Sherwood Forest Hospitals
NHS Foundation Trust

HOSPITAL OUT OF HOURS POLICY

POLICY

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Approving Body	Urgent & Emergency Care Divisional Clinical Governance Meeting
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Legal and/or Accreditation Implications	Not Applicable
Target Audience	• Hospital Out of Hours Practitioner (HOOHP); • Critical Care Outreach Team (CCOT); • Duty Nurse Manager (DNM); • Medical Registrar; • Medical Junior Doctors; • Surgical Registrar and Surgical Juniors; • Trauma & Orthopaedics Middle Grade and Junior.
Review Date	July 2022 (ext2)
Sponsor (Position)	Chief Operating Officer
Author (Position & Name)	Cheryl Beardsley, Capacity and Flow Matron
Lead Division/ Directorate	Urgent and Emergency Care
Lead Specialty/ Service/ Department	Patient Flow Team
Position of Person able to provide Further Guidance/Information	Capacity and Flow Matron

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	Not Applicable

CONTENTS

1.0 INTRODUCTION

The Hospital Out of Hours (HOOH) Policy sets out the best way to achieve effective and safe clinical care outside of normal working hours. This proposes that within SFHT we have one or more multidisciplinary teams working in the hospital and between them they will have a full range of skills and competencies to meet patients' needs.

2.0 POLICY STATEMENT

The aims of this Policy are to:

- Ensure that acutely ill patients are seen in order of priority and receive effective timely care;
- Facilitate the effective handover of sick patients throughout the hospital;
- Provide support for all team members and reduce the amount of time spent working in isolation;
- Deliver substantive handover arrangements and ensure that all of the staff working at night receive relevant information with regards to higher risk patients;
- Provide senior leadership on site to ensure safe and cohesive site working.

This clinical document applies to:

Staff group(s):
- Hospital Out of Hours Practitioner (HOOHP);
- Critical Care Outreach Team (CCOT);
- Duty Nurse Manager (DNM);
- Medical Registrar;
- Medical Junior Doctors;
- Surgical Registrar and Surgical Juniors;
- Trauma & Orthopaedics Middle Grade and Junior.

Clinical area(s)
- The Policy is applicable to wards within Kings Mill Hospital only.

Patient group(s)
- All adult in-patients.

Exclusions - Areas not covered by Hospital out of Hours service
- Women and Childrens' areas- with the exception of medical/surgical outliers on Gynaecology ward.
- ED and Emergency Admissions Unit.

3.0 DEFINITIONS / ABBREVIATIONS

ALS	Advanced Life Support
CCOT	Critical Care Outreach Team
ED	Emergency Department
DNM	Duty Nurse Manager
HOOH	Hospital Out of Hours
NERVE CENTRE	Refers to IT system supporting Task allocation.
HOOHP	Hospital Out of Hours Practitioner
OUT OF HOURS	Refers to all working out of the perceived normal working hours of 09:00hrs and 17:00hrs.
SFHT	Sherwood Forest Hospitals NHS Foundation Trust
T&O	Trauma & Orthopaedics

4.0 ROLES AND RESPONSIBILITIES

Hospital Out of Hours Co-Ordinator

The Hospital Out of Hours Practitioner (HOOHP) is an experienced registered nurse with a comprehensive range of expanded roles who acts as a senior nurse clinician with the specific role of providing centralised coordination across the hospital while also supporting the clinical team.

One Hospital Out of Hours Practitioner (Band 7) will be on duty from 17:00hrs to 08:00hrs Monday to Friday and 24 hours over the weekends and on all Bank holidays.

The HOOHP will receive and triage all requests for assistance, treatment or care from ward areas and delegate tasks using Nervecentre.

Nervecentre is a real time software programme which enables allocation to the most appropriate available team member.

The HOOHP will coordinate the doctors covering Medicine, Surgery and T&O.
There is a requirement for all doctors to cross cover all divisions to help maintain the safety of the hospital. They are expected to work closely with the HOOHP with an ethos of joint working and collaboration to:

- Support effective governance;
- Utilise protocols, policies and guidelines to inform the decision making process.
- Where appropriately qualified prescribe and administer routine and emergency medications.
- Accessing and utilising computer software to review blood results, x-rays and acting on results.
- Between 08:00hrs to 23:30hrs all automatic escalation and all clinically unwell patients will be triage and managed by CCOT. At 23:30 after handover from CCOT it then becomes the HOOHP responsibility.

- The HOOHP are expected to attend all ART calls, Cardiac arrests and when work load permits trauma calls.

- Mentoring, supporting and educating junior doctors and nursing staff.

- Triaging phone calls/bleeps from wards and prioritising workload.

- Verification of death in a patient where the death was expected.

- Maintain clear channels of communication with the Duty Nurse Manager and CCOT Teams.

- The HOOPH will be the designated ALS-qualified senior nurse with (ALS) on the resuscitation team.

- In the event of Nervecentre system failure the wards will be expected to contact the HOOHP via Vocera or Bleep. The HOOHP will manually document all tasks created during this time and allocate it to the relevant doctor via bleep.

- Where it has not been possible to cover the shift with a fully trained and qualified HOOHP due to vacancy or sickness, an appropriately trained professional will be rostered to cover the shift. This person will not have the full range of extended skills to fully perform the role but will be of a senior enough position to provide coordination to the MDT to ensure site safety.

- In the event of short notice sickness of Hospital Out of Hours practitioner, and where an appropriately trained member of staff is not available for shift, the following action should be taken:
    - Duty Nurse Manager should discuss with Medical Registrar and Silver on Call to identify the person who will be designated to hold Cardiac Arrest Bleep. This person must hold ALS and this should then be clearly communicated to HOOH Team. They will also need to identify someone to oversee the allocation of 'tasks' through Nervecentre – in the absence of a suitably qualified Nurse, this may be the Medical Registrar or their designated representative.

Critical Care Outreach Team

A CCOT service will be provided until 23:30.

One CCOT nurse (Band 6) will be available from 08:00hrs to Midnight, responding to any triggered calls for assistance, as per the Observation and Escalation Policy (Feb 2017), and following up any patients who are currently under their care.

All triggered calls are recorded on the CCOT 'call log'. All interventions are recorded on the CCOT section of the Orion database.

The CCOT will stop taking triggered calls at 23:30hrs. This will facilitate time for the handover of any current patients under their care to the HOOHP at 23:30hrs and completion of relevant data input prior to leaving at midnight.

If the CCOT nurse is occupied with a patient at 23:30hrs, the HOOHP will locate the CCOT nurse to facilitate handover in a timely manner.

If, due to unexpected sickness where no cover can be provided by CCOT from 08:00hrs-Midnight, the Duty Nurse Manager will be informed.

Duty Nurse Manager

The DNM has operational responsibility for the Trust, monitoring activity levels and waiting times in ED.

Determine the best skill mix and relocate staff as necessary to maintain a safe environment of care.

The DNM would be responsible for having an overview of Trust staffing and is the nominated Fire Officer out of hours.

He/she is also responsible for escalating situations up to the relevant manager on-call and will retain their specific role as set up in the major incident policy.

Out of Hours Doctors

It is required for speciality clinical teams to attend a handover to achieve the efficient transfer of good quality and timely clinical information.

All doctors are required to log onto Nervecentre at the beginning of the shift, they should contact the HOOHP if this is not possible. It is the responsibility of the doctor to ensure that during their shift they remain logged onto system.

Handover will be supported by the Nervecentre System and attendance is mandatory for all Out of Hours clinicians.

Nervecentre provides visibility of tasks requested by ward staff, their urgency, and allows the allocation of tasks showing staff available to complete them in real time, hospital wide. It generates an overview of activity that gives the Trust an accurate picture of what is happening across the hospital out of hours. This feeds into a wide range of activities that support safety, quality and resource allocation.

User Guides including one for Hospital at Night can be accessed via the Trust's Nerve Centre Intranet

Wards

- Responsible for identifying patients that require an intervention during out of hours period on Nervecentre.

- The Trust's Observation and Escalation Policy (April 2018) will be followed as described above.

- All clinically unwell patients will be referred through to CCOT between the hours of 08:00hrs to 23:30hrs using either automatic escalation, Vocera or bleep 888. Outside of these hours they will be referred to HOOHP.

- Generating tasks using the Task Request HOOH application on the computer. All tasks that require a urgent response should be followed up with a bleep on 620 or Vocera.

- An SBAR handover will be provided, that will ensure that all relevant details are systematically communicated in an efficient way to the CCOT/HOOHP, saving time and using valuable resources effectively.

- A member of the ward team will document in the nursing and/or medical record any direct verbal communication between the ward staff and CCOT/HOOHP nurse.

- For a member of the ward team to provide a baseline assessment for CCOT/HOOHP on arrival to the ward

- Wherever practicable, the ward-based nurse will stay with the CCOT/HOOHP nurse to provide assistance with the deteriorating patient, but also for training and education purposes.

S – Situation – What is happening at the present time?
B – Background – What are the circumstances leading to this situation?
A – Assessment – What do I think the problem is?
R – Recommendation – What should we do to correct the problem?

This should include recent observations of respiratory rate, manual pulse rate, blood pressure, temperature and NEWs score. If it is appropriate, an ECG should be also be done.

Clinical Support Worker

The Clinical Support Worker will work alongside the HOOHP providing support with venepuncture, cannulation, ECG recording and catheterisation.

To attend all cardiac arrests when workload permits.

5.0 APPROVAL

- Following consultation, this policy has been approved by the Urgent & Emergency Care Divisional Clinical Governance Group

6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

Please see tables below for timeline.

24 Hour Site Profile – Monday to Friday

08:00 to 20:00	Normal Site Working	• All teams in speciality areas. • Board rounds am and pm. • Consultant Ward Rounds. • Bed Meetings to assess Trust status 08:00hrs, 11:00hrs, 15:00hrs, 18:00hrs, 20:00hrs. • 13:00hrs meeting if Trust is on Red or Black Alert.
08:00	Duty Nurse Manager Handover to Silver on Call	• Accountability handover from night to day site management. • Handover any patients that are at risk due to mental health or lack of capacity. • Review of safe staffing – allocation of Virtual Ward.
12:30	Clinical Site Briefing – Weekends and Bank Holidays	• Identify all patients flagged as sick. • Review tasks outstanding. • Ensure plans handed over from previous shift have had appropriate actions.
20:00	Handover from Day to Night Silver on Call	• Accountability handover from night to day site management. • Handover any patients that are at risk due to mental health or lack of capacity. • Review of safe staffing – allocation of Virtual Ward.
20:00	Hospital Out of Hours Handover – Surgery and Trauma & Orthopaedics	• Surgical handover will take place on SAU – attended by Registrar and Junior Doctors. • Handover between the day and night staff is mandatory. • Handover will be led by NTL in conjunction with Specialist Registrar/middle grade to assess workload, address any relevant issues and re-deploy team. • Robust handover of patients identified as requiring further assessment/monitoring – this should include as a minimum; patient name, ward, age/DOB, Consultant, clinical detail, investigations required/done, outstanding jobs.

24 Hour Site Profile – Monday to Friday

20:30	Hospital Out of Hours Handover - Medicine	• Medical handover will take place on EAU – attended by Registrar and Junior Doctors. • Handover between the day and night staff is mandatory. • Handover will be led by NTL in conjunction with Specialist Registrar/middle grade to assess workload, address any relevant issues and re-deploy team. • Robust handover of patients identified as requiring further assessment/monitoring – this should include as a minimum; patient name, ward, age/DOB, Consultant, clinical detail, investigations required/done, outstanding jobs. • Handover to take place on EAU.
23:30	Hospital Out of Hours Practitioner Will Take Handover from CCOT	• Handover from CCOT who finishes at midnight. • The CCOT will stop taking triggered calls at 23:30hrs and will hand over to the NTL at 23:00hrs to facilitate shift completion at midnight
07:45	Handover to Day Time CCOT	• The HOOHP will handover to CCOT at 07:45hrs.
08:00	Night to Day Handover	• Handover of sick patients to day teams. • Speciality teams ensure sick and new admissions are considered.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Datix incidents submitted for non-attendance when requested	Capacity and Flow Matron	Via Datix	Ad hoc – as each individual incident arises	Reported through the respective committee/ governance structure depending on issue identified.

8.0 TRAINING / COMPETENCY AND IMPLEMENTATION

The list of roles will be used as the guide to formulate a successful induction programme. The roles are a minimum set required to achieve safe and effective clinical care and must be underpinned by a programme of education to support continued professional development of the Hospital out of hours nursing workforce. This means patients will have timely enhanced co-ordinated care and doctors in training will have the support of clinically competent, senior nursing colleagues.

Advanced Life Support – Hospital Out of Hours Team Leader will be designated person within cardiac arrest team with ALS.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix C
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix D

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- The original "Hospital at Night Operational Plan Project" which this policy has subsequently evolved from was developed in response to the European Working Time Directives for Junior Doctors. The Royal College of Nursing and British Medical Association had previously endorsed the Hospital at Night (H@N) care model.

Related SFHFT Documents:

- Observation and Escalation Policy for Adult Inpatients
- Nervecentre User Guide for Hospital at Night

11.0 KEYWORDS

HOOH; HOOHP;

12.0 APPENDICES

Appendix A – Generic Roles for a Hospital Out of Hours Practitioner – Skills for Health

Appendix B – Competency Framework for Hospital Out of Hours Practitioner

Appendix C – Equality Impact Assessment

Appendix D – Environmental Impact Assessment

Appendix A

Generic Roles for a HOOHP – Skills for Health

PHYSICAL

1. Take a presenting history from an individual to inform assessment.
2. Obtain supporting information to inform the assessment of an individual.
3. Undertake physiological measurement - utilise NEWS to assess physical status and determine the level of care required.
4. Assess an individual's health needs and status; cardiovascular, respiratory, abdominal, neurological.
5. Perform non- invasive monitoring to obtain physiological measurements; respiratory rate, blood pressure, pulse, temperature, pulse oximetry, continuous electrocardiograph.
6. Refer individuals to appropriate member of Hospital at Night team for further assessment.

TECHNICAL

7. Carry out arterial puncture and collect arterial blood.
8. Obtain venous blood samples.
9. Initiate laboratory clinical tests and correctly interpret results i.e. Biochemistry, haematology, coagulation screening
10. Requesting radiological examination e.g. chest, abdominal x-ray
11. Perform 12 lead electrocardiographs.
12. Establish a diagnosis of an individual's health condition.

CLINICAL RESPONSIVENESS

13. Review presenting conditions and determines the appropriate intervention for the individual
14. Review patents presenting with altered consciousness, dizziness, faints and fits
15. Review patients with altered body temperature
16. Review patients presenting with reduced urinary output
17. Review patients who have fallen

THERAPUTIC INTERVENTION

18. Administer pharmaceutical interventions
19. Develop and agree treatment plans for patients;
20. Provide first aid
21. Provide basic life support
22. Provide intermediate life support for adults
23. Provide advanced life support for an individual
24. Perform automated external defibrillation
25. Perform manual external defibrillation of an adult
26. Recognise indications for oxygen therapy
27. Administer medication
28. Monitor individual whilst in transit to the critical care environment
29. Support individuals who are distressed, support individuals through bereavement

TECHNICAL SKILLS TO SUPPORT THERAPEUTIC INTERVENTION.

30. Perform intravenous cannulation.
31. Insert and secure urethral catheters and monitor and respond to the effects of urethral catheterisation

CARE CO-ORDINATION

32. Receive requests for assistance, treatment or care.
33. Prioritise individuals for treatment and care following assessment. Refer individuals for further assessment, treatment and care
34. Capture and transmit information using electronic communication media.
35. Prioritise the interventions to be performed for an individual.
36. Transfer individuals to other locations for further assistance, treatment or care
37. Prepare the equipment and instrumentation required to support an intervention
38. Discharge an individual from a service of your care
39. Verify an expected death.

CLINICAL GOVERNANCE

40. Delegate duties to team members, as appropriate.
41. Determine best skill mix and relocate staff as necessary to maintain a safe environment of care
42. Support effective governance; utilise protocols, guidelines etc to inform the decision making process
43. Promote and maintain health, safety and security in the working environment
44. Manage risk in clinical areas.
45. Monitor and handle customer care issues.
46. Contribute to promoting the effectiveness of teams
47. Take responsibility for the continuing professional development of self and others

PROFESSIONAL, LEGAL AND ETHICAL DIMENSIONS

48. Ensure your own actions support the quality, diversity, rights and responsibilities of individuals
49. Act within the limits of your competence and authority.

TRAINING

50. Advanced Life Support
51. Clinical assessment course
52. None medical prescribing
53. Verification
54. Advanced Neuro assessment
55. Arterial Blood Gases
56. Minor injuries
57. Cannulation and Venepuncture

Appendix B

Competency Framework for a HOOHP

Introduction

The minimum set of competencies required to achieve safe and effective clinical care has been set out by Staffordshire University & NHS West Midlands Workforce Deanery in partnership with Skills for Health. These comprehensive competencies have been set up nationally and because of this there is national ownership. The framework will be adapted to formulate a suitable model for King's Mill Hospital.

This guidance will be used to ensure that the HOOHPs are equipped with the necessary skills to perform in their role effectively and sustainably.

This is the nursing competency required.

Minimum Competencies

The minimum competencies required highlighted as follows:

1. **PHYSICAL ASSESSMENT**
   Performing a comprehensive physical assessment and performing non-invasive monitoring to obtain physiological measurements.

2. **TECHNICAL SKILLS/ INTERVENTIONS TO SUPPORT THE ASSESSMENT PROCESS**
   Interpreting routinely performed diagnostic tests.

3. **CLINICAL RESPONSIVENESS – SENIOR PRESENCE FOR CLINICAL ISSUES**
   Responding to a request for patient review and determining appropriate interventions. The range of presenting conditions refers to the patients' physical health/illness status.

4. **THERAPEUTIC INTERVENTION**
   Represent actions dependent on whether the Nurse is licensed as a prescriber and also takes into account a requirement for the Nurse to work within their Trusts clinical governance framework regarding prescribing practice.

   The psychological intervention of providing emotional support to the family who are distressed and /or bereaved has been incorporated into the domain of therapeutic intervention

5. **TECHNICAL SKILLS TO SUPPORT THERAPEUTIC INTERVENTION**
   Represents actions that will support the Nurse in the delivery of an intervention, for example, perform urethral catheterisation.

6. **CARE CO-ORDINATION**
   This domain has been developed to capture the co-ordination function of the HOOHP role. Emphasis is placed on clinical as opposed to managerial interventions. Competence statements specific to the co-ordination of patient care have been incorporated. This includes competence statements referring to the internal and external transfer and discharge of individuals. A comment has been included about

receiving and transmitting information on health status of individuals by electronic communication media. This is to embrace the important role of the HOOHP in receiving and transmitting information regarding the clinical status of individuals using electronic communication media. This is in addition to the role of bleep filtering and the subsequent actions of prioritising care and co-ordinating team activities.

7. CLINICAL GOVERNANCE

This domain incorporates competence statements that seek to safeguard high standards of care through quality improvement activities.

8. PROFESSIONAL, LEGAL AND ETHICAL DIMENSIONS

To reflect the professional role of the HOOHP in meeting standards for performance, conduct and ethics.

9. TRAINING & STAFF SUPPORT

Management of clinical support workers ensuring compliance with appraisal and mandatory training.

APPENDIX C – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Hospital Out of Hours Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 25.10.18			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	No	Trust HR Policy, Recruitment & Selection Policy	None
Gender	No	Trust HR Policy, Recruitment & Selection Policy	None
Age	No	Trust HR Policy, Recruitment & Selection Policy	None
Religion	No	Trust HR Policy, Recruitment & Selection Policy	None
Disability	No	Trust HR Policy, Recruitment & Selection Policy	None
Sexuality	No	Trust HR Policy, Recruitment & Selection Policy	None
Pregnancy and Maternity	No	Trust HR Policy, Recruitment & Selection Policy	None
Gender Reassignment	No	Trust HR Policy, Recruitment & Selection Policy	None
Marriage and Civil Partnership	No	Trust HR Policy, Recruitment & Selection Policy	None
Socio-Economic Factors (i.e. living in a poorer	No	Trust HR Policy, Recruitment & Selection Policy	None

neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- Consultation has taken place
- This policy replaces the Hospital at Night Operational Policy and it now includes information regarding Task Manager and Nervecentre. It clarifies tasks, activities and the knowledge and clinical skills required by appointed staff to these posts. All appointments are subject to the Trusts HR Policy, Recruitment & Selection Policy and these have been subjected to EQUI in respect of persons within the protected characteristic groups.

What data or information did you use in support of this EqIA?

- Previous version of the Hospital at Night Policy which this replaces. Documented consultation previously undertaken for Trusts HR Policy, Recruitment and Selection Policy.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Alison Clarke on behalf of Cheryl Beardsley

Signature:

Alison Clarke

Date:
25:10:18

APPENDIX D – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	