – 20:00 hours the clinical site manager will act as clinical coordinator)
- At a weekend between the hours of 08:00 – 20:00 hours the Clinical Site Manager will act as clinical coordinator.

CSC Monday – Sunday: 20:00 – 08:30hrs

CSW Monday – Friday 08:00 – 00:00hrs
Saturday - Sunday: 08:00 – 21:00hrs

3 BASSETLAW@ MANAGEMENT AND STRUCTURE

The Clinical Leadership of the Hospital at Night Team will rest with the Division of Medicine Clinical Director. The Nursing Leadership will be provided by the Associate Director of Nursing for the Division of Medicine. The management of the Bassetlaw@ team will be provided by the Lead ACP in the division of Medicine.

The core Bassetlaw@ Team will consist of the following multidisciplinary team:

Member of Bassetlaw@ Team	Brief description of role
Medical Specialist Registrar (Med SpR). Includes Speciality Training Registrar ST3+, Trust employed middle grades.	Resident lead clinician (In their absence the most senior doctor present will undertake this role). They will maintain overall responsibility for clinical decision making. There will be a non-resident consultant on-call cover, who the Med SpR will report to as necessary, and have ultimate responsibility for patients under their care. if workload becomes unsafe they will liaise with the CSM/ACP and escalate to the consultant on call
Resident Medical Officer (RMO) Includes RMO, Core trainees ST1-ST3 and CT1-CT3	First clinician on-call for clinical ward tasks and immediate patient review where immediate Med SpR input is not required.

Advanced Clinical Practitioner (ACP)	Multidisciplinary team coordinator and general lead. First point of contact for all ward staff in all patient matters (with exception of cardiac arrest callouts). First point of contact for operational or site issues. Where these occur outside the remit of the ACP, they should be escalated to the CSM at Doncaster Royal Infirmary (DRI) or the Senior Manager on call (SMOC). Will triage the workload and prioritise the Bassetlaw@ team work accordingly. If clinical workload becomes unsafe they should discuss with the Med SpR and then contact the Consultant on call
Clinical Support Co-ordinator (CSC)	Support the work of the Bassetlaw@ Team with multiple skills and competencies, both clinical and operational.

Non-resident support for Bassetlaw@ Team include:

- Specialty and Associate Specialist Doctor in General Surgery – contactable via Switchboard
- On-call General Medical Consultant – contactable via Switchboard

Other key members of the hospital staff but not part of the Bassetlaw@ team include:

- Anaesthetics and Intensive Care team (On-call Anaesthetic SpR, On-call Anaesthetic Consultant)
- Maternity and Women's Health team (On-call SpR, RMO and non-resident Consultant)
- Paediatric & Neonatal Team (On-call SpR, RMO and non-resident Consultant)
- Theatre Team (On-call ODP and theatre staff)
- Emergency Department team
- Urgent speciality advice from general surgery, specialty surgery and orthopaedics from Doncaster Royal Infirmary (DRI) site – contactable via switchboard.

The Bassetlaw@ team will not be pulled from the team to provide routine nursing or caring support on the wards that are understaffed due to sickness or other unforeseen circumstances.

3.1 Medical Staff - Rota Protocol

The Medical rota will be published on a 4 monthly basis and it will be available approximately 8 weeks in advance to the key rota organisers. Once published, it will be the rota organiser's/directorate's responsibility to check and identify any anomalies or clashes and to amend day time rotas to fit the Bassetlaw@ rota. The rota organiser for the Division of Medicine will populate the names of the Doctors within their speciality covering the relevant shifts.

Rota organisers will have responsibility for dealing with absence as outlined in the DBTH Rules for medical Doctors. Please see Appendix 2.

- It is recognised that each Division will have their own procedures. Please refer to these in conjunction with the above rules.

EWTD and New Deal/New contract regulations must be followed and met at all times (please see appendix 3).

3.2 Unplanned vacancy: Weekends/bank holidays/out of hours (after 17:00hrs)

- Absence to be notified to the Medical Consultant.
- Site manager or ACP to contact Holt.
- CVs (if available) sent to consultant by e-mail.
- Consultant confirms suitability. CSM or ACP confirms suitability with agency.
- Consultant notifies duty team (to be passed on by the registrar) of arrangements. This includes redistribution of junior medical staff if no locum available.
- Liaison with the other hospital sites to see if staff can be redistributed across site.

NB. Initial contact informing of sickness should be to the CSM/ACP and consultant on call. If the initial contact is with a third party then it is they who must inform the on call Speciality Consultant/CSM/ACP**.**

Work practice in the event of absence of one member of the medical team at Bassetlaw

If a member of the Bassetlaw@ Team is absent the remaining team members will share the workload as much as possible. If patient safety is deemed to be at risk by the absence of clinical staff, all specialities that are covered by the Basetlaw@ team should be informed

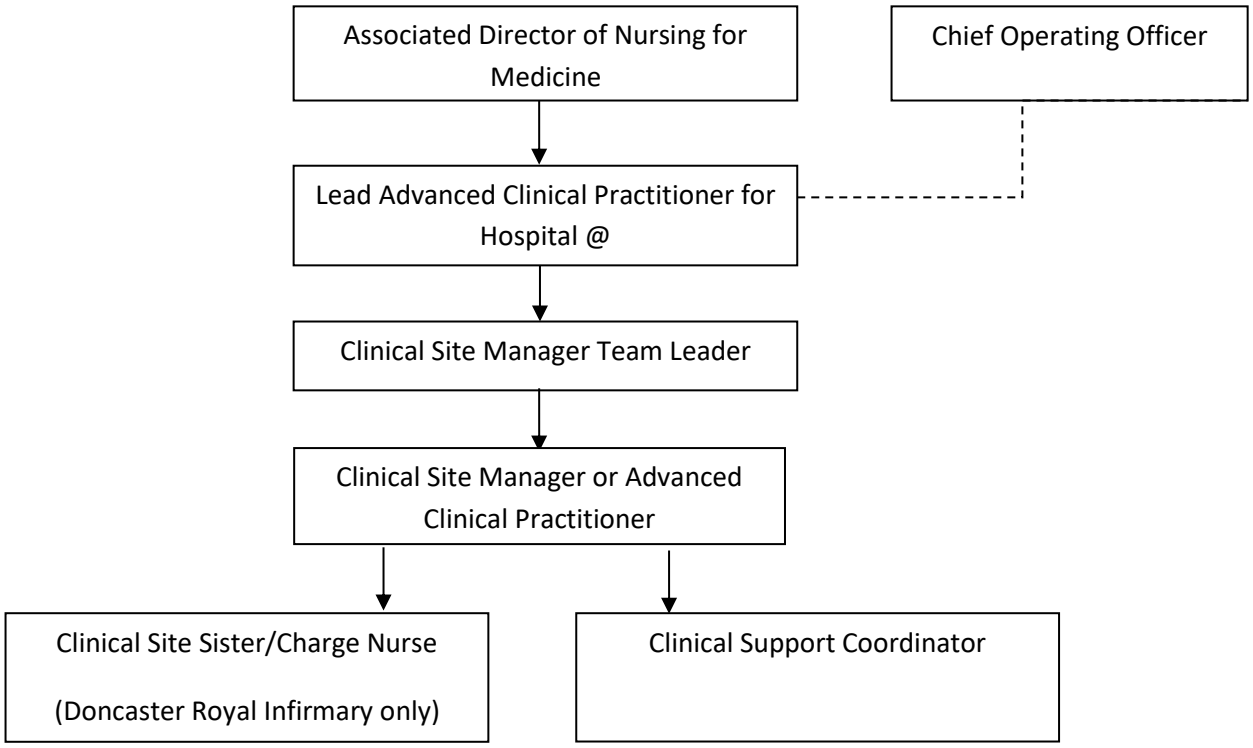
and asked for support. If no support can be found by re-distribution or agency staff then the manager on call as well as all the involved Consultants should be informed of the situation.

Gaps in the Bassetlaw@ teams should be declared to the medical Consultants, clinical directors and Lead ACP during office hours, who should let their on call SpRs and CSM/ACP know of the deficit.

Decisions for covering Bassetlaw at night when there are staffing deficits need to be taken in context with staffing across all DBTH sites. This needs to take into account both activity on all sites and current staffing levels. It is often safer to have a staffing deficit in a large team than a small team so may be appropriate to move staff from DRI to Bassetlaw.

3.3 Nursing staff structure

Nursing Structure flow chart



There will be 1 ACP on duty at night, who will take on the role of Team Coordinator. The ACP coordinator will be a senior member of the Bassetlaw@ team and will provide a comprehensive range of clinical skills to patients including initiating treatment plans where required.

The ACP coordinator will have responsibility for the duty management of the hospital overnight and the effective co-ordination during the shift and working closely with the Med SpR. They will co-ordinate the work load according to availability and clinical competence to carry out the care required and will also liaise with the CSM team at Doncaster as appropriate.

They are not to be used as a replacement for qualified ward staff in the event of sickness. In addition to senior nursing staff there will be a clinical support coordinator (CSC) who will provide support to the multidisciplinary team. They are not to be used as a replacement for ward staff in the event of sickness. The CSC will have a range of competencies which include:

- Obtaining samples of venous blood (venepuncture)
- Placement of intravenous cannula
- Obtaining ECG recordings
- Catheterisation
- Measuring and recording observations (temperature, blood pressure, pulse, respirations, oxygen saturations, blood glucose, consciousness level, urine test, pain, calculate NEWS2 and escalate as per Physiological Observations and Prevention of deterioration in the Acutely Ill Adult Policy - PAT/T 33
- Preparing patients for examination
- Summoning help and commencing first aid or basic life support in the event of a medical emergency.
- Requesting/completing tasks on the electronic task management system/Nervecentre.
- Monitor patient flow via electronic symphony and communicate to the Bassetlaw@ Team about capacity
- Liaise with ED to expedite patient transfers and impending breaches and act to prevent breaches.
- Up-date CAMIS bed management system following transfers.
- Liaise with ambulance services in the event of patient transfers
- Provide support to Trust staff in the use of the electronic bleep system/nerve centre.

The rota is available via the DBTH e-Roster System. It is the responsibility of the Lead ACP to ensure the rota is kept up to date and any changes are recorded.

A list of the Bassetlaw@ team's telephone numbers will be kept by the Lead ACP and Clinical site Manager. The Lead ACP for Bassetlaw@ will ensure that this is kept up to date.

3.4 Absence from work – Procedure for nursing staff

Expected absence must be reported as soon as reasonably possible and normally before 14:00hrs to the Lead ACP for Bassetlaw@ or CSM. An expected length of absence should be indicated and a brief reason for the absence given. The Lead ACP or CSM taking the call will then send a text to all ACP's who are on rest days, this should then be requested on NHSP. Where it has not been possible to cover the absence within the Bassetlaw@ team an email should be sent to the CSM team to try and arrange cover, If an ACP/CSM is available to cover this should be booked via NHSP. Where it is not possible to cover the absence, 'in hours' the Head of nursing and general manager for medical services should be made aware. 'Out of hours' the Duty Matron AND 1ST on call should be made aware.

If in the eventuality that the ACP duty cannot be covered the following options should be followed:

- The band 6 CSM will transfer from Doncaster to cover the Bassetlaw Site and act as clinical coordinator.
- A request for medical cover should be made to Holt.

If a CSC is absent from work then a text will be sent to all CSC, CSW and Patient Flow Coordinators (PFC) who are on rest days and a request to NHSP. The Lead ACP for Bassetlaw@ should be informed of any absence by email and s/he will then hold the responsibility for entering the sickness onto the e-Roster system.

(i) Between 20.00hrs and 09.00hrs

All absence should be reported to the ACP coordinator/CSM. An expected length of absence should be indicated and a brief reason for the absence given. If an ACP / CSC is absent then a text will be sent to all ACPs / CSC's who are on rest days and a request to NHSP. The lead ACP should be informed via email.

All staffing shortfalls should be discussed at handover.

4 HANDOVER

Handover is a **critical** element of the model with good handover supporting continuity of care and good team working. Continuity of information underpins all aspects of a seamless and high quality patient experience and therefore an efficient and effective multidisciplinary handover procedure and meeting are essential. The handover meeting will not negate the need for continuous liaison throughout the night regarding patient care and needs. All

members accessing handover must be made aware of the procedure for handover as outlined in the Handover Policy PAT PA 31.

Each specialty is responsible for ensuring that their staff (including new staff in post) are provided with adequate training to enable them to use Nervecentre the electronic task management System.

It is essential that all those expected to attend handover do so. If in the case of a life threatening patient emergency this is not possible, the ACP or CSM coordinator should be informed as soon as possible.

The out of hours on call handover will take place in the Clinical Site Operational room, ground floor at 16:30hrs. The electronic devices will be allocated to the on call out of hours team and the CSM will act as clinical coordinator. All out of hours tasks should have been inputted on to Nervecentre the electronic task management system. A verbal handover should also take place between medical teams and the sign in sheet completed.

The site operational handover will take place in the Clinical Site Operations room at 08:00hrs and 20:00hrs. The ACP, CSC and CSM should attend. The handover should include:

- Any issues on the Bassetlaw Hospital Site
- Staffing shortfalls
- Patient Flow
- Patients handed over from the DCC outreach team
- Patients waiting bed allocation from ED
- Handover of electronic devices

The medical handover takes place in the Clinical Site operations room on the ground floor at 20:30hrs and 08:45hrs on ambulatory Care. The handover should include:

- General Introductions and sign attendance sheet.
- Allocation of electronic device/Return of electronic device
- Any gaps in the rota
- Handover of acutely ill, unstable and newly admitted patients together with the allocation of outstanding tasks should have already been inputted on the electronic task management system in preparation for handover.
- Sick patients should be handed over using the SBAR tool (Appendix 4), if a specific doctor is required this should be noted at handover and prioritized.
- The ACP and clinical lead will allocate these tasks accordingly i.e. to the most appropriate professional who is available and has the competency to carry out the duty.
- The ACP coordinator (20:30hrs) or CSM (08:45hrs) will provide an overview of admissions – to include patients in A&E awaiting ward beds.
- Any operational issues to be discussed

- If there is a priority call during handover, all critical staff should attend as usual and the ACP co-ordinator will continue the handover with the remaining doctors.

Patients who have been cared for by the DCC nursing outreach team should be added to Nervecentre and referred to the CSM. The patient will then be handed back to the core speciality team at the morning handover in the normal manner and any issues communicated.

Patients reviewed by the Bassetlaw@ team within the medical, surgical and orthopaedic speciality should be handed back to the speciality teams at the morning handover in the normal manner and any issues communicated.

During the shift the Site Operational Room (Ground floor) will act as a central point of contact for all members of the team to meet.

4.1 Electronic Handover System

All routine tasks that are required to be performed in the out of hour's period by Doctors, ACP's, CSM, CSC's and CSW's should be added to Nervecentre. The task management system will identify and include:

- Number of patients requiring review
- Patients recently admitted with relevant comments and actions needed
- Patients due to be admitted
- Patients requiring review/urgent investigations and whether these have been requested
- Urgent results awaiting review
- Jobs and task allocation
- Patient at risk list
- Any unexpected urgent problems- however these should be flagged as a completed job (i.e. they should have already been dealt with)
- NEWS2 score for each entry
- Fully auditable system

The Nervecentre electronic task management system will be accessed via a desktop or electronic hand held device. When a message is created it will be directed to the Nervecentre electronic message board where it will be triaged, prioritised and allocated to the appropriately trained member of the Bassetlaw@ Team. During the hours of 17:00hrs till 20:00hrs Monday to Friday and over the weekend this will be coordinated by the CSM.

The Doctor, ACP, CSM, CSW or CSC will then access the message allocated to them from their 'my tasks' and acknowledge that they have received the task and complete when they have performed the task.

Any patient with a NEWS2 score of 7 or 3 in one parameter as per the Trust NEWS2 escalation guidelines (see Appendix 1) or red/urgent tasks should be bleeped through to the coordinator as an urgent task on bleep number 3235. The clinical coordinator will then allocate the task to the most appropriate professional to make them aware of the patient to enable them to prioritise the patient above all other tasks. A notification will be sent to the Med SpR for all red tasks.

Tasks will be prioritised as urgent, immediate or routine and should be completed in this hierarchical order by the Doctor, ACP, CSC, CSW or CSM.

Any patients accepted by the CSM/ACP/SPR/Doctor/CSC/CSW out of hours must be added to the electronic task management system.

4.2 Website Failure

In the event that Nervecentre is unavailable (e.g. network down), a paper version of the system should be used and forms will be available in the site operations office. Paper information should be completed and returned to the ACP coordinator in preparation for handover. The traditional bleep system should then be used and bleep numbers supplied to all patient areas.

In the event of IT failure refer to the Information & Communication Technology (ICT) Business Continuity Policy – CORP/ICT 11.

4.3 Bleep protocol and procedure

The bleep protocol consolidates good practice relating to communication between medical and nursing staff and removes unnecessary pressure and interruptions. Where possible, jobs that require completion on the ward should be raised via Nervecentre. It is counterproductive and could be dangerous to use it for routine and non-urgent calls.

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

4.4 Bleep Failure

All urgent tasks should be notified by telephone via switchboard, the ACP coordinator will ensure she has collected contact numbers for all the out of hours team and shared with switchboard. The ACP coordinator will also inform all of the wards of the situation.

In the event of a bleep failure please refer to the Information & Communication Technology (ICT) Business Continuity Policy – CORP/ICT 11.

Action cards for Bleep failures, IT failures and Nerve Centre Failure can be found in the site operations office.

4.5 Cardiac Arrests

There is no change to the operating procedures for cardiac arrest in the Bassetlaw@ team.

For cardiac arrest bleep 2222.

The whole of the Bassetlaw@ Team would be expected to form the cardiac arrest team and would require their bleeps to hold that facility.

5 TRAINING/SUPPORT

The Bassetlaw@ team will provide leadership, role model the Trust values and be a point of contact for junior staff out of hours. They will complement the clinical medical team, promote education and learning in the clinical environment, supporting the Trust's clinical educators and instructor's encouraging on going skills attainment and ensuring optimum care standards for all patients. The team will:

- Provide educational support and supervision to staff who undertake additional skills training.
- Utilise the recognised Trust assessment tool in line with Trust policies related to clinical assessment.
- Continue to enhance patient safety agenda through educational and to encouraging teaching and learning 'at the bedside'.
- Provide clinical skills support to all ward's and departments.
- Provide strategic coordination of the nursing workforce, to ensure optimum staffing levels throughout the site in order to maintain consistently safe care standards, building on plans provided by the Divisons. There is an expectation that staff members comply with this redeployment as necessary.
- Provide training/support for using Nervecentre the electronic task management system

- ACP's to be trained to commence and troubleshoot the use of Non-invasive ventilation (NIV).
- ACP's to gain competency of selected Orthopaedic and Surgical conditions and complications.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
A&E 4 hour wait	Circulated daily to the business support managers. ED	Daily	Reported to Trust Board monthly
Incidents – reported via the DATIX system	Ward Managers Matrons Lead ACP for Hospital@	On an individual incident basis	Local clinical Governance group
Complaints	Lead ACP for Hospital@	On an individual incident basis	Local clinical Governance group Division of Medicine Management meeting
Morbidity and Mortality	Mortality review group	Monthly	Local Clinical Governance Risk management
Task completion times from request	Lead ACP for Hospital@	Monthly Basis	Local Clinical governance Division of Medicine Management meeting
Cardiac arrests	Lead ACP	On an individual basis	Local clinical governance Trust clinical governance

7 DEFINITIONS

ACP	Advanced Clinical Practitioner
CSM	Clinical Site Manager
CSC	Clinical Support Coordinators

CSW	Clinical Support Worker
DCC	Department of Critical Care
ECG	Electrocardiogram
ED	Emergency department
HOOH	Hospital out of hours
NHS	National Health Service
NEWS	National Early Warning Score
PFC	Patient Flow Coordinator
RMO	Resident Medical Officer
SAS	Speciality and Associate Specialist
SBAR	Situation, Background, Assessment, Recommendation
SMOC	Senior Manager on call
SPR	Specialist Registrar

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 4).

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Clinical Site Management Team Operational Policy – (PAT/PA 33)
Mental Capacity Act – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – (PAT/PA 19)
Handover Policy – (PAT/PA 31)
Information & Communication Technology (ICT) Business Continuity Policy – (CORP/ICT 11)
Physiological Observations and Prevention of Deterioration in the Acutely Ill Adult – (PAT/T 33)
Privacy and Dignity Policy – (PAT/PA 28)
Fair Treatment for All Policy – (CORP/EMP 4)
Equality Analysis Policy – (CORP/EMP 27)

10 REFERENCES

The service has been designed to be consistent with both the Trust Operational Plan 2018/19 and a number of national and local initiatives and imperatives which include:

Continued junior doctor post reductions and EWT Regulations (2012)

Francis Report and Nursing Acuity (2013)

Future Hospital: Caring for medical patients (2013)

HiSLAC 7 Day Service Review (2015)

Hospital at Night: Safer Care Safer Training. Benefits Realisation & Business Case (2007)

Hospital Out of Hours Operational policy (257, v4). Sheffield Teaching Hospitals.

https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-1-handover

https://www.rcplondon.ac.uk/projects/outcomes/future-hospital-commission

NHS Operational Framework 2016 / 17

The recognition by the GMC and Deanery of workload issues with junior doctors.

Trust early implementer status for priority clinical standards – 2,5,6 & 8 (1) .

APPENDIX 1 – NEWS2 ESCALATION GUIDE

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NEWS IPOC

AFFIX LABEL HERE IF AVAILABLE

NHS Number: _____
District Number: _____
Surname: _____
Forename(s): _____
Address: _____
_____
D.o.B.: _____

Clinical Response to NEWS triggers

NEWS	Observations	Clinical Response
0	**Minimum 12 hourly***	Continue NEWS monitoring with every set of observations ***Minimum 4 hourly observations if:** admission to hospital / transfer from critical care in last 24 hrs, acute brain injury, NIV, CPAP, Airvo, O_2 therapy, chest drain, tracheostomy, epidural, PCA, opiates commenced, or dose or route change.
LOW **Total 1-4**	**4 hourly** Must score 0 for at least 12 hours before reducing frequency to 12 hourly	**HCA:** Refer to Registered Nurse using SBAR & document referral **RN:** Face-to-face assessment of the patient – then decide if increased frequency of observations and/or review by Dr / ACP is required. Acute rise in EWS, clinical concern or new sepsis should all be reviewed by Dr / ACP. If in doubt whether to escalate repeat observations within 1 hour & review. Communicate using SBAR & record actions & decisions. **Dr / ACP if attending:** ABCDE assessment & investigations, formulate & document management & monitoring plan. Consider modifying observations & escalation for NEWS score in this category (below)
		Modified observations & escalation instructions (eg target limits - please Date, Time & Sign) SpO_2 ☐ **Scale 2** (88-92%)
MEDIUM **Total 5-6 or 3 in one parameter**	**Hourly** or as documented monitoring plan by Dr / ACP	**HCA:** Refer to Registered Nurse & Nurse in charge using SBAR & document referral **RN:** Urgent face-to-face assessment of the patient. Contact ward doctor / ACP for urgent review within 30 minutes. Consider escalation to Critical Care Outreach if advice needed / patient is not improving. Recheck NEWS hourly until NEWS <5 & the patient is stable for at least 2 hours **Dr / ACP:** ABCDE assessment & investigations, formulate & document management & monitoring plan. Refer to Critical Care Outreach if advice needed / no improvement. If the patient does not improve within 60 minutes call for senior review. **Senior Medical Review:** Assess patient and implement appropriate management plan. Establish criteria for further review / senior review Review DNACPR status, treatment & escalation plan. Consider modifying observations & escalation for NEWS score in this category (below)
		Modified observations & escalation instructions (eg target limits - please Date, Time & Sign)
HIGH **Total 7 or more**	**Every 30 minutes** or as documented monitoring plan by Dr / ACP	**HCA:** Urgently refer to Registered Nurse & Nurse in charge of ward/department using SBAR & document referral. **RN:** Immediate face-to-face assessment of the patient. Escalate to senior doctor immediately. Inform Critical Care Outreach if advice needed / patient is not improving. **Dr /ACP & Senior Medical Review:** Immediate assessment and management. Senior Dr to assess response. Senior Dr to review DNACPR status, treatment & escalation plan. Refer Critical Care Consultant / Outreach / if advice needed / no improvement (SpR/ middle grade out of hours) or if admission to critical care is deemed necessary. Consider modifying observations & escalation for NEWS score in this category (below)
		Modified observations & escalation instructions (eg target limits - please Date, Time & Sign)
- If fever >38.3 and/or total NEWS =/>3 – refer to Sepsis Pathway (WPR44232) for screening & treatment **- Critical Care Outreach Team Bleep: 1980 (DRI), 3558 (Bassetlaw). ACP=Advanced Clinical Practitioner**		

News2 – Policy reference number PAT/T 33

APPENDIX 2 – DBTH RULES FOR DOCTORS

Hello and welcome to DBTH

Here are a few guidance notes and rules around rotas, leave and sickness, which you will find useful.

Rotas & Forms

You will be given access the live rotas on the SharePoint site, once you start in the hospital. Annual Leave/Study Leave/Swap forms/Additional session claim forms are available for you to access on the SharePoint system. Alternatively, you can obtain these from the Clinical Staffing Team office – **Level 9, East Ward Block, DRI**.

Annual Leave

The medicine rotas are not structured to incorporate holidays, therefore, you are able to request your leave when required.

Study Leave

First discuss this with your Educational Supervisor and obtain their approval. If in agreement complete the form and submit it to Clinical Staffing for documenting. Please note that you must not book any courses until your leave has been approved.

Rota rules in place, which you must adhere to, prior to requesting Annual/Study Leave:

- Leave will not be approved if rostered to work Nights, Weekends or Bank Holidays.
- You must complete an annual leave request form and obtain signature from your Consultant, prior to submitting your form to the Clinical Staffing Team. It is the responsibility of you and your specialty to ensure there is enough cover on the ward, to enable you to take your leave.
- If you are rostered to be on call when you are requesting to take leave, it is then your responsibility to swap your shift, prior to requesting your leave.
- If you are rostered to work a Bank Holiday, you will get the time back in lieu.
- **Please note that all leave must be requested at least six weeks in advance.**

Swaps

If you need to swap a shift, please arrange it as early as possible. You will be required to completed a swap form or send an email to document the swap, and send to the Clinical Staffing Team.

Sick Leave

If you are unable to work because of sickness you must:

Contact the Clinical Staffing Department and your ward, as soon as you know you are unable to work. If it is out of hours you must contact the Consultant on call. It is not acceptable to leave the message with one of the nurses or another doctor. Inform them of the shift(s) you should be working so they can arrange cover and give an estimate of how long you will be absent from work.

While absent from work because of sickness you are required to:

Contact us, as indicated above, 24 hours -if possible- but at least 4 hours before the start of your next expected shift to state whether you are or you are not able to return to work. If you remain unable to work you should give a further estimate of how long you will be absent for.
After the 2nd day of sickness – you'll need to provide a Self Certificate (SC1).
After the 7th day of sickness – you'll need to provide a Medical Certificate (Med3).

Upon return to work:

You will have a back to work interview with your allocated mentor / clinical supervisor and will need to complete the Return to Work interview form.

The trust does have a sickness policy and this can be triggered if:

1. A pattern of absence is identified e.g. Nights, weekends.
2. Had 3 episodes of sickness in any 6 month period
3. Had more than 8 days in any year

If the employee does trigger the trust sickness policy then they may be referred to Occupational health.

Regards

Clinical Staffing Team
Email: clinicalstaffing.team@dbh.nhs.uk
Tel: 01302 642341

APPENDIX 3 – EUROPEAN WORKING TIME DIRECTIVES FOR DOCTORS

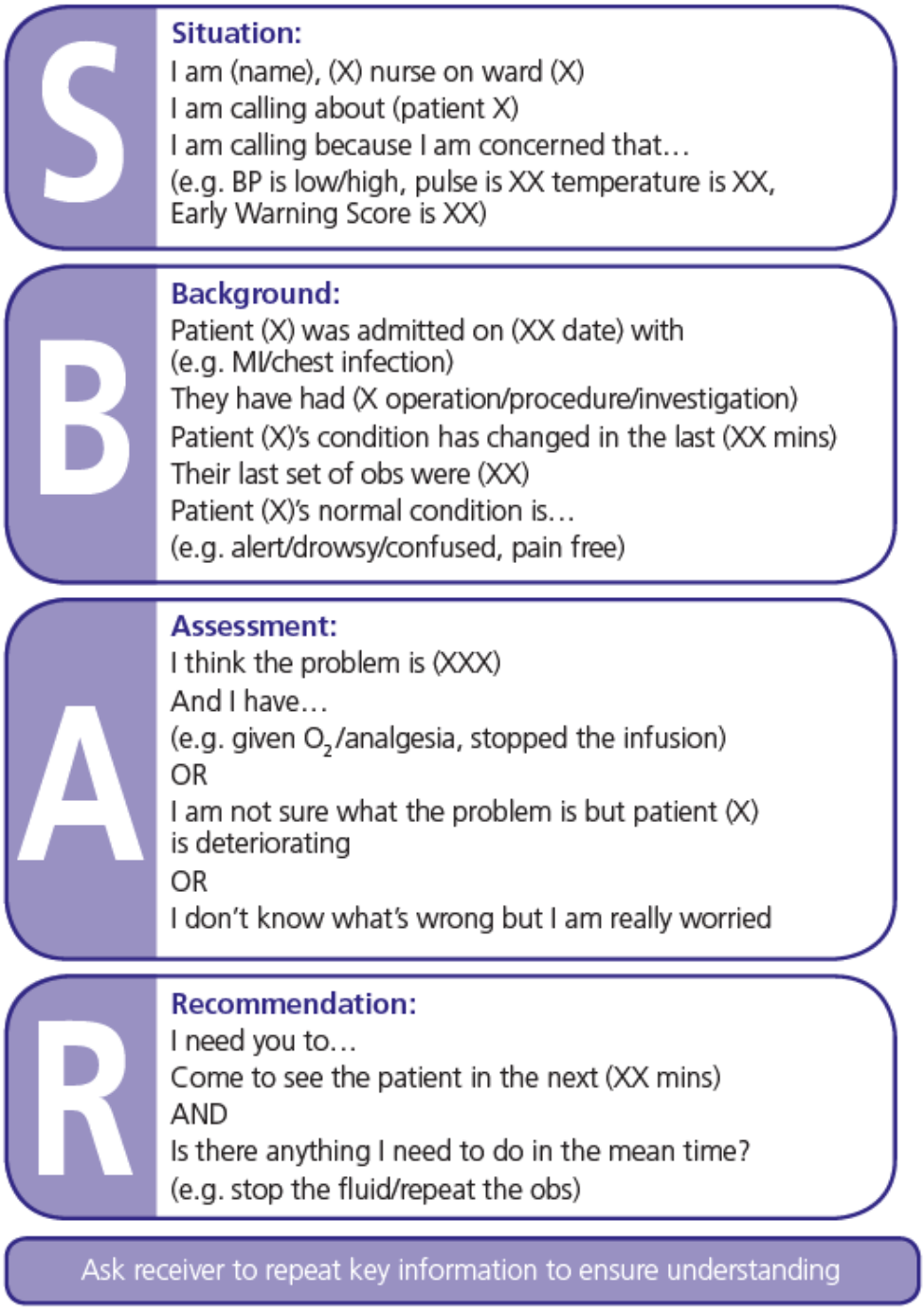
Junior doctors rest requirements under New Deal and Working Time Regulations

Working Hours	Full shift	Partial shift	24 hour partial shift	On-call	Source
Maximum working hours per week (26 week average)	48 hours				WTR
Maximum continuous working hours	13 hours (compensatory rest should be provided if exceeded)				WTR
Minimum rest between duties	11 hours (compensatory rest should be provided if exceeded)			12 hours (New Deal)	WTR

Time off	Full shift	Partial shift	24 hour partial shift	On-call	Source
Minimum continuous time off	One period of minimum 48 hours and one period of minimum 62 hours every 28 days	One period of minimum 48 hours and one period of minimum 62 hours every 28 days	One period of minimum 48 hours and one period of minimum 62 hours every 28 days	One period of minimum 48 hours and one period of minimum 62 hours every 21 days	New Deal
Minimum continuous time off	24 hours in a seven day period, or 48 hours in a 14 day period. Maximum continuous duty 13 days				WTR

Rest at Work	Full shift	Partial shift	24 hour partial shift	On-call	Source
Minimum rest in duty period	All doctors in training should receive natural breaks. A natural break is 30 minutes continuous rest after four hours work. This is in addition to other rest requirements laid out below.				New Deal
Minimum rest	At least 30 mins continuous rest after approx. four hours' duty	25% of out of hours duty	6 hours	50% of out of hours duty period (if only 8-12 hours rest at w/e then compensatory rest)	New Deal
Timing of continuous rest	At least 30 mins continuous rest after approximately four hours' duty	At any time. Frequent short periods of rest are not acceptable	4 hours' continuous rest between 10pm and 8am	At least five hours between 10pm and 8am	New Deal

APPENDIX 4 – SBAR



The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

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APPENDIX 5 – EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Policy	Nicholas Malliband	Joanne Sayles	New	24/04/2018

1) Who is responsible for this policy? Divisional Director for Medicine

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes?

3) Are there any associated objectives? Legislation, targets national expectation, standards:

4) What factors contribute or detract from achieving intended outcomes? –

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] -

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken]

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: July 2020

Checked by: Nicolas Mallaband Date: 6th August 2018