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PATIENT SAFETY MANUAL

for nurses in adult in-patient areas

Building healthier lives

Edition 3

Welcome to the third edition of the Patient Safety Manual for nurses working in adult areas.

The safety manual is a reference guide designed to help registered nurses deliver safe, reliable, evidence based care on all hospital sites.

The manual is presented in simple format and contains all essential information which has been extracted and aligns to Trust policies, procedures and guidelines. The content of the manual is based on top safety issues and incident themes identified within UHB, to ensure that lessons are learned throughout our organisation.

This manual was last updated 06/08/26

Contents

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SBAR

Good communication is vital for good patient care. Use **SBAR** to improve your verbal and text communication during:

- **Handover & referrals**
- **Safety briefings & huddles**
- **Escalation**
- **Any documentation**

S

Situation

Your name, ward and why you are calling.

B

Background

Patient diagnosis, history and treatment.

A

Assessment

Your assessment of the patient's condition in relation to your concerns.

R

Recommendation

What actions you want from the call and the time scale.

Resuscitation Council UK

GUIDELINES 2025

NHS University Hospitals Birmingham NHS Foundation Trust

Adult in-hospital resuscitation

Maintain personal safety

Collapsed/sick patient

Shout for HELP and assess patient

Signs of life?
- Check for responsiveness and normal breathing
- Experienced ALS providers should simultaneously check for a carotid pulse and (if attached) ECG, continuous arterial BP, $ETCO_2$

NO (or any doubt)

CARDIAC ARREST

Call, Compress, Collect*
CALL for help/resuscitation team
START CPR
COLLECT resuscitation equipment

High-quality CPR*
Give high-quality CPR with oxygen and airway adjuncts
Switch compressor at every rhythm assessment

Defibrillation*
Apply pads/turn on defibrillator/AED
Attempt defibrillation if indicated**

Advanced life support
When sufficient skilled personnel are present

Handover
to resuscitation team

YES

MEDICAL EMERGENCY

Call and collect*
CALL resuscitation/medical emergency team if needed
COLLECT resuscitation equipment

Assess*
ABCDE assessment – recognise and treat
Give high-flow oxygen (titrate to SpO_2 when able)
Attach monitoring
Vascular access
Consider call for resuscitation/ medical emergency team (if not already called)

Handover
to resuscitation/ medical emergency team

* Undertake actions concurrently if sufficient staff available
** Use a manual defibrillator if trained and device available

Resuscitation Council UK

GUIDELINES 2021

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Anaphylaxis

Anaphylaxis?

A = Airway **B** = Breathing **C** = Circulation **D** = Disability **E** = Exposure

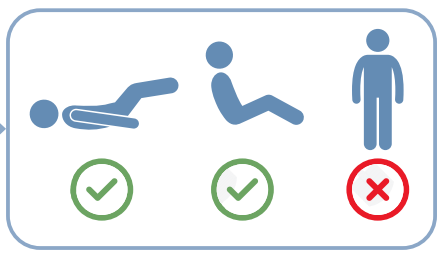
Diagnosis – look for:

- Sudden onset of Airway and/or Breathing and/or Circulation problems[1]
- And usually skin changes (e.g. itchy rash)

Call for HELP

Call resuscitation team or ambulance

- Remove trigger if possible (e.g. stop any infusion)
- Lie patient flat (with or without legs elevated)
  - A sitting position may make breathing easier
  - If pregnant, lie on left side



Give intramuscular (IM) adrenaline[2]

Inject at **anterolateral aspect** – middle third of the thigh

- Establish airway
- Give high flow oxygen
- Apply monitoring: pulse oximetry, ECG, blood pressure

If no response:

- Repeat IM adrenaline after 5 minutes
- IV fluid bolus[3]

If no improvement in Breathing or Circulation problems[1] despite TWO doses of IM adrenaline:

- Confirm resuscitation team or ambulance has been called
- Follow REFRACTORY ANAPHYLAXIS ALGORITHM

1. Life-threatening problems

Airway
Hoarse voice, stridor

Breathing
↑work of breathing, wheeze, fatigue, cyanosis, SpO_2 <94%

Circulation
Low blood pressure, signs of shock, confusion, reduced consciousness

2. Intramuscular (IM) adrenaline

Use adrenaline at 1 mg/mL (1:1000) concentration

Adult and child >12 years:	500 micrograms IM (0.5 mL)
Child 6–12 years:	300 micrograms IM (0.3 mL)
Child 6 months to 6 years:	150 micrograms IM (0.15 mL)
Child <6 months:	100–150 micrograms IM (0.1–0.15 mL)

The above doses are for IM injection **only**.
Intravenous adrenaline for anaphylaxis to be given **only by experienced specialists** in an appropriate setting.

3. IV fluid challenge

Use crystalloid

Adults:	500–1000 mL
Children:	10 mL/kg

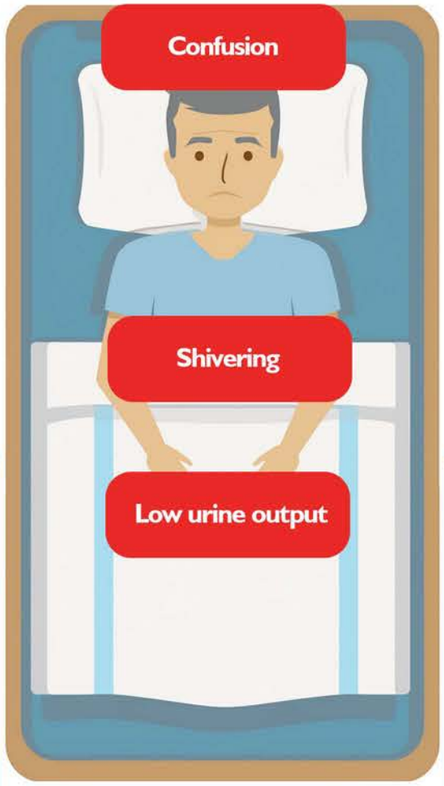
THINK SEPSIS AT UHB

If sepsis is suspected or confirmed, and if trained to do so, start the Sepsis 6 straight away

For any sick or deteriorating patient, think "could my patient have sepsis?"

Rapid comprehensive clinical assessment is required for all patients with suspected sepsis. **Signs and symptoms of sepsis in adults include:**

- High Early Warning Score
- Hypotension (Sys BP ≤ 100mmHg)
- High or low temp (>38°C or <36°C)
- Tachypnoea (RR ≥22/min)



- Drowsiness
- Sweating
- Skin mottling
- Cool peripheries

DON'T FORGET to look for underlying source of sepsis

- Pneumonia
- Abdominal infections (e.g. Cholangitis, Appendicitis)
- Urinary Tract Infection
- Skin or soft tissue infection
- Catheter-associated
- Meningitis
- and many others

Investigations

Send bloods including:
- U&Es, LFTs, CRP
- FBC, Clotting
- Lactate
- Blood cultures (before antibiotics - see below)

Urinalysis ± MSU

Consider appropriate imaging
- CXR
- USS abdomen

THE UK SEPSIS TRUST

NHS University Hospitals Birmingham NHS Foundation Trust

Are friends, family or carers expressing concerns of deterioration?
Please bleep the outreach number for your site.
Contacts: Christopher.Pollard@uhb.nhs.uk (sepsis lead HGS sites) sepsis@uhb.nhs.uk

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SEPSIS SCREENING TOOL

ACUTE ASSESSMENT AND SEPSIS 6

SEPSIS SCREENING TOOL ACUTE ASSESSMENT — AGE 16+

PATIENT DETAILS:

DATE: **TIME:**
NAME:
DESIGNATION:
SIGNATURE:

01 START THIS CHART IF SEPSIS IS SUSPECTED

Factors prompting a sepsis screen include (NB normal/ low temperature does not exclude sepsis):

- ☐ NEWS2 has triggered
- ☐ Carer or relative concern
- ☐ Recent chemotherapy / risk of neutropenia
- ☐ Patient looks unwell
- ☐ Evidence of organ dysfunction (e.g. lactate >2mmol/l)
- ☐ Assessment gives clinical cause for concern

Consider any advance directive or care planning carefully. People who are frail, have communication difficulties, who are socioeconomically deprived or from minority ethnic groups are at higher risk.

YES

CALL FY2+ TO COMPREHENSIVELY RISK ASSESS

Measure lactate and calculate NEWS2 using latest vital signs

Always interpret vital signs and NEWS2 in context of medical history, medications and response to treatment

02 IS NEWS2 7 OR ABOVE?

OR IS NEWS2 5 OR 6 AND ONE OF:

- ☐ Any one NEWS2 parameter with score of 3
- ☐ Mottled or ashen skin
- ☐ Non-blanching rash
- ☐ Cyanosis of skin, lips or tongue
- ☐ Deterioration since last assessment
- ☐ Deterioration since recent intervention
- ☐ Lactate > 2 mmol/L OR known AKI

NO

03 IS NEWS2 5 OR 6?

OR IS NEWS2 1-4 AND ONE OF:

- ☐ Any one NEWS2 parameter with score of 3
- ☐ Mottled or ashen skin
- ☐ Non-blanching rash
- ☐ Cyanosis of skin, lips or tongue
- ☐ Deterioration since last assessment
- ☐ Deterioration since recent intervention

YES

RED FLAG

START SEPSIS SIX

YES

AMBER FLAG

1. Send full set of bloods including VBG
2. Consider discussing with a senior decision-maker
3. Consider IV fluids
4. If antimicrobials needed, ALWAYS give within 3h

I have prescribed antimicrobials ☐

This patient does not require antimicrobials as:

- I don't think this patient has an infection ☐
- Patient already on appropriate antimicrobials ☐
- Escalation is not appropriate ☐
- Other_____

NAME: **GRADE:**
DATE: **TIME:** ■■:■■

NO AMBER CRITERIA = FY2+ TO CONSIDER ANTIBIOTICS/ OTHER DIAGNOSIS
ALWAYS REASSESS IF PATIENT DETERIORATES OR SITUATION CHANGES
DOCUMENT RISK ASSESSMENT IN MEDICAL NOTES

THE UK SEPSIS TRUST

SEPSIS SCREENING TOOL - THE SEPSIS SIX — AGE 16+

PATIENT DETAILS:

DATE: **TIME:**
NAME:
DESIGNATION:
SIGNATURE:

COMPLETE ALL ACTIONS WITHIN ONE HOUR

01 INFORM SENIOR CLINICIAN

TIME ☐☐:☐☐

NOT ALL PATIENTS WITH RED FLAGS WILL NEED THE 'SEPSIS 6' URGENTLY. A SENIOR DECISION MAKER (ST3+ or equivalent) MAY SEEK ALTERNATIVE DIAGNOSES/ DE-ESCALATE CARE.

02 GIVE OXYGEN IF REQUIRED

TIME ☐☐:☐☐

START IF O_2 SATURATIONS LESS THAN 92% - AIM FOR O_2 SATURATIONS OF 94-98%
IF AT RISK OF HYPERCARBIA AIM FOR SATURATIONS OF 88-92%

03 SEND BLOODS INCLUDING CULTURES

TIME ☐☐:☐☐

BLOOD CULTURES, VBG, BLOOD GLUCOSE, LACTATE, FBC, U&Es, LFTs, CRP AND CLOTTING. LUMBAR PUNCTURE IF INDICATED. CONSIDER RAPID PATHOGEN ID

04 GIVE IV ANTIBIOTICS, THINK SOURCE CONTROL

TIME ☐☐:☐☐

ACCORDING TO LOCAL GUIDELINES, CONSIDER ESCALATION IF ALREADY ON ANTIBIOTICS
CONSIDER ALLERGY STATUS AND POSSIBLE NEED FOR ANTIVIRALS/ ANTIFUNGALS
EVALUATE NEED FOR IMAGING/ SPECIALIST REVIEW TO HELP IDENTIFY SOURCE
IF SOURCE AMENABLE TO DRAINAGE ENSURE ACHIEVED AS SOON AS POSSIBLE BUT ALWAYS WITHIN 12H

05 GIVE IV FLUIDS, CONSIDER VASOPRESSORS

TIME ☐☐:☐☐

GIVE BOLUS OF 250mL HARTMANNS/ SALINE OVER 10-15 MINS. REPEAT IF NO IMPROVEMENT, GIVE UP TO 1000mL. IF NO IMPROVEMENT AFTER 1000 mL CALL SENIOR(ST3+) TO ATTEND.
SENIOR DECISION MAKER TO CONSIDER PERIPHERAL/ CENTRAL VASOPRESSORS, DISCUSS WITH ITU

06 MONITOR

TIME ☐☐:☐☐

USE NEWS2. MEASURE URINARY OUTPUT: THIS MAY REQUIRE A URINARY CATHETER
REPEAT LACTATE AT LEAST HOURLY IF INITIAL LACTATE ELEVATED OR IF CLINICAL CONDITION CHANGES

IF WORSENING/ NOT IMPROVING AFTER ONE HOUR – ESCALATE TO CONSULTANT
REASSESS NEWS2 AT LEAST EVERY 30 MINS

Link to the latest UHB sepsis guidance

Link to the UK Sepsis Trust

UHB Guide to commonly used insulin *

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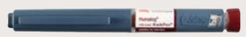
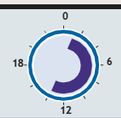
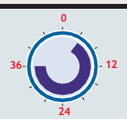
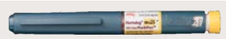
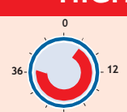
Type	Duration	Insulin		Available in	Administration	With IV insulin
Rapid		Apidra (Glulisine)		Vial, Cartridge, Disposable pen	• Immediately before, with or immediately after meals. • If not administered as prescribed may lead to increased risk of hypoglycemia. • Should be omitted if patient not eating. (If BG elevated then will require medical review). • Can be used for corrective doses. • Fiasp onset of action is within 4 minutes compared to 10-15 for other rapid acting preparations. • Trurapi must not be prescribed with any other rapid acting insulin.	• Stop VRIII 30 minutes after subcutaneous dose. • Ensure patient has background, long acting insulin (Intermediate, long and ultra long insulins).
		Humalog (Insulin Lispro)		Vial, Cartridge, Disposable pen		
		Novorapid (Insulin Aspart)		Vial, Cartridge, Disposable pen		
		Fiasp (Insulin Aspart)		Vial, Cartridge, Disposable pen		
		Trurapi (Novorapid) Biosimilar		Vial, Cartridge, Disposable pen		
Inter-mediate		Humulin I		Vial, Cartridge, Disposable pen	• 30 minutes before meals or bed. • Insulin must be resuspended by gently mixing before use. • **MUST NOT** be omitted if Nil by Mouth	• **Continue with IV insulin.** (Stop VRIII 1 hour after subcutaneous dose).
Long		Lantus (Glargine)		Vial, Cartridge, Disposable pen	• As prescribed. • **Must** be given within 1 hour of prescription time. • **Must NOT** be omitted if Nil By Mouth. • For new long acting prescriptions select biosimilar option. • Existing long acting insulin prescriptions are not interchangeable with biosimilars (Lantus is not interchangeable with other biosimilar Glargine insulins). • **Do NOT** replace existing prescriptions with biosimilars without diabetes team input.	• **Continue with IV insulin.** (Stop VRIII 1 hour after subcutaneous dose).
		Levemir (Detemir)		Cartridge, Disposable pen		
		Semglee (Glargine) Biosimilar		Disposable pen		
Ultra Long (once daily insulin)	 Profile over 48 hrs	Tresiba 100 (Insulin degludec)		Cartridge, Disposable pen	• As prescribed. • **Must** be given within 1 hour of prescription time. • **Must NOT** be omitted if Nil By Mouth. • Only titrate every 3-4 days. • Must be at least an 8 hour gap between doses.	• **Continue with IV insulin.** (Stop VRIII 1 hour after subcutaneous dose).
Mixed		Humalog Mix 25		Vial, Cartridge, Disposable pen	• Immediately before, with or immediately after food. • Must be paused when VRIII in progress. • Insulin must be resuspended by gently mixing before use.	• Stop VRIII 30 minutes after subcutaneous dose.
		Novomix 30		Cartridge, Disposable pen		
		Humalog Mix 50		Cartridge, Disposable pen		
Mixed (Human)		Humulin M3		Vial, Cartridge, Disposable pen	• 30 minutes before food or evening meal. • Insulin must be resuspended by gently mixing before use.	• Stop VRIII 30 minutes after subcutaneous dose.

CAUTION High Strength

HIGH STRENGTH INSULIN – RISK OF OVERDOSE IF DEVICE USED INCORRECTLY

 Profile over 48 hrs	Tresiba 200 (Insulin Degludec)	 NON-FORMULARY	Disposable pen	• As prescribed. • **Must** be given within 1 hour of prescription time. • **Must NOT** be omitted if Nil By Mouth. • If own supply not available, can be replaced (dose for dose) with Tresiba 100. • Please ensure the units per ml are correct when prescribing.	• **Continue with IV insulin.** (Stop VRIII 1 hour after subcutaneous dose).
	Humalog 200 (Insulin Lispro)	 NON-FORMULARY	Disposable pen	• Immediately before, with or immediately after meals. • Should be omitted if patient not eating. (If BG elevated then will require medical review). • If own supply not available, can be replaced (dose for dose) with Humalog 100 units/ml.	• Stop VRIII 30 minutes after subcutaneous dose. • Ensure patient has background insulin.
	Toujeo 300 (Glargine)		Disposable pen SoloStar and DoubleStar	• As prescribed. • **Must** be given within 1 hour of prescription time. • **Must NOT** be omitted if Nil By Mouth. • Toujeo is available in 2 disposable pens • SoloStar pen - contains 1.5 ml of solution for injection, equivalent to 450 units. • DoubleStar pen - contains 3 ml of solution for injection, equivalent to 900 units.	• **Continue with IV insulin.** (Stop VRIII 1 hour after subcutaneous dose).
Variable action please seek advice from Diabetes team	Humulin R U500 (Insulin Lispro)		Disposable pen	**DIABETES CONSULTANT ONLY PRESCRIPTION.** • Please contact diabetes CNS team for advice. • Humulin R U500 must be discarded when the patient using it is discharged.	• As advised by the diabetes team.

DOSE MUST NEVER BE DRAWN OUT OF PEN WITH SYRINGE

REGULAR INSULIN MUST BE RESTARTED BEFORE STOPPING VRII

Safety Standards

- Each patient **must** have their own labelled insulin.
- Insulin safety needles **must be** used for all insulin administration by staff and patients whilst in hospital.
- Staff **must not** remove non-insulin safety needles, as high risk of needle stick injury. Patients to remove own needle and deposit in sharps bin.
- All 'in use' insulin **must be** labelled with patient's name, hospital registration number and date insulin was opened.
- All 'in use' insulin **must be** stored at room temperature and discarded 28 days after opening, apart from Levemir and Toujeou to be discarded 6 weeks after opening and Tresiba to be discarded after 8 weeks after opening.
- **Only** insulin syringes should be used to draw up and administer insulin from a 10ml vial.
- Insulin **must not be** drawn up from a 3ml cartridge or disposable pen using a syringe.

Self-administration

- Patients who administer their insulin at home and have been assessed as safe, competent and accurate in insulin administration should be able to self administer in hospital if able (assessment **must** be documented as per self assessment guidelines).
- When assessing patients ability to self-administer insulin safely, the whole process must be assessed: adding a needle, reconstitution, test dose, injection technique and disposal of sharps.
- All self administered insulin doses must be accurately documented in the medical record by Registered Health Care Professional: including the dose and time administered.
- Patients initiated onto insulin **must** be provided with an Insulin Passport / insulin safety card.

Insulin management

- Ward medical team to review diabetes control daily. If out of target (4-12mmol) follow diabetes plan or consider referral.
- In some patients targets may differ due to individual needs such as frailty, renal function, palliative care.
- **Consistently** elevated blood glucose (BG) or recurrent hypoglycaemia **must** trigger a diabetes referral.
- Check and document ketones if BG above 15mmols in type 1 diabetes or 20mmols in type 2 diabetes and inform medical staff immediately if positive.
- PRN doses should be used with caution. Rapid acting insulin **must** be used as first line for PRN/ correction doses.
- If requiring frequent PRN/correction dose review regular prescription of insulin.
- PRN doses of rapid acting insulin must be administered at meal times (4-6 hourly) unless ketotic (1.5mmol/mol or ++) when it may be advised 2 hourly by the diabetes team.
- Insulin doses/regime will require review for surgery or planned procedure please refer to the In-patient management of adults with diabetes undergoing surgery.
- When adjusting insulin, doses are usually adjusted by 10-20% every 2 to 3 days. The insulin dose preceding the first out of target result should be adjusted first.
- If parenteral feed or steroid therapy commenced or altered please monitor glucose closely and refer to the relevant policy available on the Trust Diabetes intranet page.
- Deterioration in renal function may change insulin profile, leading to reduced insulin requirements.

Insulin preparations/devices

3ml Pre-filled insulin pen	Default device in hospital, for patients new to insulin or unable to self administer. **SHOULD** be used by staff for insulin administration.
10ml Vial	For use with CSII (Continuous subcutaneous insulin infusion/insulin pump). Can be used to administer insulin with an insulin safety syringe.
3ml Cartridge	For use in reusable pens as requested by patient or diabetes team.
Actrapid 10ml Vial	For use in IV insulin infusions. Avoid stat and corrective doses unless advised by Diabetes Team.

Please review before discharge to ensure accurate TTO's prescription, as device may have changed during admission.

With thanks to the diabetes teams across sites for input.

Version 7: Sep 2022DiabetesTeamAuthors:A.Murphy(DiabetesRenalCNS)andL.Peters(DiabetesCNS).

*Please note insulins listed are those commonly used and is not an exclusive list of currently available insulins.

BNF, EMC and JBDS Safe use of insulin.

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Treatment of Hypoglycaemia for adults with diabetes: Defined as Blood Glucose (BG) less than 4.0mmol/L with or without symptoms

Hypoglycaemia is a serious condition and should be treated as an emergency regardless of level of consciousness

For further details: Treatment of Hypoglycaemia for adults with diabetes

Mild

Patient conscious, orientated and able to swallow

Get Hypo Bag

Get Hypo Bag
Stop IV insulin (if running)
Give ONE quick acting carbohydrate option:
5-6 Dextrose tablets
60ml oral/NG/PEG glucose shot e.g. Lift®

Recheck BG after **15 minutes**

If BG still less than 4.0mmol/L repeat quick acting carbohydrate as above, recheck in 15 minutes
(Maximum of 3 cycles of treatment can be given before requiring IV glucose 10% - See 'Severe' pathway)

If BG ≤ 2.5mmol/L after 2 cycles: TREAT AS SEVERE

Moderate

Patient conscious, confused/disorientated or aggressive but able to swallow

Get Hypo Bag
Stop IV insulin (if running)
Give ONE quick acting carbohydrate option:
2 tubes of fasting acting dextrose gel 40%w/v
60ml oral/NG/PEG glucose shot e.g. Lift®
Glucagon 1mg IM injection

Recheck BG after **15 minutes**

If BG still less than 4.0mmol/L repeat quick acting carbohydrate as above, recheck in 15 minutes
(Maximum of 3 cycles of treatment can be given before requiring IV glucose 10% - See 'Severe' pathway)

If BG ≤ 2.5mmol/L after 2 cycles: TREAT AS SEVERE

Severe (MEDICAL EMERGENCY)

Patient unconscious/ fitting, aggressive, nil by mouth (NBM)/unable to swallow or not responding to treatment

Get Hypo Bag
Check ABCDE, FAST BLEEP MEDIC.
Stop IV insulin (if running)

- Give 200ml 10% IV glucose over 15 minutes (using a large vein and flush adequately).
- Consider 100ml 20% glucose in cardiac/renal failure
- **Stay with patient** to ensure the correct dose of IV glucose is administered and monitor patient's condition until hypoglycaemia is resolved and BG is above 4.0mmol/L

GLUCAGON 1mg IM injection* (should only be used for the treatment of insulin induced severe hypoglycaemia if venous access cannot be established)

Recheck BG after 15 minutes. If BG less than 4.0mmol/L repeat above step (IV glucose not GLUCAGON)

If patient is on IV insulin, stop immediately. **Must** be reviewed or restarted once BG is above 4.0mmol/L, within 1 hour

When BG **above 4.0mmol/L**

If eating and drinking: give 20g long-acting starchy carbohydrate e.g. 1-2 slices bread or Fortisip® compact or 2 biscuits.
For patients on enteral feeds: restart feed or give ½ Fortisip® / Fortisip® compact via tube

If NBM or if 2 or more hypos in 24 hours – give 10% IV glucose infusion at 100ml/hour until specialist review

After IM GLUCAGON 1mg, 20g rapid acting carbohydrate and 40g of starchy carbohydrate (double the amounts above) will be required to prevent further hypoglycaemia

Please document all hypoglycaemia treatments, dose adjustments and referrals in the patient's notes

- **Do not omit subsequent doses of insulin, consider dose reduction.**
- **Continue BG monitoring before meals and before bed for 48 hours. Review insulin and/or oral hypoglycaemic doses. If on IV insulin when BG above 4mmol/L restart but review regime**

***Glucagon may take up to 15 minutes to work and may be ineffective in treating hypoglycaemia in undernourished patients, in severe liver disease, sulphonylurea induced hypoglycaemia and in recurrent hypoglycaemia**

All patients with severe/repeated episodes of hypoglycaemia on diabetes medication should be referred to the Diabetes Team. For patients without diabetes refer to Endocrine Team

Never omit long-acting insulin in patients with Type 1 diabetes

Neurological Observations For Adult Patients

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Indications

- Suspected/confirmed neurological condition including stroke
- Head injury prior to or during hospital stay
- Unexplained loss of consciousness
- Assessment in acutely unwell patient
- Post falls (see opposite)
- Neurosurgery please refer to:
  SOP for Post-Operative Neurological Observations Following Neurosurgery

Post falls

- Any un-witnessed fall
- Head injury is suspected/reported/witnessed, or cannot be excluded
- New onset of neurological symptoms
- Head pain/tenderness
- Currently on anti-coagulant medication
- For further information refer to:
  Procedure for the Prevention and Management of Inpatient Falls.

Frequency

DO NOT OMIT IF THE PATIENT IS ASLEEP

Post falls		Neurological conditions		Post thrombolysis/thrombectomy	
How often?	How long?	How often?	How long?	How often?	How long?
½ hourly	2 hours	½ hourly	2 hours	¼ hourly	2 hours
1 hourly	4 hours	1 hourly	4 hours	½ hourly	6 hours
2 hourly	6 hours	2 hourly	6 hours	1 hourly	16 hours
Neurological observations post fall should be carried out for a minimum of 12 hours.		4 hourly	12 hours	4 hourly	72 hours

* Neurosurgery please refer to Standard Operating Procedure for Post-Operative Neurological Observations Following Neurosurgery
* **All conditions: if any deterioration in the patient's condition then revert to ½ hourly observations and for urgent review by medical team within 10 minutes if in the Emergency Department and 30 minutes on all wards and other departments**
* Neurological conditions and post falls: if no change in condition at 12 hours, need for/frequency of neurological observations should be reviewed and decisions documented in the patient's medical notes
* **Communicate Neurological Observations For Your Patient:** on handover including frequency, change of condition or change of neurological observations

Remember 'Fresh Eyes' observations on change of GCS and at least once during a 12 hours period
For further information refer to Guideline for Performing Neurological Observations For Adult Patients
Neurological Observations training - access Moodle Package here.

Quick reference – administering blood

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Before ringing the porter, THINK:

- Has the reason for blood transfusion been documented in the PICS noting/blood transfusion care pathway (BTCP)?
- Have specific blood components been prescribed at the correct rate?
- Have special requirements (e.g. irradiated/CMV negative) been prescribed if required?
- Does the patient have patent IV access?
- Have baseline observations been recorded (within 60 minutes of commencing the transfusion)?
- Is there documentation that the patient has received verbal and written information, and verbally consented?
- Has the patient's ID been checked (ensure correct spelling) and the collection form been completed by the patient's side?

Arrival of blood components - before accepting, check:

- The collection form against the traceability tag (attached to the component).
- The blood component against the traceability tag (check product type, unit/batch number, blood group, any special requirements and expiry date).
- For leaks, haemolysis and discolouration.
- The time the unit was removed from the fridge is documented - sign the collection form.

Commencing the transfusion:

- 2 registered & competency assessed practitioners to independently check/administer.
- Check patient ID with the patient, prescription chart, traceability tag and wristband.
- Check blood component against the traceability tag, ensure all details match exactly.
- Prime blood giving set with the component.
- Start the transfusion; at Heartlands, Good Hope and Solihull sign & date traceability tag and tear the yellow section of the traceability tag off.
- Document the start time and unit or batch number on the prescription via PICS where available, or on the blood transfusion care pathway (BTCP).
- Volumetric pumps to be used where possible and rate checked by both practitioners.
- **BHH/SOL** - place the traceability label in the box on the ward/department for blood bank staff to collect.
- **GHH** - send traceability tag back to blood bank as soon as the transfusion has commenced.

During the transfusion:

- Check & record observations 10-20 minutes after commencing.
- Observe the patient throughout for reactions.
- Inform the patient to notify nursing staff if experiencing any symptoms during the transfusion
- **In the event of a possible reaction PAUSE the transfusion and contact the medical team using SBAR**.
- **Contact the transfusion laboratory** as soon as possible if:
  - > the transfusion is abandoned due to a potential/confirmed reaction,
  - > the patient deteriorates following a transfusion with symptoms which cannot be explained by the underlying condition
- and follow the clinical guideline for the Management of Transfusion Reaction.
- For moderate and severe reactions complete a DATIX and a transfusion reaction form (TRF), notify the doctor and take relevant samples. Return blood back to blood bank with the TRF (if the transfusion is discontinued).
- Document all events in PICS/in the notes.

After the transfusion:

- Document 'finish time' on the prescription in PICS where available, or the BTCP.
- Check and record observations at the end of the transfusion.

For further guidance on transfusion reactions see **here**

Any discrepancies identified do not transfuse - return the blood to the blood bank and resolve.

V5

Fluid Balance Chart Indications

- NEWS^2 score ≥5 or Obstetric MEOWS ≥3 or clinical judgement
- Unconscious patient
- New choking / swallowing risk (check SLT recommendations) or impaired swallow
- Sepsis / suspected sepsis
- Bowel obstruction / liver or cardiac failure / acute pancreatitis / sickle cell anaemia / SIADH
- Pre-eclampsia /eclampsia
- Anti-partum and post-partum haemorrhage
- Any fluids given parenterally (IV or SC) or enteral feeds
- Nil by mouth
- Diarrhoea / vomiting
- Post-operative patients
- Excessive fluid from drains / wounds / wounds / stoma < 1500ml in 24hr / NPWT
- First 24 hours on CCU
- Post transfer from level 2 care in the last 48 hours
- New electrolyte imbalance or increasing urea / creatinine
- Known or suspected AKI
- IV furosemide challenge
- Urinary catheter (except long term catheters in the absence of acute illness)
- Urine output < 0.5mls/kg/hr over 2-4 hours or < 100mls in 24 hours or > 200mls/hr
- Medications increasing risk of AKI (e.g. chemotherapy / contrast (24 hours before and after procedure) / some antibiotics e.g. aminoglycosides / ACE inhibitors and diuretics
- Loss of independence (e.g. poor vision, delirium / dementia / weak limbs / stoke / poor memory)

Minimum urine output guide 0.5ml/Kg/hr			
Kg	**hourly**	**12 hrly**	**24 hrly**
40	20	240	480
50	25	300	600
60	30	360	720
70	35	420	840
80	40	480	960
90	45	540	1080
100	50	600	1200
110	55	660	1320
120	60	720	1440

Escalation Pathway

Routine Monitoring

Registered Nurse / Midwife

Document on PICS:
- Complete hydration risk assessment daily.
- Fluid input / output at least 3 hourly.
- Report concerns and document escalation in clinical noting.

Review:
- Review fluid input and output at the start, middle and end of shift for accuracy, unless clinically indicated otherwise.
- Review hydration risk assessment daily to determine level of risk.
- Monitor in line with the patient's condition

Communicate:
- Handover concerns verbally and in written handover to next shift or when transferring the patient to another clinical area.

Doctor

Document:
- Clinical rationale for fluid balance management plan i.e. restrictions, frequency of monitoring, daily weights.
- Escalation plan.

Review:
- Indication for monitoring daily on ward round.

Communicate:
- Fluid balance management plan to named nurse.

Clinical deterioration

For example:
- **Sepsis**
- **Dehydration**
- **Clinical concern**
- **NEWS2 ≥ 5**
- **Obstetric MEOWS ≥3**

Registered Nurse / Midwife

Document :
- Input / output hourly.
- ABCDE assessment.

Refer: to resident doctor if urine output < 0.5mls/kg/hr for 2 consecutive hours (check urinary catheter is not dislocated/ kinked) or if any cause for concern. Document.

Inform: Critical care Outreach Team.

Follow: NEWS2 / Obstetric MEOWS pathway if triggered

Doctor

Review:
Escalation to Specialist Registrar or Consultant within 1 hour if not responding to treatment and NEWS2 ≥ 5, or MEOWS ≥ 3 for Obstetrics, as per escalation pathway.

Document.

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Hydration Risk Assessment

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Does the patient have 1 or more of the high risk indicators
(see 'Fluid Balance Chart and Escalation Pathway')

No

Can the patient drink independently?

Nutritional Risk Assessment Score Low Risk 0-3 or Malnutrition Universal Screening Tool (MUST) score 0

Been an inpatient for >24 hours

Yes

LOW RISK

Actions

Continue to encourage regular fluid intake

Re-assess nutrition & hydration assessments on change of condition or otherwise daily

No

- Nutritional Risk Assessment Score ≥ 4
- Malnutrition Universal Screening Tool (MUST) score ≥1
- Patient declining fluids or vulnerable patients who are reluctant to drink
- Patients who are confused, agitated or have an altered state of alertness/ cognition
- Patients requiring assistance to drink or thickened fluids*
- Fluid balance chart discontinued in last 24 hours
- Unplanned/emergency admission to Acute Medical Unit (AMU) / Surgical Assessment Unit (SAU) in last 24 hours

YES

MEDIUM RISK

Actions

Commence Nutrition and Hydration Chart
Consider if red tray / jug required
Inform medical team and document
Provide reassurance/support
Prompt regular toileting
Review continence assessment
Regular mouth care
Provide assistance where required

Review nutrition & hydration assessments on change of condition or otherwise daily

***If the patient requires thickened fluids an assessment must be completed by a registered practitioner**

Note:

All patients in assessment areas must have either a hydration chart or a fluid balance chart for the first 24 hours.

Yes

HIGH RISK

Actions

Start fluid balance chart or record fluid balance on PICS

Document fluid input/output 3 hourly for routine fluid balance maintenance

or

hourly where clinical deterioration suspected or confirmed

Inform medical team that patient is high risk and document

Regular mouth care

Remember: If your patient is nutritionally at risk food intake must be documented

Reassess need for fluid balance chart daily

For more information see:
Guideline for Fluid Balance Monitoring in Adult Patients

Suggested Indications—Adapted from Salisbury NHS Foundation Trust

Nil by Mouth (NBM) procedure

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Patient is NBM - decision and rationale must be clearly documented in PICS/ medical records and a yellow Trust sign placed behind the bed

NBM for surgery/procedures

Please refer to the following guidelines for surgical fasting:

Pre Op Fasting Chewing Gum Guideline

SOP for Fasting in the Peri-operative Period

All time critical and regular medication must still be administered; an alternative route for feeding/hydration and administration of medication may be needed.

It may be necessary to seek an alternative product. Advice should be sought from your ward pharmacist or from Medicines Information (0121 424 5508) as doses and frequencies may be different.

Please refer to the guideline above. Any delay or omission must be escalated immediately.

If a patient is nil by mouth for 24 hours, with no alternative means of hydration, nutrition or medicines management, concerns **must** be escalated to the patient's consultant. Any discussions and actions must be clearly documented.

If these needs still remain unmet, the Deputy Divisional Director of Nursing, Divisional Director of Nursing, and Divisional Director **must** be informed

NBM due to medical issues e.g. dysphagia

Consider alternative route for feeding/ hydration and administration of medications. Refer to appropriate specialist teams as required.

Alternative routes for hydration/ nutrition/administration of medicines include:

- Fine bore nasogastric feeding tube
- Naso jejunal feeding tube
- Intravenous fluids
- Parenteral nutrition (PN)

Clearly document all decisions in PICS/medical records including fluid balance, hydration, nutrition and drug administration.

Enteral Feeding Guidelines

Ensure a high standard of oral care is provided.

Mouth Care Guideline

Please note: this flow chart is a condensed version of the Standard Operating Procedure for Managing Patients Nil by Mouth.
For further information access:
Standard Operating Procedure for Managing Patients Nil By Mouth

The International Dysphagia Diet Standardisation Initiative (IDDSI)

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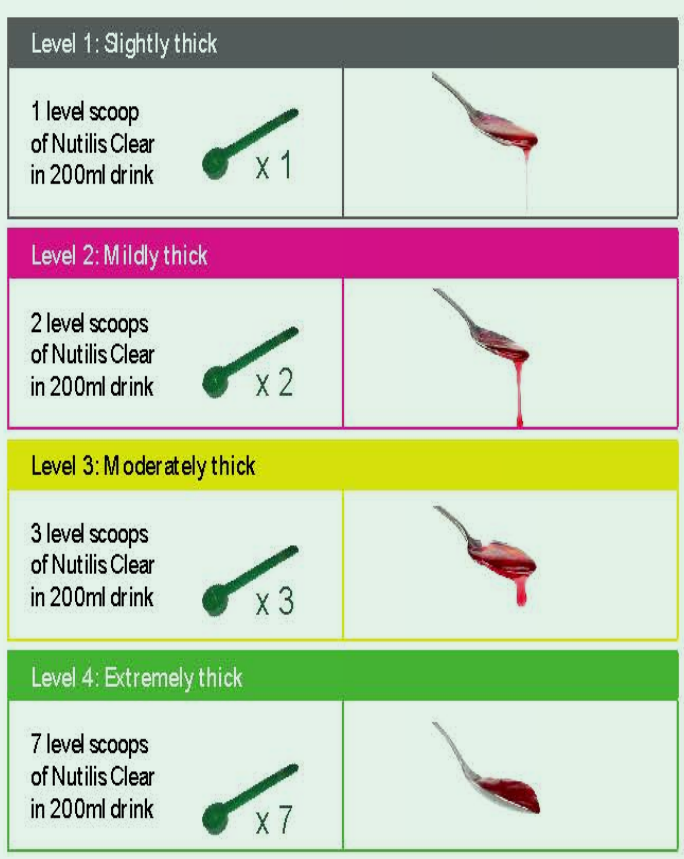
'Dysphagia' is the medical term for swallowing difficulties and a sign or symptom of disease which can affect people of all ages.

Signs of swallowing problems include coughing, choking, recurrent chest infections drooling and inability to hold food in the mouth, regurgitation, food sticking in the throat, weight loss, difficulty chewing/pocketing food.

IDDSI is a standard terminology with a colour and numerical index describing texture modification for food and drink.

Thickening fluids



- **Ensure prompt referral to speech and language therapy (SLT):**
  - Via PICS where available
  - Where PICS is unavailable, via telephone at Heartlands Hospital: ext 40432, Good Hope Hospital: ext 47056, Solihull Hospital: ext: 44126
- SLT recommendations **must** be communicated to all staff in handovers, safety briefings and before meal services
- Only SLT recommendations **must** be written on the pink sign using IDDSI terminology. This **must** be placed in a visible position above the patient's bed.
- Pink signs **must** accompany the patient if they are transferred within the hospital.
- Staff **must** be familiar with the correct IDDSI terms for each level and use these when communicating SLT recommendations to colleagues.

For further information access:

Standard Operating Procedure - Dysphagia

Standard Operating Procedure for Managing Patients Nil By Mouth

Key guidance for management of fine bore nasogastric feeding tubes in adults

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- ⇒ **pH is the first line check** and gastric aspirate must be pH 4.5 or below.
- ⇒ every tube must have a completed NG line flag attached with insertion date and time.
- ⇒ every tube must be secured using a Grip-Lok where possible.
- ⇒ enteral syringes should be used to flush the tube with water and to administer medication.

On NG tube insertion confirm tube position with pH testing. If no aspirate or aspirate pH is above 4.5 request X-Ray.

- ⇒ Request x-ray specifically "To confirm NG feeding tube placement".
- ⇒ Interpretation must be by a credentialed Health Care Professional / radiology report.
- ⇒ The NG feeding tube position must be fully documented in the patient's medical record before it can be used.

Existing NG feeding tubes: confirm tube position with pH testing. If no aspirate or pH is above 4.5 use the Risk Assessment in the daily care plan.

- ⇒ For criteria to confirm the position of an existing nasogastric tube, see flow chart 3.
- ⇒ Results of risk assessments must be documented in the daily care plan.
- ⇒ Remember: it is **NEVER** safe to risk assess a newly inserted nasogastric tube for use.

Training requirements

- ⇒ Completion of online theory: **Moodle training**
- ⇒ Practical competence at ward level
- ⇒ Training entered on EasyLearning validation.

If an NG tube is identified as being incorrectly positioned, it must be removed immediately

For full procedure for the insertion and management of fine bore nasogastric feeding tubes in adult patients see:

Insertion & Management of Fine Bore Nasogastric Feeding Tubes & Fine bore Nasogastric Feeding Tube LocSIPP

1: Inserting a Fine Bore NG Feeding Tube in Adults

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Multi-disciplinary team decision to insert an NG feeding tube - taking into account risks, benefits and intended outcome fully documented in medical records

Gain **informed consent** and document mental capacity assessment and best interest decision in medical records.
(Remember the patient information leaflet 'Having a nasogastric tube')

Contraindications:
- Base of skull fractures or unstable cervical spine injuries.
- Intestinal obstruction.
- Tracheoesophageal fistula/ pharyngeal pouch

NG fine bore feeding tubes should only be inserted during the hours of 0800-1800 unless there is an urgent clinical need.

Gather equipment
- Apron and non-sterile gloves
- Nasogastric fine bore feeding tube
  (Ryles/drainage tubes must **not** be used for feeding)
- 50-60ml enteral syringe
- Grip-lok device to secure the tube
- pH indicator strips
- Water for flush –freshly drawn drinking tap water
- Glass of water and straw – (if patient is allowed to drink)
- Nasogastric line flag to label the NG tube

Cautions:
- Nasal/facial trauma or disease.
- Nasal/pharyngeal/oesophageal obstruction/ ulceration/ varices.
- During the use of continuous positive airway pressure (CPAP) or non-invasive ventilation (NIV).
- Maxillofacial surgery/trauma/disease.

- **Explain the procedure to the patient**
- Ensure the patient is comfortable and supported in an upright position on a bed or chair supporting their head. The patient's head should not tilt backwards.
- Agree upon a signal to allow the patient to stop the procedure if required.

This flowchart must be used in conjunction with
- Flowchart 2: Confirming Position of a Newly Inserted Fine Bore NG Feeding Tube
- Flowchart 3: Ongoing Care of an NG Feeding tube
- UHB Procedure for the Insertion and Management of Fine Bore Nasogastric Feeding Tubes in Adult Patients

Measure NEX
(See UHB Procedure for the Insertion and Management of Fine Bore Nasogastric Feeding Tubes in Adult Patients (Appendix 3) for further instructions)

Nasogastric placement
1. Insert the tip of the tube into the nostril and slide it backwards and inwards along the floor of the nose to the nasopharynx. If any obstruction is felt withdraw and try a different angle or alternative nostril.
2. If the patient is allowed to drink offer sips of water via a straw as the tube passes into the nasopharynx.
3. Advance the tube until the pre measured length (cm marking) has been met (NEX).

Failed attempts
After 2 failed attempts, reassure patient and seek senior / nutrition nurse support. All attempts must be documented.

If the patient becomes distressed, cyanotic or has an unresolved coughing episode remove the tube immediately.

Confirm NG tube position
Check the position of the tube to confirm position in the stomach by aspirating the nasogastric tube and checking pH as per Flowchart 2.
Feeding via the tube MUST NOT BEGIN until the correct position of the tube has been confirmed and documented.

As per Flowchart 2: Confirming Position of a Newly Inserted Fine Bore NG Feeding Tube aspirate **pH 4.5 or below confirms gastric placement.**

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2: Confirming Position of a Newly Inserted Fine Bore NG Feeding Tube in Adults

Aspirate tube with a 50/60ml enteral syringe

Aspirate is obtained

Aspirate pH is 4.5 or below

Start feed

Aspirate pH is 5.0 or above

Consider the following:
- If patient is on PPI and if so try again in 30 min.
- If patient is receiving continuous feeding and if so stop for 1 hour and try again.
- If patient has a safe swallow, ask them to take an acidic drink and retry in 30 min.

Aspirate pH is 4.5 or below

Start feed

Aspirate pH is 5.0 or above

X-ray required to confirm position

Aspirate is not obtained

Try the following and attempt to aspirate after each step:
- Turn patient onto left side
- Inject 10ml of air into the tube using 50/60ml syringe
- Provide mouth care.
- Ask the patient to take an acidic drink if they have a safe swallow

If the above steps do not work, leave for 1 hour and reattempt to obtain aspirate.

Aspirate is obtained

Check pH and proceed according to result

Aspirate is not obtained

X-ray required to confirm position

If at any point the tube is identified to be incorrectly positioned it must be removed immediately.

Competent doctors and agreed additional healthcare practitioners (who have evidence of competence against approved expanded practice protocols) can review x-rays to confirm correct placement of the NG tube but only if the following 4 criteria exist:

1. The chest x-ray view must be adequate – tube path following upper oesophagus down to below the diaphragm, avoiding the contours of the bronchi.
2. The NG tube must remain in the midline down to the level of the diaphragm.
3. The NG tube must bisect the carina.
4. The tip of the NG tube must be clearly visible below the left hemi-diaphragm. (The tip of the NG tube should be 10 cm beyond the gastroesophageal junction to be confident that it is within the stomach).

If the patient falls out of the above criteria then a radiology review must take place before feeding commences.

Locum doctors must not review x-rays and confirm NG placement unless they have completed the Trust training and have evidence of competence/ credentialing.

Following review of the chest x-ray, the competent doctor/healthcare practitioner must document in the patient's notes that that the NG tube meets the 4 criteria detailed above, clearly listing each of the criteria, and additionally stating that the tube is safe to use for feeding. This must be completed before the tube is used.

3: Confirming Position of an Existing Fine Bore NG Feeding Tube in Adults

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Aspirate tube with a 50/60ml enteral syringe

Aspirate is obtained

Aspirate pH is 4.5 or below

Start feed

Aspirate pH is 5.0 or above

Consider the following:
- If patient is on PPI and if so try again in 30 mins.
- If patient is receiving continuous feeding and if so stop for 1 hour and try again.
- If patient has a safe swallow, ask them to take an acidic drink and retry in 30 mins.

Aspirate pH is 4.5 or below

Start feed

Aspirate pH is 5.0 or above

Complete risk assessment

Aspirate is not obtained

Try the following and attempt to aspirate after each step:
- Turn patient onto left side
- Inject 10ml of air into the tube using 50/60ml syringe
- Provide mouth care.
- Ask the patient to take an acidic drink if they have a safe swallow

If the above steps do not work, leave for 1 hour and reattempt to obtain aspirate.

Aspirate is obtained

Check pH and proceed according to result

Aspirate is not obtained

Complete risk assessment

Standards for a risk assessment to confirm tube position has not changed and feed can continue

1. Tube length is the same as documented after the last X-ray or pH test confirming position.
2. There has been no recent vomiting/activity which may have led to tube displacement.
3. A conscious and alert patient confirms that the tube feels unchanged.
4. Visual check to ensure the nasogastric tube is not coiled in the mouth. Remove nasogastric tube if coiling detected.
5. Fixation device has not moved or worked loose.
6. Review what the value of the pH result was before x-ray confirmation of the tube position.

If there is any doubt regarding the position of the NG tube DO NOT administer any feed, medication or fluids via the tube. Request chest x-ray.

Medicines Management: Nil by Mouth
"To give or not to give? "

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❖ Nil By Mouth prior to:

- ► **routine elective surgery** - regular oral medication with up to 30ml water up to 1 hour pre-operatively
- ► **endoscopy or transoesophageal endoscopy (TOE)** - regular oral medication with up to 30ml water up to 2 hour pre-operatively

❖ Patients may be kept Nil by Mouth for other reasons:

- ► ***Unconsciousness***
- ► ***To rest the gut***
- ► ***Emergency admission***
- ► ***Swallowing difficulties***
- ► ***Intolerance to oral medication***
- ► ***Delayed gastric emptying or obstruction***

❖ In all situations, it is important that consideration is given to how the patients regular medications will be continued.

❖ Medications **must** be reviewed by the clinical team and a decision about whether to omit or give documented in PICS or the medical notes and communicated.

❖ It may be necessary to change the route of administration or seek an alternative product. Advice should be sought from your ward pharmacist or from **Medicines Information (0121 424 5508)**, as doses and frequencies may be different**.**

If you are unable to give a medication because a patient is Nil by Mouth, always discuss this with the relevant clinician.

Any high risk or time critical drug omissions must be escalated to the clinical team immediately. Pharmacy advice can be sought if necessary.

See Medicines Management: Avoiding Omissions/Delays for a list of such medications.

Remember, this list is not exhaustive. If in doubt ASK.

For more information, please refer to:

Trust Procedure for Managing Patients who are Nil by Mouth

Trust Guidelines for Management of Patients who are Fasting during the Peri-Operative Period

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Controlled Drugs (CDs): Best Practice with Alfa

Ordering

- Use the Alfa Electronic Controlled Drug System (Alfa) to order CDs.
- REMEMBER – units are equivalent to the number of tablets/capsules/ampoules
- Always check you are using your own Alfa login and passcode when using Alfa
- You can check on the status of your order through the 'existing order' button

Receipt

- Check the number on the pharmacy bag and tamper-proof seal match the entry on the CD delivery sheet before signing to accept delivery.
- It is the responsibility of the individual accepting the order must:
  - Ensure name, form and quantity of medicine supplied matches the order on Alfa
  - Record the receipt of stock in the clinical area on Alfa with a witness
  - Lock away the medicines in the CD cupboard immediately
- For any discrepancies refer to the Controlled Drug procedure.

Recording Keeping

- **DAILY** Controlled drug stock checks must be completed by two members of registered staff. *(NB – only items not administered within the previous 24 will require a stock count, as a count is done during the administration process)*
- Balance discrepancies identified must be highlighted to the Nurse In Charge immediately and investigated as per the Trust Controlled Drug procedure.

Administration

- Staff administering CDs must ensure they are competent and present throughout the entirety of the administration process:
  - Identify the required controlled drug from the patient's prescription
  - Ensure that the required medicine is removed from the cupboard
  - Document administration in Alfa and confirm balance is correct
  - Document administration in PICS in the usual way
- **REMEMBER the 5Rs**

Disposal

- Controlled Drugs must be destroyed in such a way that the drug is denatured or rendered irretrievable – *using a DOOP kit or equivalent*
- Expired, unwanted or 'patient own' CDs must be returned to Pharmacy for disposal
- It is only appropriate to destroy the following within the clinical area:
  - *damaged, dropped or not fit for use medicines*
  - *part used vials, ampoules, syringes, infusions bags*
  - *doses drawn up which have not been used*
  - *discontinued infusions/ PCA syringes.*
- Any destruction or return to Pharmacy must be documented in Alfa with a witness

REFER TO THE CONTROLLED DRUG PROCEDURE FOR FURTHER SUPPORT

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Controlled Drugs (CDs): Best Practice with Paper Registers

Ordering

- Signature of the individual ordering the CDs, must **appear on the approved signatory list** at the back of the CD order book or list maintained in pharmacy (*where applicable*)
- Each item requested must be ordered on a **separate page** and **clearly written**, documenting the drug name, strength and quantity requested.
- Check that the order has been duplicated on both pages, using the carbon paper

Receipt

- Check the number on the pharmacy bag and tamper-proof seal match the entry on the CD delivery sheet before signing to accept delivery.
- It is the responsibility of the individual accepting the order to:
  - Ensure name, form and quantity of medicine supplied matches the order in the order book
  - Record the receipt of stock in the clinical area in the paper CD register, with a witness.
  - Each preparation in the CD register must have only one in use page at any given time. All page numbers must be kept up to date on the index page.
  - Lock away the medicines in the CD cupboard immediately
- For any discrepancies refer to the CD procedure

Recording Keeping

- **DAILY** CD stock checks must be completed by two members of registered staff.
- All CD register entries must be legible and made in ink. Errors must be bracketed **<u>not</u>** crossed through.
- Balance discrepancies identified must be highlighted to the Nurse/ODP in Charge immediately and investigated as per the Trust CD procedure.

Administration

- Staff administering CDs must ensure they are competent and present throughout the entirety of the administration process:
  - Identify the required controlled drug from the patient's prescription
  - Ensure that the required medicine is removed from the cupboard
  - Document administration in Alfa and confirm balance is correct
  - Document administration in PICS in the usual way
- **REMEMBER the 5Rs**

Disposal

- Controlled Drugs must be destroyed in such a way that the drug is denatured or rendered irretrievable – *using a DOOP kit or equivalent*
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  - *damaged, dropped or not fit for use medicines*
  - *part used vials, ampoules, syringes, infusions bags*
  - *doses drawn up which have not been used*
  - *discontinued infusions/ PCA syringes.*
- Any destruction or return to Pharmacy must be documented in the CD record book, balance amended and signed by both individuals.
- Old/completed CD record books must be retained securely in the clinical area for 2 years from the date of last entry OR where the record book contains details of CD destruction/wastage for 7 years after the last date of the entry.

ALL CD STATIONERY MUST BE LOCKED AWAY WHEN NOT IN USE

REFER TO THE CONTROLLED DRUG PROCEDURE FOR FURTHER SUPPORT

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Medicines Management: Avoiding Omissions/Delays

Roles and responsibilities for Nurses

Are you familiar with the medication?
You should know the drug type, it's action and the consequences of omission/delay. Check out the BNF/pharmacy intranet page, or ask pharmacy, the relevant doctor or a senior nurse.

Is the medication critical to the situation? Would omission or delay be a risk to the patient's health?
The adjacent list provides a quick reference, however always discuss with a pharmacist, the relevant clinician or a senior nurse. If appropriate, ask the patient, relative or carer.

Are you having difficulty in obtaining the medication?
Ensure that you know how to obtain medications, both in and out of hours. Ensure all medication supply streams are explored before omitting a medication – e.g. use of patients own/supplies from a previous ward. Escalate to a senior nurse, doctor and/or pharmacist if you are still unable to obtain the medication.

Are you about to omit or delay a dose of a medicine?
Escalate this to the senior nurse on duty or the relevant medical team. Delays/omissions should be appropriately coded on the written prescription chart/EP/PICS and documented, with an explanation, in the medical notes.

Omission or delay in the administration of the medications on this list must be discussed with the prescriber or relevant physician.

- **All <u>systemic</u> anti-infectives, oral and parenteral.**
- **Medications used in resuscitation: e.g. *Glucose/Glucagon, Naloxone, Flumazenil, IV Acetylcysteine; anaphylaxis treatment.***
- **All <u>systemic</u> steroids (regular and short course), e.g. prednisolone.**
- **All insulins.**
- **Parkinson's medications.**
- **Pyridostigmine for the treatment of Myasthenia Gravis**
- **Anticoagulants and VTE Prophylaxis**
- **Anti-epileptic medications (includes benzodiazepines and Gabapentin/Pregabalin if prescribed for seizures).**
- **Regular strong opioids for chronic/post-operative pain.**
- **Anti-rejection medications.**
- **Desmopressin – all routes.**
- **Antipsychotic medications such as clozapine**
- **Treatments for the management of acute, severe symptomatic electrolyte disturbances**

<u>IMPORTANT</u>:
Delay of these 'critical' drugs constitutes an adverse incident which <u>MUST</u> be reported on Datix.

<u>Top Tips</u>:

- **Familiarise yourself with the correct process for receipt and storage of medication following delivery from pharmacy – use bedside lockers where available/appropriate to reduce time spent searching.**
- **Familiarise yourself with the correct process for administration of medications.**
- **Ensure effective communication regarding missed/omitted doses in handovers, safety briefings/huddles and if the patient is transferred.**
- **Complete all appropriate documentation on transfer of a patient to another department; familiarise yourself with the Trust's transfer policy.**

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Medicines Management: Fit For Discharge?

Preparation

- TTO to be drafted in advance where possible. Allow 48 hrs for complex discharges *e.g. End of life medications, blister packs & home IV antibiotics*
- Identify special considerations such as anticoagulation → Ensure appropriate follow up is planned.
- Contact your ward pharmacy team to support with TTO dispensing
- Identify patients own drugs (PODs) suitable for use and/or if the patient has supplies at home.

Remember:

Some medicines may need to be stored in the Controlled Drug cupboard, refrigerator or bedside locker; make sure all medicines are collected before discharge.

Before Discharge

- Re-print the most current discharge letter
- Check all TTO medicines dispensed match those listed on the letter **and** the list of medicines on PICS/prescription chart
- Check all medicines labels are for the individual patient with specific directions on how they should take the medicine.
- Remove any inpatient medication/PODs not required for discharge *(with consent if the patient has capacity)*
- Confirm if the patient uses any additional aids e.g. a blister pack and ensure the medicines have been dispensed this way. Contact Pharmacy for advice.
- Contact the ward Pharmacy team or Pharmacy dispensary if there are any discrepancies, alterations or deletions identified to rectify

Counselling

Before your patient is discharged, always check:

- Are they clear which medicines have been prescribed and how they need to be taken?
- Are they aware of any changes which have been made to the medication regimen ?
- That there is no possibility of duplicating therapy with supplies at home.

Remember to:

- Highlight and explicitly explain medication courses *e.g. antibiotics and/or steroids*
- Test the patient's understanding
- Ask a senior nurse or a pharmacist if you are unsure of important counselling points for a medication.

You can signpost patients to the Patient Medicines Helpline information on the Discharge Letter:

Medicines Helpline

If you have any questions or concerns about your medication, please call the Medicines Helpline on 0121 424 4682 (Monday to Friday, 10 am - 1 pm and 2 pm - 3 pm). For non-medicines related enquiries please call the correct switchboard: Queen Elizabeth Hospital on 0121 371 2000, Heartlands, Good Hope or Solihull on 0121 424 2000.

UHB guide to falls prevention

University Hospitals Birmingham
NHS Foundation Trust

F - Footwear
A - Assessment
L - Level of observation
L - 'Leave it low before you go'
S - Safe environment

Bed rails
All patients must be assessed to see if it is appropriate to use rails whilst they are in hospital.
Always consider and record the patient and relative/carers preferences to the use of bed rails.

Equipment
Assess need for specialist falls equipment such as:
Hi-lo bed
Bed/chair alarm
Red non slip socks
Mobility aid such as:
walking stick/frame and well fitting slippers.

Specialist falls advice
Contact falls team for advice if required.

Medication
Be aware that certain medications increase the risk of falls (particularly those with a sedative effect or those that lower blood pressure).
Ask the doctor or pharmacist to **review medication.**

Call bell
Check your patient is able to use a call bell and it is within reach & working.

Falls Risk Assessment
All patients admitted to the hospital must have a Falls Risk Assessment. This must be completed within 6 hours of admission, and every 7 days thereafter or sooner. Risk assessment should also be repeated following an inpatient fall or if the patient's condition changes.

Mobility
If patient is unsteady ask for physiotherapy review and advice on mobility and correct walking aids Consider **Eat, Drink, Dress, Move** Avoid immobilising patients as a risk reduction measure.

V4

For further guidance see **Procedure for the Prevention and Management of Inpatient Falls**

UHB adapted National Pressure Injury Advisory Panel (NPIAP) categorisation guide

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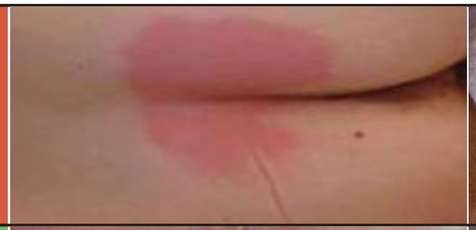
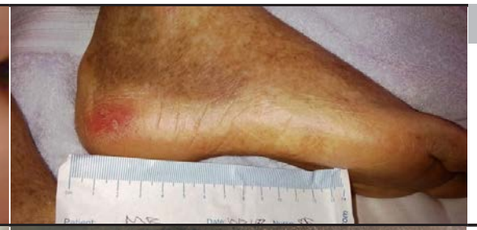
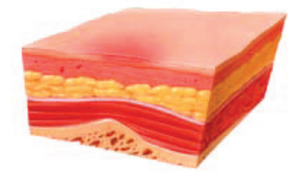
Category 1
Intact skin with non-blanching erythema (redness) of a localised area, usually over a bony prominence. Changes in sensation, temperature, or firmness may precede visual changes. Darker skin may not have visible blanching.



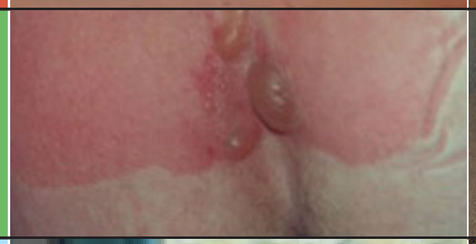


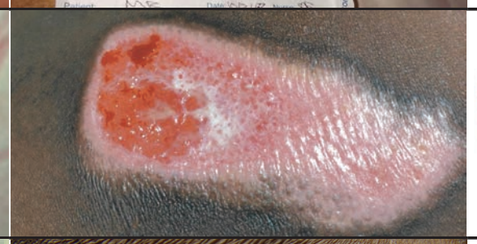
Progression of a pressure ulcer

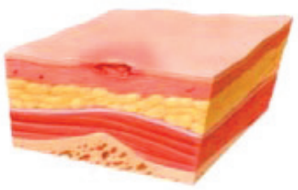


.....Epidermis
.....Dermis
.....Subcutaneous layer
.....Muscle/Bone

Category 2
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, without non-removable slough and may also present as an intact or ruptured serum-filled blister.

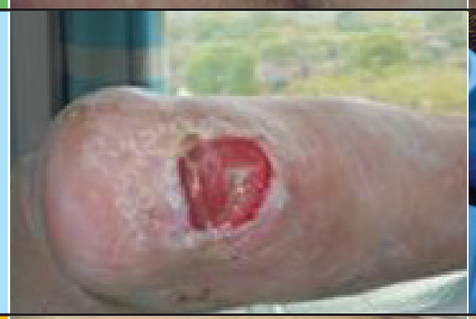


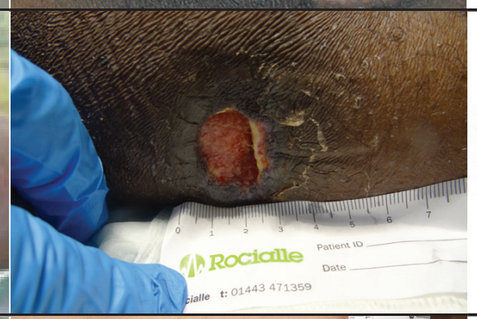




.....Epidermis
.....Dermis
.....Subcutaneous layer
.....Muscle/Bone

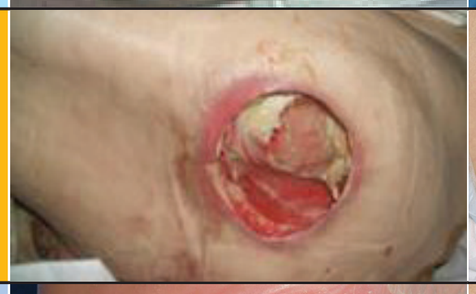
Category 3
Full thickness loss of skin. Subcutaneous layer may be visible but bone, tendon or muscles are not exposed. Some slough or necrosis may be present. May include undermining and tunnelling. The depth of a Category 3 varies by anatomical location e.g. bridge of the nose, ear, back of the head and malleolus do not have subcutaneous tissue and these ulcers can be shallow.

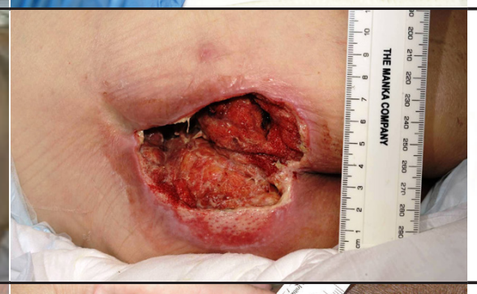




.....Epidermis
.....Dermis
.....Subcutaneous layer
.....Muscle/Bone

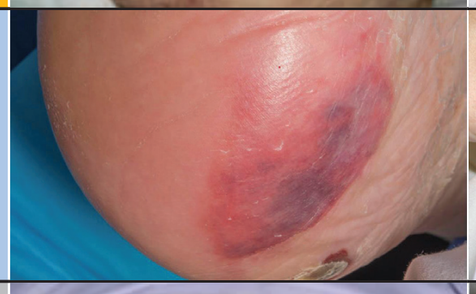
Category 4
Full thickness tissue loss with exposed tendon, muscle, bone or palpable bone. Slough or necrosis may be present. Often include undermining/ tunnelling. The depth of a Category 4 varies by anatomical location e.g. bridge of the nose, ear, back of the head and malleolus do not have subcutaneous tissue and these ulcers can be shallow.

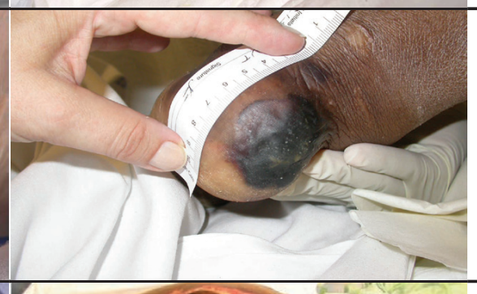


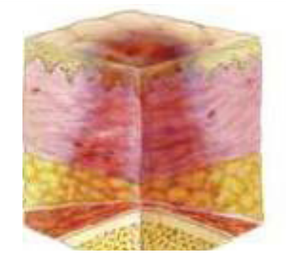


.....Epidermis
.....Dermis
.....Subcutaneous layer
.....Muscle/Bone

Deep Tissue Injury (DTI)
Intact purple/maroon area of discolouration or blood-filled blister. Pain and temperature change often precede skin colour changes. Discolouration may appear differently in darker pigmented skin. Evolution may be rapid exposing additional layers of tissue even with optimal treatment or may resolve without tissue loss.

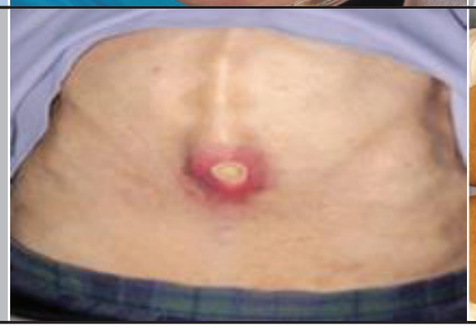


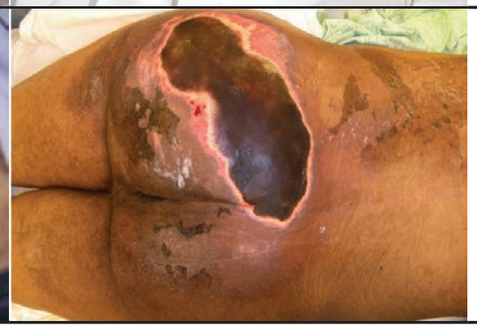


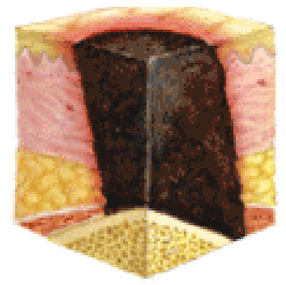


.....Epidermis
.....Dermis
.....Subcutaneous layer
.....Muscle/Bone

Unstageable (Depth Unknown)
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough or necrosis. Until enough slough and/or necrosis are removed to expose the base of the wound, true depth cannot be determined, but it will be Category 3 or 4. Stable (dry, adherent, intact without erythema) eschar/necrosis on the heels serves as 'the body's natural (biological) cover' and should not be removed.







.....Epidermis
.....Dermis
.....Subcutaneous layer
.....Muscle/Bone

Reference: National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury AlliancePreservation and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2019.

Tissue Viability Service (TVS) Patient Referral Priority Pathway

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Utilise your TV Link Nurses and TV resources for first line information and advice

PRIOR TO REFERRAL

- Remove all dressings (including compression bandages) on admission and complete a wound assessment, skin inspection and document findings.
- For all existing chronic wounds, contact community nurses to establish any pre-existing plan of care.
- If chronic wound is the reason for admission a referral to TV may be appropriate following a full wound assessment (see point above).
- Request medical photography where appropriate.
- Consider the exclusion criteria.
- Pressure ulcers (PU) must be validated by 2 registered practitioners and reported on Datix.

EXCLUSION CRITERIA

Referral for the following will not be considered appropriate:

- Skin conditions with no active wound: referral should be made to Dermatology.
- Patients with healing wounds / Category 1 and 2 PU.
- Patients that have had no documented wound assessment.
- Patients with diabetic foot ulcers that are under the care of the Diabetic Foot Team.
- Cellulitis without active ulceration.
- Patients previously seen by the TVS who have no new identified wounds or there are no new concerns.

Referrals will be prioritised using the following criteria:

Priority 1

- Trust Acquired PU (TAPU) categories 3/4/DTI and unstageable
- Complex wounds/ wounds requiring Negative Pressure Wound Therapy (NPWT) /Larvae/incisional management/ conservative sharp debridement/specialist dressings
- Unexplained rapid deterioration in any wound
- Safeguarding concerns related to TV
- Difficult to manage wounds e.g. fungating wounds that are painful/bleeding/malodourous.

Priority 2

- PU on Admission (POA) category 3/4/DTI and unstageable where more detailed assessment is required or there is no appropriate community plan or there are concerns regarding infection or deterioration
- Wound progress/symptoms are affecting the patient's quality of life
- Deteriorating wounds despite an appropriate plan of care
- Severe moisture lesions/skin excoriation
- Leg ulcer management

Telephone advice will be given where appropriate for:

- Non-complex wounds
- Healing wounds
- Advice on pressure reducing/relieving equipment within the Trust
- Where another service is required
- To support discharge
- Static/non-healing wounds

All sites core service hours 8-4 Monday to Friday
Refer via PICS where available; for urgent advice (QEHB) contact ext. 18816.
Where PICS is unavailable refer on ext 40499 (BHH and SOL) or 47933 (GHH).
Provide as much information as possible to enable the Tissue Viability Team to prioritise using the above pathway

MOISTURE ASSOCIATED SKIN DAMAGE (MASD) PATHWAY

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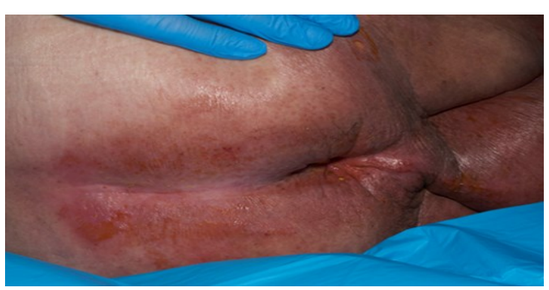
Assessment and Skin Damage Diagnosis

1 Incontinence Associated Dermatitis (IAD)

Caused by

Urine or liquid faeces

Erythema and inflammation of the skin, erosion can occur as a result of exposure to urine and faeces

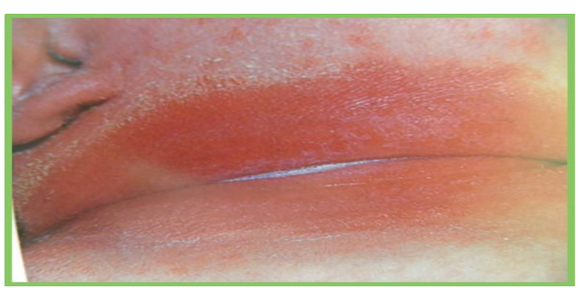


2 Intertriginous Dermatitis (MASD within skin folds)

Caused by

Perspiration

Mild, mirror image erythema on each side of the skin fold. May have erosion as a result of exposure to chronic perspiration

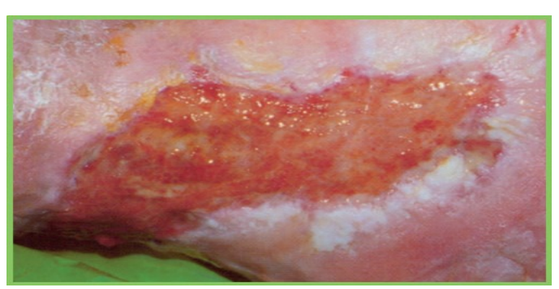


3 Periwound Dermatitis

Caused by

Wound exudate

Erythema and inflammation of skin within 4cm of wound edge, may show erosion

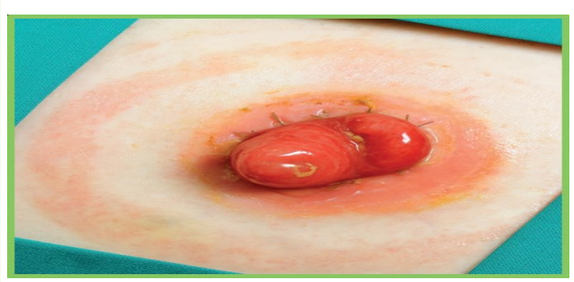


4 Peristomal Dermatitis

Caused by

Bodily fluids e.g. urine, faeces, gastric

Erythema and Inflammation skin related to moisture from stoma excretions



Adopt a multi disciplinary approach to ensure underlying cause of MASD is identified and treated

Implement following care:

Refer to the Wound Management Guidelines and Wound Product Formulary

Cleanse with PH neutral cleanser

Apply barrier film* if skin broken

Apply barrier cream* if skin intact

Reassess any incontinence products in use to ensure appropriate

If faecal incontinence of type 6 - 7 four times a day or more please consider faecal management device (see Guidelines for use of Faecal Management Systems)

Implement following care:

Examine skin folds thoroughly, gently lifting them to avoid creating or exacerbating traction and fissure formation

Avoid products containing Chlorhexidine gluconate, alcohol or perfumes

Cleanse skin with PH neutral cleanser

Apply barrier film *

Consider use of devices/products to wick moisture from affected skin. Discuss options with TVNs

Implement following care:

Base dressing choice on absorbency and ability to manage type of exudate

Protect peri-wound areas from by cleansing & applying barrier film*

Avoid adhesive dressings over affected skin

Consider if wound infection is affecting type and level of exudate

If the wound is not healthy or progressing, further investigation may be required to establish co-morbidities, refer to Tissue Viability for advice

Implement following care:

Apply barrier film* at appliance change until advice from Stoma Care Nurses is obtained

Urgent referral to Stoma Care Nurse Specialist for assessment and advice regarding the size and shape of the stoma and to ensure correct product/s are being used

If any other concerns regarding stoma care please contact Stoma Care Nurse Specialist for support and competency training

If no improvement or deterioration in condition, refer to TVN and/or Dermatology/Colorectal CNS/Continence CNS

In all instances complete an assessment, document planned care and report MASD on Datix

Patient must be included in all decisions relating to treatment ensuring informed consent obtained where possible
Non-concordance documentation should be completed if applicable

*** For guidance on application of barrier products please see the Medi Derma barrier product guide**

Learning Disability & Autism Standards – Inpatient Checklist

University Hospitals Birmingham
NHS Foundation Trust

A structured framework supporting the provision of appropriate care, maintenance of safety, and protection of vulnerable patients.

ADMISSION What must be completed – **REMEMBER** communication is key!	☑
The patient must be coded correctly for Learning Disability / Autism	
The LD inpatient admission checklist must be completed by a Registered Nurse and can be accessed and printed from the Learning Disabilities and Autism Share Point page	
HOSPITAL PASSPORT	
MUST be completed within **24 hours** of admission	
If the patient **does not have a hospital passport**, print a blank hospital passport form from the Learning Disabilities and Autism Share Point page Ask the patient and/or their NOK/Carer to complete it A completed passport will support staff providing care for the patient	
Scan onto Clinical Portal or Concerto.	
A copy should be kept in the end of bed folder for staff to refer to throughout the patients stay	
Ensure that the patient is referred to the **Learning Disability Inbox** patient via PICS or email to: vulnerabilities@uhb.nhs.uk	
RESPONSIBILITY FOR CARE	
Identify the consultant responsible for the patient and inform the patient and carer	
MULTIDISCIPLINARY TEAM MEETING	
MUST take place within 72 hours of admission for plan of care; appropriate representation is key, use MDT proforma	
NEXT OF KIN (NOK) / CARER	
Document NOK/Carer details	
Give NOK/Carer *Partners in Care* leaflet	
Ensure flexible visiting which may be required and may be beneficial for the patient	
Does the patient need an Independent Mental Capacity Advocate (IMCA)	
Recognise NOK/Carer expertise – they will be able to support and assist patient's care needs	
RESPECT – RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT	
Patients **MUST** have individual plan to ensure the right care and treatment in an anticipated future emergency in which they no longer have the capacity to make or express choices.	
MENTAL CAPACITY **WE ASSUME CAPACITY BUT ASK YOURSELF…….**	
Can the patient understand the information given to them about a decision? Can they retain information long enough to make a decision? Can they weigh up information? Can they communicate their decision? If they can't do ANY one of these, complete a Mental Capacity Assessment	
Complete Mental Capacity Assessment (MCA) for each specific decision and consider Deprivation of Liberty Safeguarding (DoLS) if appropriate	
THINK!	
Nutrition and Hydration – refer to dietetics as appropriate	
Reasonable Adjustments for the patient care / experience	

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WHAT DOES GOOD CARE LOOK LIKE FOR ANDREW?

For our patients with a Learning Disability (LD), Autism, or both.

Have you completed a Hospital Passport for me? It will support you with my care

MAKING REASONABLE ADJUSTMENTS

- Find out whether **Reasonable Adjustments** need to be made. These could be anything that would improve the patient's ability to access the health service or that would improve their experience of their care.
- Action any plans required for discharge.
- If the patient requires support in the community, telephone Single Point of Access.
- **Think Carer** – offer the 'Partners in Care' leaflet to relatives/ carers.
- Be supportive of **flexible** visiting for this group of patients.

EMOTIONAL AND SOCIAL SUPPORT

- If the patient is known by any Community Teams e.g. Health Facilitation Team – contact them to ensure we understand the patient's individual needs.
- **Complete a Hospital Passport.**
- Consider triggers which may result in changes in behaviour and/or cause the patient distress.
- Consider things that help to calm and reassure the patient.

SUPPORT WITH PERSONAL CARE NEEDS

- **Ensure MCA is completed if required.**
- Check what level of support the patient needs with their personal care. Review regularly in case of changes.
- **ReSPECT** process to be used, if appropriate.

GOOD COMMUNICATION AND CARE AND CARE

- **Ensure the patient is coded correctly on PICS/Concerto.**
- Find out what communication styles, care requirements and aids are used / needed by the patient. Use Communication Boxes in clinical areas and information for the patient in Easy Read format.
- **Responsibility for care –** identify consultant responsible and inform patient / carer.
- **Multidisciplinary Team (MDT) Meeting** to take place within 72 hours of admission for plan of care; appropriate representation is key.

ASSESSING ELIMINATION

- Ensure assessment of bladder and bowel function on admission.
- Consider what is normal for the patient and if that is currently different.
- Monitor patient's bowels – record daily and monitor for signs of constipation.

NUTRITION & HYDRATION SUPPORT

- Ensure Nutrition and Hydration assessments are completed. Ensure the patient is referred to Speech and Language Therapy (SLT) / Dietetics / Nutrition Team as required.
- Identify the patient's normal route for their nutrition and hydration needs i.e. if via NG/ PEG. Escalate if this is not being managed effectively.
- Identify any recent changes and / or issues.

ASSESSING PAIN

- Use appropriate pain assessment tools which allows the patient to express their level of pain to you.
- Observe how the patient may demonstrate they are in pain
- Ensure that their pain score is recorded.
- Administer appropriate pain relief; consider **STOMP** (Stopping over medication of people).

Need advice or support regarding a patient with LD/Autism
Contact the Learning Disabilities Advice Line: 07768926651

For further advice and guidance, including LD standards/flowcharts/admission checklist and resources please see the
Trust Learning Disabilities Intranet Site

Caring for the person in their last days/hours of life (1)

University Hospitals Birmingham NHS Foundation Trust

RECOGNITION: Is your patient in their last hours or days of life?

Medical Management Plan:

- Have the patient/family:
  - » been informed the patient may die?
  - » discussed the ReSPECT/Treatment Escalation and Limitations (TEAL)/DNACPR plan with the Consultant/Registrar in charge of care? Do they understand?
- Is there an agreed plan about stopping procedures such as bloods, blood gases, x-rays, weighing?
- Is the overall medical management plan clear to the patient, their family and all staff?
- Start Comfort Observations?

Multidisciplinary team (MDT) assessment and review should take place at least daily or if the patient's condition changes.

Plans should be discussed with the patient and their relatives.

- Explain to families the focus of care is comfort.
- Listen, consider and act upon the concerns, worries and wishes of the patient and their significant others.
- Ask for help from other professionals as needed e.g. Chaplaincy; Speech and Language, Palliative Care and/or Complex Discharge Teams.
- Give the family the 'information for you when your loved one is dying' leaflet. Allow them time to read and process the information and answer any questions they may have.

Comfort Observations (2)

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Starting comfort observations:

- Activate Comfort Observations on PICS/NEWS chart (registered nurse)
- Has the Death and Dying daily care plan been started? (PICS)
- Are anticipatory drugs prescribed? (EOL drug bundle)
- Regular Mouthcare with patient's favourite beverage

Comfort Observations:

Twice daily manual pulse, respiratory rate to help monitor for signs of comfort or distress along side Symptom management.

Question:

- Review all medications. Avoid medication that might cause discomfort without giving benefit.
- Discuss with the medical team.

Symptom Control:

- The patient should be reviewed 4 hourly by a registered nurse for signs of symptoms and distress; pain, respiratory, nausea and vomiting, restlessness and agitation.
- West Midlands Palliative Care Guidelines

'Increase the comfort: stop unnecessary discomforts'

Caring for the person in their last days/hours of life (3)

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Communication:

- Facilitate open visiting at End of Life for the family (in line with current visiting guidance).
- Invite the family to participate in care (considering current IPC guidance).
- Address the patient's and relatives' priorities and concerns. Consider:
  - » preferred place of care e.g. home/hospice/hospital
  - » concerns for dependants
  - » fear of dying/distressing symptoms
  - » eating and drinking at the end of life – is speech and language therapy referral indicated?
  - » spiritual support

Care nearing and after death:

- Ask:
  - » Have the family been contacted? Do they want to be present?
  - » Are there any religious or cultural requirements before or after death?
  - » Have the family been invited to participate in the last offices (considering current IPC guidance)?
- Performance of last offices should follow the Bereavement Policy.
- The family should be given the Trust Bereavement booklet.
- Property should be returned to the family/stored safely for the family to collect on ward in purple property bag.
- The patient should be safely transferred to the mortuary within 4 hours of death.

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7 Minute Briefing
Enhanced Care

What is Enhanced care?

Enhanced care is put into place for patients who, without additional observation or supervision, may be at risk of harm to themselves or others.

You should follow the trust Enhanced care policy to mitigate risks to your patient.

1

Who may need it?

There are many reasons a patient may require Enhanced care. Some common examples are:

- ❑ Confusion, distress or agitation – this may be due to a long-term medical conditions or short term for example infection
- ❑ Patients with a Learning Disability, Autism, Dementia or Cognitive Impairment who are unable to keep themself safe or are at risk of harming others
- ❑ Drug or alcohol withdrawal or misuse
- ❑ Risk of falls

2

3

Risk Assessment

It is important that patients at risk are assessed and managed appropriately.
The Enhanced care risk assessment document is known as the "ENHANCED CARE BUNDLE"

The **Enhanced Care Bundle** must be completed for all patients requiring Enhanced care, except for patients with Mental Health needs. For this group of patients please us the **Therapeutic Observation & Engagement tool** (**TOE)**

The Enhanced Care Bundle has 5 sections:
1. Review and rationale for Enhanced Care
2. Staffing requirements
3. Daily review
4. Behaviour chart
5. Record of care

It is important staff use the Enhanced care Bundle to mitigate risk ensuring patients are kept safe and supported. You can contact the Vulnerabilities team for support and advice.

Guidance for staff can be found on the intranet

Levels of observation

4

An appropriate level of observation should be identified (levels 1-4).
Level 1 – General observation (Cohort)
Level 2 – Intermittent (Cohort)
Level 3 – Continuous in full & uninterrupted eyesight at all times
Level 4 - Continuous within arm's length at all times
Descriptions of the levels can be found in the **Staff guidance document.**

We should provide a level of observation that is the least restrictive for our patient, while maintaining patient safety.

Meaningful Engagement

5

The purpose of meaningful engagement is to promote person centered care, ensuring the person feels valued, has a sense of purpose and ensure they feel listened to , included and understood.

Utilise the **"All About Me"** and **"Hospital Passport"** to help understand your patients' needs and requirements.

Providing meaningful engagement can help reduce length of stay in hospital, improve health outcomes and patient experience.

Reviews

6

Patients receiving Enhanced Care should have the levels of observation reviewed daily (at a minimum). You should also review if the situation changes.

The outcomes of the reviews should be documented on the daily review chart in the booklet.

Staff must:
- Escalate any concerns to the nurse in charge.
- Inform the patient of any changes you are making
- Remember to remove Enhanced Care when it is no longer required.

Support and Advice

7

- Vulnerabilities Team email vulnerabilities@uhb.nhs.uk
- Referral via PICS (under support teams tab)
- Advice line (Monday – Friday 8-4) 07768926651

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Being in hospital can be a confusing and frightening experience for a person living with dementia

Communication/ Accessible Information Standard

- Ensure any communication needs are flagged on Oceano
- Use your communication box
- Engage with interpreting services if needed e.g. BSL

Reasonable adjustments

- Any reasonable adjustments made such as; overnight stays, move to a side room, flexible visiting to help with care, etc. (this list is not exhaustive) should be recorded on admission

Think carer – The carers call to action

- Offer *Partners in Care* document which should be kept in the notes once completed
- Refer to Carer Coordinator for Carer Card
- **Responsibility for Care** a named consultant will be responsible for the care of the patient and their name should be communicated to the relatives/carer(s)
- **MDT/Discharge** – begins from admission and relatives or carer(s) should be involved in all MDT's or discharge planning discussions

Coding/flagging

- Ensure dementia diagnosis is recorded on Trust systems (PICS/ Concerto/Oceano)

'All about me'

- The *All about me* or equivalent document should be available within 24 hours of admission

What does good dementia care look like?

Medication review

- Medication should be reviewed on admission to prevent overmedication or the use of medication which is detrimental to the patient's condition
- Assess pain using an appropriate tool as patient may not be able to communicate if they are in pain

DNACPR or ReSPECT or TEAL

- Patients and carer(s)/ families are where possible involved in discussions and the decision
- Advanced decision making should be clearly documented

Nutrition and hydration

- An accurate MUST/ NUTRITION score should be obtained on admission and implement the food diary, Red Tray System and fluid chart for those at risk
- Referrals should be made as necessary to SLT/ dietitian

Mental capacity assessment/ DoLS/ LPA

- Capacity should be assumed for all patients including those with dementia
- Support the person to make decisions themselves and discuss with family and carers if appropriate
- If a person's capacity is in doubt then a MCA should be completed
- DoLS should be completed for people with dementia. If they:
  - are under continuous supervision and control
  - are not free to leave
  - lack capacity to consent to their care arrangements

For more information contact the Vulnerabilities team: vulnerabilities@uhb.nhs.uk

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6 PROVEN STRATEGIES TO PREVENT DELIRIUM IN OLDER ADULTS

01

STIMULATING THE MIND

Promote daily socializing, reading, listening to music, completing mind challenge games (such as crossword puzzles), and activities or conversations that help remind older adults what day/month/year it is.

02

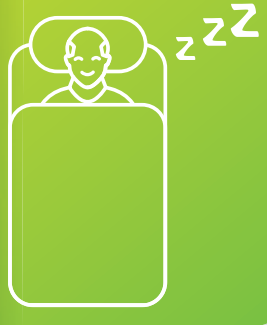
MOVING

Promote physical activity - at least 3 times a day.

03

SLEEPING WELL

Use techniques to promote relaxation and sufficient sleep.



04

SEEING AND HEARING

Ensure hearing aids and glasses are available at all times, if needed.

05

STAYING HYDRATED

Ensure plenty of fluids are taken throughout the day to avoid dehydration.

06

EATING

Ensure nutritious food is available throughout the day, and promote eating with others if possible.

DELIRIUM IS PREVENTABLE!

For all older adults, use these proven strategies to help prevent delirium*.

If delirium develops, support the older adult by continuing to use these strategies.

REGIONAL GERIATRIC PROGRAM OF TORONTO
www.rgptoronto.ca

**Adapted with permission from: A Multicomponent Intervention to Prevent Delirium in Hospitalized Older Patients (Inouye et al., 1999)*

Safeguarding adults

Process for escalating and reporting a safeguarding concern for adults with care and support needs

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Care and support is the mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent.

As a nurse or midwife you have a professional duty to put the best interests of the people in your care first and to act to protect them if you feel they may be at risk.

Abuse can be:

- Physical abuse
- Domestic violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Exploitation & Human trafficking
- Discriminatory abuse
- Organisational abuse
- Neglects and acts of omission
- Self neglect

If you suspect or have a concern about the safety or wellbeing of people you come into contact with

↓

Stage 1: Take immediate action to ensure that the individual is SAFE. Make safeguarding personal and involve the person in the process

↓

Stage 2: Inform nurse in charge / matron of your clinical area

If you are unable to do this for whatever reason

↓

Stage 3: Contact senior nurse of the hospital or site for advice and support

8am-4 pm
matron / head nurse / adult safeguarding advice line

Out of hours
1st on bleep holder / duty matron / night practitioner

↓

Stage 4: Following an intitial fact find to inform your assessment follow flow chart on P15 of the adult safeguarding procedure.Make referral as appropriate using Trust Intranet page. The referral must be completed by the person who has identified the concern and gatherered the information ASAP and before the end of the shift. Document in patient notes.

↓

Stage 5: For further issues e.g. perpetrator causing concern on hospital premises contact senior nurse for clinical area, out of hours contact site team.

Further resources:
The Trust Adult Safeguarding team can offer help and support 8-4 Mon to Fri and can be contacted via switch. There is also lots of useful information available in the

Adult Safeguarding Policy and Procedure

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Guidance for the management of safeguarding children/unborn child

0-18 years

Abuse can be physical, emotional, sexual and/or neglect.
Parental issues that may be associated with abuse/neglect of children include:
Substance misuse, mental health problems, learning disabilities and chronic physical ill health
Remember to 'Think Family'

Staff member has concerns about a child's welfare (must act on same day)

Discuss concerns with a colleague or named professional for safeguarding.
'Out of hours': contact the on-call paediatric consultant, Multi-Agency Safeguarding Hub (MASH) or the Emergency Duty Team (EDT).
- **If sexual abuse is suspected staff should seek advice from the West Midlands Paediatric Sexual Assault Service (WMPSA)(delivered by Mountain Healthcare LTD)**

Agreed the child has significant/ complex needs which are not being met and/or is at risk of significant harm

- **Complete Children Services referral form (within 24 hours)**
- **Check the postcode for the patient to ensure referral is sent to correct Local Authority.**
- **When prompted for safeguarding team email address please use - uhb.safeguardingchildren@uhb.nhs.uk**
- **Discuss referral with parents unless unsafe to do so**
- **If you have immediate concerns that child is at risk of harm, please call Children services to discuss verbally and follow up with a written referral. If out of hours, please call the Emergency duty team number (out of hours EDT)**
- **If CPIS is positive and you feel threshold has been met to complete a safeguarding referral, then please contact the identified social care team to inform them. If out of hours, please call EDT.**

Conflict of opinion about whether a referral should be made

Discuss with named nurse named midwife or named doctor

Agreed the child has no significant/complex unmet needs and no risk of significant harm

For Early Help - Health visitor, School Nurse, Locality Hub

Useful telephone numbers

- **Named doctor via switchboard**
- **Safeguarding Team**
  QE 14752 **BHH** 41522 **GHH** 47137 **M-F** 8-4
- **Named midwife via switchboard**
- **Midwifery advice line Mon - Fri 9.00 - 17.00**
  07740 066685
- **Safeguarding office 0121 424 9235**
- **Social work referrals**
  Birmingham 0121 303 1888 out of hours 0121 675 4806
  Solihull 0121 788 4300 out of hours 0121 605 6060
  Staffordshire 0800 131 3126 out of hours 0345 604 2866
- **WMPSAS 0808 196 2340**

More detailed guidance is available on the safeguarding children's website/

UHB Safeguarding Children Policy and Procedure

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When can a patient be prevented from leaving a UHB hospital?

The patient is detained under the Mental Health Act to a UHB Hospital → Patient can be prevented from leaving hospital

The patient is detained under the Mental Health Act to another hospital, but on leave to a UHB hospital → Patient can only be prevented from leaving if on leave to UHB under s.17(3)

Patient in ED assessed under MHA, application for detention completed and bed found → Patient can be prevented from leaving

Patient in hospital (incl ED), is incapable of deciding whether to stay/accept treatment → Power to prevent from leaving if patient assessed as not having the capacity for the decision

Patient receiving treatment under Court Order in hospital → Power to prevent patient from leaving if Court Order permits detention in hospital

Patient is waiting for assessment by Liaison Psychiatry Team in ED

Patient in ED has been assessed by Liaison Psychiatry Team, but is awaiting MHA assessment to decide if they should be detained

Patient in ED assessed under MHA and decision made that they need a MH bed, but application cannot be completed due to lack of MH beds)*

→ No power to prevent patient from leaving unless:

1. The patient presents an immediate risk to themselves or others;
2. To prevent a crime (e.g. an assault), or
3. Lack of capacity

In any of the above, for a negligible period

* In these circumstances, the escalation process must be followed to ensure appropriate escalation and consideration of admission based on risks.

For further support and advice please contact:
Restraint policy/procedure – Children, Young Person and Adult Restraint Policy and Procedure.
Mental Health Compliance Team – MentalHealthActAdministration@uhb.nhs.uk
Safeguarding - The Trust Adult Safeguarding team can be contacted via switch Monday to Friday 8am-4pm

Withholding Treatment Process (Yellow/Red Cards)

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(1) Patient/relative /visitor displays unacceptable behaviour.

(2) Verbal warning issued by staff and Datix completed. Any threatening, sexist, racist or homophobic comments or behaviour should be report to the Police by the member of staff using the 101 number.

(3) Unacceptable behaviour must also be recorded in the patient's notes and communication between staff is key.

(4) If behaviour continues contact one of the local Security Management Specialists and we can send the yellow card letter template for completion. The letter once drafted will come back to the security management team to add conditions and QA it prior to it being signed by Matron or Ops Manager for the division. * Warnings/Exclusions can only be issued to patients who have capacity

(5) If behaviour still continues we can look to exclude but only if the patient is MFFD. If not the clinical teams will need to look at transferring care to another provider.

(6) We can also exclude relatives and visitors if the severity of the incident warrants it.

(7) We can go straight to exclusion for a patient with capacity if the severity of the incident warrants it but the conditions in box (5) will apply if they are not MFFD.

Please note:
The new Trust wide withholding treatment policy has now been approved and is available on the intranet **here**
At BHH, GHH and SH we will place a warning marker on the patient's electronic record advising staff that they may pose a risk to safety. We are currently working with IT to expand this to QEH once clinical systems are aligned. Please contact the Local Security Management Specialists (ext. 42438 or ext. 41481) for further advice on the process should it be needed.
As an interim measure we will send an updated log of all current warning and exclusions to the QE Site team and site Security teams on a weekly basis.

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MANAGING PATIENT SAFETY INCIDENTS

IMMEDIATE ACTIONS FOR ALL STAFF

Make the situation safe

Take immediate steps to protect patients, staff and others.

Reduce ongoing risk

Address any immediate hazards to prevent further harm.

Preserve helpful information (not a forensic scene)

If equipment, documentation or the care environment may help us understand what happened, keep it safely aside where possible.

Inform the senior clinician/manager promptly

Early notification ensures the organisation can respond supportively and begin compassionate communication with those affected.

Complete an incident report

Near misses, low-harm and no-harm events offer critical learning — please report them so the organisation can improve systems.

HARM SEVERITY LEVELS

Near Miss	**An event that could have caused harm but did not, due to chance or timely intervention.** ➞ *Provides valuable learning about system vulnerabilities.*
No Harm	**The incident occurred, but no harm came to the patient.** ➞ *Still important for identifying improvement opportunities*
Low Harm	**Minimal short-term harm requiring additional observation or minor treatment.**
Moderate Harm	**Short-term harm requiring further treatment, potential procedure, transfer of care, or prolonged recovery.**
Severe Harm	**Permanent or long-term harm affecting the patient's quality of life or function.**
Death	**The incident directly resulted in a patient's death.**

For incidents resulting in moderate harm or above a Duty of Candour is required.

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Patient Safety Incident Response Framework (PSIRF)

Incident reporting helps us understand how care works in practice, identify system pressures, and improve patient safety. Reporting is not about blame — it is about learning, openness and supporting safer care.

Promoting learning • Supporting openness • Strengthening safety

Near miss	No harm	Low harm	Moderate harm	Severe harm	Death

- Usually managed locally within departments/teams
- Learning shared to prevent recurrence
- Apology and explanation offered where appropriate
- Supports continuous safety improvement

- Senior manager notified immediately
- Duty of Candour initiated
- Appropriate PSIRF learning response considered (e.g. learning review, MDT reflection, systems-based analysis)
- Focus on understanding *how the system contributed*, not individual blame

SUPPORT & RESOURCES

Reporting and Management of Safety Events Policy	Patient Safety Incident Response Policy and Plan
Duty of Candour Policy	Duty of Candour (Being Open) Procedure

Clinical Governance Facilitation Team (RiskManagement@uhb.nhs.uk), Patient Safety Team (patient-safety.team@uhb.nhs.uk)

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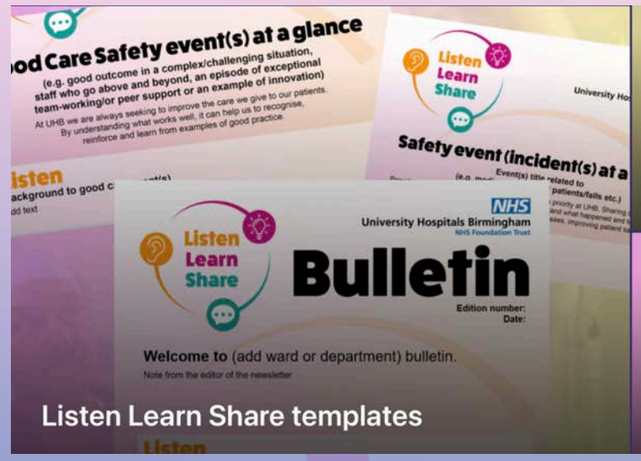
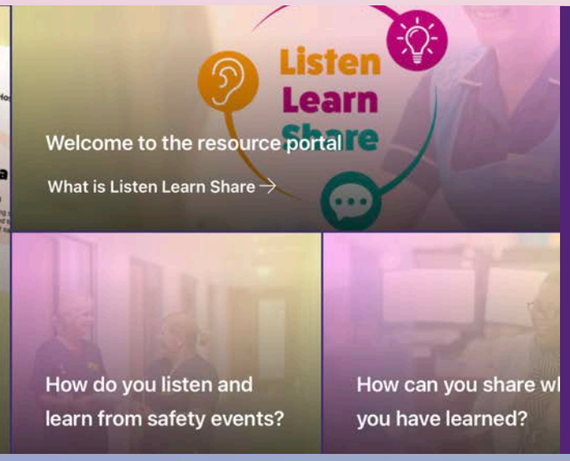
Listen Learn Share

Our organisational approach that promotes open, supportive, and non-judgemental conversations about patient safety events and examples of good care. It aims to foster learning, reflection, and shared improvement so that colleagues and patients benefit from collective experience.





Visit our **ListenLearnShare-ResourcePortal**
A 'one stop shop' of information, resources, templates and shared learning from across the Trust supporting learning from safety events and good care.

Learning Listen Learn Share Ambassador

Why not become a Learning Ambassador for your area.

Learning Ambassadors have an important role in stimulating a learning culture.

They can: offer support, be role models, provide trust and safety, and they can engage in sharing learning with colleagues in their departments, as well as in other areas.

Learning Ambassadors work collaboratively promoting learning from safety events (incidents and good care) both locally and wider across the Trust.

Want to know more about listen Learn Share, or are interested in becoming a Learning Ambassador for or area:
contact the Patient Safety Team e-mail **patient-safety.team@uhb.nhs.uk**