Clinical Review, Hospital at Night and Handover Policy

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### DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust
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1 Executive Summary

This policy has been developed to ensure that the Trust has in place a systematic approach for the appropriate and timely review of all patients and for the handover of patients from one clinical team to another, both at shift change for junior doctors and for consultants at the time of change of an on-call period.

The policy has been developed to ensure that there is specific understanding of:

- What is regarded as timely review of all new admissions
- Who should undertake and the timing of subsequent clinical reviews
- Principles and process for the Hospital at Night Team
- Who is required to attend handover
- What is the designated time for handover
- What is the designated venue for clinical handover
- What is the structure for how clinical information is communicated, recorded and retained.

2 Introduction

Appropriate and timely assessment and review combined with accurate recording of clinical information is vital to patient safety. Furthermore, it is essential to ensure that critical information is effectively communicated between individuals and clinical teams. This is particularly important when services go into out-of-hours period, to ensure the most vulnerable and high risk patients are handed over effectively. This is when the principles of Hospital at Night (H@N) come into place.

With a reduction in junior doctors hours and increasing sub-specialisation, the number of individuals potentially caring for a patient during their hospital stay has increased. The need for comprehensive handover of clinical information has become more important than ever.

The NHS England, supported by Health Education England and the Royal College, have called for greater consultant involvement and presence in the hospital at the weekends and outside of normal working hours with the aim of improving patient outcomes and to enhance the training of the next generation of NHS professionals. This has led to what is now known as the 10 Keogh Standards for seven day working and includes the following;

1) Patient Experience

Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and
social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

2. Time to first consultant review
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible (adhering to agreed college national standards) but at the latest within 14 hours of arrival at hospital.

3. Multi-disciplinary Team (MDT) review
All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.

4. Shift handover
Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

5. Diagnostics
Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week:
- within 1 hour for critical patients;
- within 12 hours for urgent patients; and
- within 24 hours for non-urgent patients

6. Intervention / key services
Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as:
- critical care;
- interventional radiology;
• interventional endoscopy; and
• emergency general surgery.

7. Mental health
Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week:
• Within 1 hour for emergency care needs
• Within 14 hours for urgent care needs

8. On-going review
All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

9. Transfer to community, primary and social care
Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken.

10. Quality improvement
All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Handover of care is one of the most perilous procedures in medicine and when carried out inadequately, can be a major contributory factor to subsequent error and harm to patients.

3 Definitions
• Clinician – a health professional with responsibility for direct patient care
• **Shift** – the period of work in which there is a designated responsibility to provide care
• **Handover** – transfer of key issues, tasks and changes in management plan from one care professional to another.
• **Plan of care** – the plan for the particular patient which should always be recorded in the patient care record or notes
• **Key tasks** – important tasks which must be undertaken within the period of responsibility for care.
• **Record of handover** – a record of the team members participating in handover
• **Handover summary sheet** - a list of patients/tasks to be handed over
• **Senior decision making clinician** – a consultant, specialist registrar or core trainee / speciality doctor with an appropriate higher professional qualification.

4 **Scope**

This policy specifically applies to the assessment and review of emergency admission, the inpatient review of elective admissions and to the handover between shifts/H@N in relation to the medical care of patients.

It applies to all situations where clinical care is transferred from one healthcare professional to another while the patient remains in the same care environment.

5 **Purpose**

The purpose of this policy is to provide a determination of:

• The standards for the assessment and review of emergency admission and the continuity of care during an acute care episode.
• The standards for the review of elective admissions.
• The standards of handover which must be delivered by individual clinicians and clinical teams.
• A high level structure and approach to handover, while facilitating the innovation and development of handover processes which are the most effective for each group and clinical area.

6 **Roles and Responsibilities**

Individuals and organisations have a shared responsibility to ensure that effective communication lies at the very heart of good patient care. The regular clinical review and handover is a vital aspect of continuity of care and the continuity of information
is vital to the safety of patients. All staff providing clinical care are responsible for complying with the policy.

Executive Medical Director:
The Executive Medical Director will be responsible to the Trust Board for ensuring Trust wide compliance with this policy.

Clinical Directors:
Clinical Directors are responsible to the Executive Medical Director for implementation of the policy and ensuring there is a process for handover of patients at each change of junior and senior doctor period of responsibility within their clinical areas.

Clinical Leads:
Clinical leads will ensure at service level they have a clear and written process for handing over patients between takes/shifts, ensuring timely review by a senior Doctor when indicated on admission and during a patients admission and ensuring local service processes feed into the H@N team as needed.

Consultants
On-call consultants are responsible for ensuring that all patients admitted during their on-call period are reviewed, clinically assessed and appropriate investigations are initiated and acted upon. This should also ensure that inter-consultant referrals are acted on in timely fashion. Consultants should ensure that all new admissions have a Consultant review within 14 hours of admission. All patients should have a consultant-agreed management plan. Consultants are responsible for responding to cases of escalation to ensure appropriate review takes place in the event of deterioration and that plans of care are communicated to the team out of hours.

Speciality Registrars, Speciality Doctors and Associate Specialists:
On-call Speciality Registrars and Staff Grades are to ensure that an accurate record of patients admitted is maintained, and that there is a plan of care for each patient. This should include location for treatment, name of the responsible Consultant and detail or working diagnosis and a management plan. They are to attend an appropriate handover meeting at each shift change. They should escalate to the consultant on-call any clinical issues that need more urgent assessment and intervention.

Middle grade doctors, not on-call should handover to the on-call team any patients requiring clinical review by the on-call team. Direct face-to-face handover should be the norm.
**Foundation Year Doctors:**
On-call Foundation Year Doctors and core trainees or equivalent Doctors are to see all patients admitted during their on-call period other than those seen directly by a more senior Doctor and to ensure that ALL patients are reviewed by a Speciality Registrar, Staff Grade or Consultant in a timely fashion. They are to keep a record of key tasks for each patient. They are to attend the handover that takes place at the operational hub, at the agreed times. During this time, handover of patients will take place, as well as handover of tasks to be completed or results to be reviewed by the on-call team. Foundation Year Doctors must respond to tasks allocated by the Clinical Coordinators at night and ensure that these are completed in a timely way or escalated back to the coordinator if not completed.

**Critical Care Outreach Service (CCOS):**
The day CCOS Practitioner will track at risk and sick patients and will prepare a list of these patients ready for the oncoming Advanced Practitioner (AP) from CCOS. Any patients on the CCOS list requiring attention and/or review will be handed over at the H@N meeting. The outgoing CCOS AP will prepare an updated list of these patients ready to handback to the oncoming day CCOS Practitioner.

The H@N/CCOS AP has a generic skills set and will work across the whole of the acute hospital. Their workload is determined by patient and clinical priorities that present during the night.

**Hospital at Night Clinical Coordinators**
The Hospital at Night Clinical Coordinators will be responsible for chairing the Hospital at Night meeting and auditing attendance. At night the coordinators will receive all clinical bleeps and triage the calls and allocate the task to the most appropriate member of the Hospital @ Night team. The filtering of the bleeps should ensure the right person is allocated appropriate tasks to ensure effectively and timely safe care for patients. The Coordinator will be responsible for escalating significant concerns to the Senior Manager on Call, if required.

**Clinical Site Managers**
The Clinical Site Managers are responsible for maintaining over all safety of the site out of hours and ensure patient flow is optimal. All site issues, other than clinical bleeps, will be sent via the clinical site managers who will maintain full site overview and safety to include escalation to Senior Manager on Call when required. The Clinical site manager will update the team during the Hospital @ Night handover of the current status and situation on the organisation.

**7 Policy Detail/Course of Action**
Each Clinical Business Unit must ensure departments within it have an agreed process for timely review of patient’s and handover occurring within their area. The timing and frequency of clinical review should be governed by the clinical condition of the patient. The following is a minimum standard that must be adhered to.

### 7.1 Timing of clinical review

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible (adhering to agreed college national standards) but at the latest within 14 hours of arrival at hospital (Keogh Standard 2). A suitable consultant is one who is familiar with the type of emergency presentations in the relevant specialty and is able to initiate a diagnostic and treatment plan.

All admissions should be reviewed by a consultant on the post-take ward round. This applies both on weekdays and at weekends and can be delegated by the named consultant to a suitable qualified doctor on a named patient basis. The consultant should be made aware of any decision and available for support if required (Keogh Standard 8).

Patient review should take place in line with the National Early Warning Scoring System and care should be escalated as dictated by the system to ensure timely review and escalation of care.

### 7.2 Clinical handover

Each Clinical Business Unit must ensure departments within it have an agreed process for handover occurring within their area. Each professional group must agree and document their specific processes in relation to:

- Who is required to attend handover
- Who is leading handover
- What is the designated time for handover
- What is the designated venue for clinical handover
- What is the structure for how clinical information is communicated, recorded and retained

It is important that each area has a mechanism of recording that handover has occurred and that the agreed items are being handed over effectively between shifts. There should be a team-based record of all patients discussed at each handover meeting and a list of which clinicians attended.

All records of handover should be retained for **6 months** and each department or clinical business unit must agree how they will ensure this happens, such that the
records are available for audit and review. This can be done via the handover function on E-Carelogic.

It is essential that all information relating to a plan of care for any patient is recorded in their clinical record and kept up to date.

Due to the patient specific information contained on handover sheets it is vital that confidentiality is maintained and therefore the sheets must be disposed of in confidential waste at the end of use and it is the responsibility of each member of staff to do so.

Weekends present a period of increased risk to patients when the normal clinical team caring for a patient may not be available. It is essential that high standards of patient handover are maintained and consideration should be given to use of the Weekend handover form (Appendix A and Appendix B).

**Weekend Bloods:**
- The responsible inpatient clinical teams on Friday will assess patients that require bloods to be taken over the weekend and leave out a completed form ready for the weekend. Attention must be paid to the clinical need for bloods and if results are required for over the weekend to influence treatment plans or facilitates discharge. If not, these bloods should wait until Monday.
- The responsible inpatient clinical teams that make request for bloods over the weekend must ensure they have communicated the need to review these bloods with the relevant on call team – otherwise bloods will be taken and not reviewed.
- The clinical assistant from critical care outreach will undertake these requested blood tests on the wards over the weekend.
- If the clinical assistant finds duplication of requests they will discuss this with the on-call medical team to avoid unnecessary blood tests.

**7.3 Interconsultant referrals**

Referrals between consultants form an important part of patient care. Clinical situations requiring assessment by a consultant of another speciality within 24 hours of the request should be made via direct discussion by a senior decision making clinician. Less urgent referrals should be made by the use of the interconsultant referral form. These should be signed by the requesting consultant and should be very specific as to the reason for referral. In the absence of the consultant signing the form there should be a clear note that the consultant has consented to the referral. A record of the Interconsultant referral form should be kept on e-care logic.
If there is a request for the patient to be transferred to the care of another consultant, the patient should remain under the care of the consultant initiating the referral until the patient has been reviewed and the receiving consultant has agreed to accept the patient. This must be clearly documented in the patient’s notes.

Patients accepted to the Intensive Care Unit (ICU) remain under the care a referring consultant.

It is the consultant’s responsibility to look after patients under the care of our Trust. All patients will be admitted under a named Consultant. It is against the principles of Good Medical Practice to deny a patient care because they have do not clinically belong to someone. When the responsibility for ownership of a patient is not clear all those who have been consulted have a duty to resolve quickly the issue of ownership. In this case the patient will be allocated to the Consultant on-call for the condition requiring emergency admission. This includes those patients that are admitted with an emergency surgical condition that are not going to theatre. These patients will be admitted under the relevant surgical team and then, if appropriate, referred by the Consultant surgeon on their post take ward round to an inpatient medical Consultant. If accepted they will be transferred to the relevant Medical Consultant’s care.

In the case of ED patients with conditions that are usually managed in tertiary centres the Trusts Consultant teams will need to agree which relevant speciality will care for the patients admitted through ED while they await transfer for a bed in another hospital. Patients that do not require to remain in ED must be accepted and cared for while they await transfer. The Group Director for Urgent & Emergency Care and Medical Director or Deputy will be the final arbitrator if required.

8 Hospital at Night (H@N)

The H@N team facilitates effective clinical care at night, from the hours of 20:00 and 08:00 and at the weekends. The H@N team consists of a multi-disciplinary team who have the range of skills and competencies to meet the patients’ immediate needs. The H@N team aim to improve and maintain patient safety and clinical effectiveness during the out-of-hour’s period. All Trust policies and procedures, in line with clinical governance must be adhered to at all times. Regular audit will include handover attendance, out-of-hours ICU transfers, and transfer of patients between wards out-of-hours, bleeps at night and responsiveness and referrals to the CCOS AP.
• H@N Handover takes place in the conference room on level B at 21:00-21:30hrs. The handover in the morning will take place at 08:00 – 08:30 in the same location. The meeting will be chaired by the H@N Clinical Coordinator.
• On arrival at the beginning of the H@N shift, all members will sign in and confirm bleep numbers on the ‘sign in sheets’.
• During handover, H@N team members will discuss and agree any specific responsibilities for the shift, noting skill mix/experience of team members in the event of any specific issues.
• Urgent work will be prioritise and allocated accordingly.
• Specialties will hand over specific patient cases and work for the night ahead.

8.1 H@N team

The competence of the H@N team members and the appropriate delegation of clinical duties are vital to the success of the team on duty. The Medical SpR on duty will be the clinical leader for the team.

• Clinical Site Co-ordinator – H@N Leader for the Night (bleep 200)
• Medical SpR – (bleep 911)
• Medical Doctor on call (bleep 912)
• Surgical SpR (on call) (available via switch board)
• Surgical/Orthopaedics/Gynae/ENT/Urology - FY2 (contact switch board for bleep number)
• Advanced Practitioner/ Critical Care Outreach (bleep 006)
• Hospital at Night Clinical Coordinator (bleep 086)
• First-On-Call Anaesthetist (bleep 787)
• Critical care outreach clinical assistant (bleep 044)

8.2 Handover

During handover, clinical duties will be allocated to the most appropriate member. Post-handover, from the hours of 22:00 and 07:00, the Clinical Coordinator via bleep filtering will delegate duties according to who is available and has the competency to carry out the duty. This excludes the first on-call anaesthetist and the surgical and orthopaedic registrars on call.

• Clinical Business Units within Medicine and Surgery included in the H@N arrangements must ensure that their members attend H@N handover.
• At H@N handover, the outgoing staff are required to give a verbal report and written details of patients who require monitoring or treatment using the
standard pro forma, available via the allocated computer in the Medical Assessment Unit (MAU).

- The CCOS AP will have an updated list of at risk/sick patients to inform the H@N team of any concerns or patients that need a senior review overnight.
- Only emergency bleeps will be responded to during the handover time (20:00hrs – 20:30hrs).

8.3 Bleeps

H@N works on a basis of bleep filtering between the hours of 22:00 and 08:00, via the Clinical Coordinator (bleep 086). This supports better communication between clinical staff, ensuring that patients are prioritised appropriately and seen by the right person at the right time (Appendix E). This system also provides the additional benefit of an audit trail, providing data which can support business cases for further training and resources in line with patient need. Only emergency calls will be answered during the handover period.

Any team member receiving inappropriate calls from the wards should redirect them to the Clinical Coordinator.

- From the hours of 22:00 - 07:00hrs, calls from the wards will be to the Clinical Coordinator via the bleep 086. The clinical coordinator will delegate the task to the appropriate team member and will themselves communicate to that individual regarding the task.
- Wards will not contact the Medical or Surgical Team direct; except for emergency calls '2222'.
- Internal and external referrals between medical and surgical staff will go directly to the referring speciality from the referrer. Medical and Surgical teams must inform the clinical coordinator of all external referrals accepted out-of-hours.
- Bleeps for the CCOS Clinical assistants should be made direct to them on bleep 044. These bleeps should be recorded and audited.

8.4 Process at Handover Meeting

The handover will start at 21:00hrs promptly. IT facilities will be available. It is the responsibility of each speciality to present a paper copy (when available) of the day intake and at risk patients. This should include patient’s name, patient’s date of birth patient’s IW number and diagnosis. The Standard operating Procedure for the handover meeting is available in Appendix C. The process consists of:

- Introductions and attendance (Appendix D)
• Clinical Site manager will provide an overview of the hospital capacity – including patients awaiting ward beds in the Emergency Department (ED).
• Surgical patients handover first, followed by medical patients
• Handover of unwell patients (including CCOS list of at risk/sick patients)
• Handover of newly admitted patients
• Handover of outstanding tasks (not routine tasks)

8.5 Patient Reviews out-of-hours

From the hours of 21:00 and 08:00, the Clinical Coordinator will delegate tasks according to who is available and has the competency to carry out the duty. Therefore, there may be occasions when team members will be asked to work outside their individual speciality.

All patients should have an escalation plan clearly documented on their medical notes. If a patient becomes acutely unwell and has a high NEWS score, CCOS will be made aware by the Clinical Coordinator.

• Ward patients will generally be reviewed by the AP, who will decide on the best course of action and/or management plan for the patient.
• The AP will refer to the SpR as necessary.
• Referrals to the ICU out-of-hours should be made between consultants. However, the assessment/ triage might be completed by the ICU resident, or the Advanced Critical Care Practitioner (ACCP) or the ICU Consultant.

8.6 Specific clinical areas

Labour Ward

• There is agreement that the on-coming consultants will physically attend labour ward at 08:30hrs (at 12:30hrs if there is a change of consultant) and at 16:30hrs. They will do an Obstetric and Gynaecology ward round at 08:30hrs as well as reviewing patients during the day.
• The off-going Consultant; will handover verbally at 16:30hrs, even if there is nothing going on in Obstetrics and Gynaecology.
• The SpR calls the on-call consultant at 21:00hrs to tell them what is going on.

Critical Care

• Referral to ICU should happen on a consultant to consultant basis. If the referral is from the Emergency Department the specialty consultant should be involved.
• For details please read the ICU Admission and Discharge Policy.
• All patients on ICU should be reviewed by the referring consultant at the latest 14 hours after admission to ICU, and on a regular basis as needed while on ICU and again latest 14 hours post discharge from ICU.
• It is the responsibility of the referring consultant to request transfer of care to a different consultant. The patient remains under the care of the referring consultant until the new consultant has formally accepted the patient and this has been documented in the notes by the referring or accepting team.
• All level 2 and 3 patients will be reviewed twice daily by an ICU consultant.
• Patients with primarily medical conditions that are admitted to ICU, if the patient is admitted between 0800-2000 they must receive a post take Consultant review by the Acute Medical Consultant nominated for the Acute Take on that day. They will remain under their care until the following day when they will automatically be transferred to the Physician on-call Consultant for the day of the admission.
• If the patient’s care would be more appropriately overseen by another specialist, this should be agreed between the referring consultant and the ICU consultant. An interconsultant referral requesting transfer of care will be made by the referring consultant.
• Should the referring consultant not be available it is their responsibility to nominate a deputy/hand over care. If a patient is admitted to ICU under a short-term locum medical consultant who then leaves the Trust, ownership of the patient should be transferred to the consultant on-call the following day.
• If an Acute Medicine Consultant is the physician on-call the subsequent ownership of the patient will go to the physician who is on-call the following day, as above and the ICU team will inform that Consultant.
• The patient remains under the care of the referring consultant until the new consultant has formally accepted the patient and this has been documented in the notes by the referring or accepting team.
• All level 2 and 3 patients will be reviewed twice daily by an ICU consultant.
• Once a patient’s ACP (augmented care period) has ended, the referring consultant/team will be informed. All level 1 and 0 patients (ACP ended) who remain on ICU for logistic reasons will remain under the care of the referring consultant and should be reviewed by the referring consultant or their team on a daily basis.

Emergency Department

• These standards for the Emergency Department are based on the recommendations from NHS Improvement via the Emergency Care improvement work stream.
• A senior emergency department (ED) decision making clinician will see new patients on or as close to arrival as possible in the ED.
• The ED team will not admit a patient likely to be able to go home just to avoid a breach of the emergency care standard.
• Specialities will have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and must not insist on ED based investigations that do not contribute to the immediate management of the patient.
• Patients referred from primary care (or any other clinical service) should be routed directly for specialty assessment via the operations centre. If this does not occur and the patient attends the ED, the patient will be transferred to the specialty considered most appropriate by the ED team unless immediate medical intervention is required.
• Patients will only be sent to the ED as a result of advice by speciality teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. The ED team will provide clinical support to patients within the resuscitation area in conjunction with the specialty to whom the patient was referred. In order to do this the ED team must be informed by the team to whom the patient was referred in advance and the specialty team will attend immediately the patient arrives.
• Transfer patients from Critical Care will take priority in in-patient bed allocation over and above any other calls for that available bed.
• No speciality will refuse a request to assess any ED patient. If subsequently it is considered that an alternative speciality would provide more appropriate care, it is the responsibility of the first speciality (and not the ED team) to arrange the transfer. The ED team will continue to provide clinical support to patients within the resuscitation area. The Baton can only be passed forward.
• The ED team will highlight any patient recently discharged from an inpatient admission or under current investigation or treatment for assessment by the suitable specialty and refer as appropriate. This should help the speciality team to avoid unnecessary admissions.
• If there is a failure for different specialties to agree on accepting a patient within 45 minutes post referral time, the ED consultants have the authority to admit any patient to any level one bed in the speciality that they consider best able to meet that patient’s clinical needs.
• All specialities must ensure that they inform the ED Nurse in Charge and/or the responsible ED Doctor of any actions required and key information such as infection control issues

9 Consultation

This policy has been shared via all stake holder groups to gain agreement and approved via the current recognised governance committees.
10 Training

This Clinical Handover Policy does not have a mandatory or non mandatory training requirement.

11 Monitoring Compliance and Effectiveness

The areas that will be monitored and audited for compliance with this policy and local processes will be broken down into three areas, clinical review of patients, clinical handover of patients and hospital at night.

11.1 Hospital at Night (H@N)

These measures will be monitored monthly by the CCOS and the Bed Management Team:

- Attendance at the daily hospital at night handover meeting (Appendix C)
- Out-of-hours (after 20:00hrs and 22:00hrs) ICU transfers back to general ward areas
- Transfer of patients between wards out-of-hours
- Referrals to the CCOS AP.

12 Links to other Organisational Documents

- Intensive Care Unit Admission and Discharge Policy
- Emergency Department Crowding Policy

13 References


National Confidential Enquiry into Patient Outcome and Death (2005) *An Acute Problem*. NCEPOD.


14 Appendices

Appendix A  Surgical Weekend handover form
Appendix B  Acute Weekend handover
Appendix C  Night Handover Standard Operating Procedure (SOP)
Appendix D  Hospital @ Night Sign in Sheets
Appendix E  Financial and Resourcing Impact Assessment on Policy Implementation
Appendix F  Equality Impact Assessment (EIA) Screening Tool
## Weekend handover form

<table>
<thead>
<tr>
<th>Surgical Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weekend Handover</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary/Working diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weekend plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Estimated date of discharge</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ongoing issues</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DNA/CP order in place</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESULTS TO BE CHECKED (please state)</td>
<td></td>
</tr>
<tr>
<td>Bloods</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date / /</th>
<th>Bleep no.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Print name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
</tr>
</tbody>
</table>

### Appendix B

**Acute Clinical Directorate**

**Weekend Handover**

<table>
<thead>
<tr>
<th>Sick patient:</th>
<th>Requires W/E review</th>
<th>Nurse led W/E discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IW number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis:**

**Interventions:**

**Plan:**

**Potential complications and action required over weekend:**

**Results to be checked over weekend (please state):**

**Cardiopulmonary resuscitation in event of cardiac arrest IS indicated:**

**Cardiopulmonary resuscitation in event of cardiac arrest NOT indicated:**

**DNACPR 'purple' form completed:**

**Date of discharge planned for:**

Can he discharged if the following parameters are achieved and are agreed with patient’s consultant:

1.  
2.  
3.  
4.  

**Signed:**

**Print name:**

**Bleep number:**

**Date:**

Ensure patient is flagged on PSAG tool to ensure weekend review.
Appendix C

Night Handover Standard Operating Procedure (SOP)

**Aim:** Good handover is vital for patient safety, by ensuring a structured handover process which will provide effective and efficient clinical care and support a standardised process and handover paperwork.

**Meeting Handover Room:** Conference room Level B

**Time of Handover:** 21:00hrs and 08:00

**Length of meeting:** Thirty minutes.

**Hospital at Night handover meeting membership:**

- H@N Clinical Coordinator (chair)
- Site Co-ordinator
- Medical registrar
- FY1/FY2 / CT Medicine/ Surgical/Ortho/Gynaec
- Critical Care Outreach /Advanced Practitioner
- Critical Care Outreach Clinical Assistant
- Anaesthetic consultant (ICU) and First on-call anaesthetist

**Documentation:** Currently paper driven. Handover sheets are available via the allocated computer in MAU.

**Attendance Sheets:** Available at all handover meetings. Hospital at Night Clinical Coordinator (CCOS) monitor attendances.

**Handover Information:**

**Patient in emergency areas:** Emergency patients awaiting admission or who are giving cause for concern will be recorded on Handover sheet. Patients of concern will be discussed at night handover meeting. Five copies of the handover sheet are to be printed and handed over to the night team.

**Patients in other acute areas:** Patients in other acute areas giving concern will be handed over to the on call team during the H@N handover. On call teams will log information using agreed handover sheet.

**Weekend Plan:** All patients of concern (high risk of deterioration) will have a weekend plan sticker attached to their medical notes. These patients will be alerted to the on-call teams during handovers.
Process:

- Introductions and attendance (*Appendix D*)
- Handover should be a team process and one central meeting will take place and not individual multiple meetings.
- Clinical Site-Co-ordinator will provide an overview of the hospital capacity – including patients awaiting ward beds in the Emergency Department (ED).
- All parties present will respect the process of the meeting and give their undivided attention. Information shared by each speciality will consist of patients waiting admission and in-patients where concerns are identified.
- Handover of unwell patients (including CCOS list of at risk/sick patients)
- Critical Care Outreach will feedback any patients of concern within each area.
- Handover of outstanding tasks (not routine tasks)
- Each clinical group i.e. medicine will hand over to their opposite team member in a succinct and timely fashion in a separate part of the room.
- Rearranging order of team handing over shall be decided by the chair. Meeting will finish within thirty minutes.
- All members will remain for the full hand over to avoid disturbing the meeting.
- Completed Attendance Log and handover sheets will be held by / returned to the Clinical Coordinator for audit purposes.
### Appendix D

**Date:**

**Time:** 08:00

*Please see reverse for 21:00 sign in sheet.*

<table>
<thead>
<tr>
<th>Clinical Co-ordinator</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical:</strong></td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
<tr>
<td>SpR:</td>
<td></td>
</tr>
<tr>
<td>FY1:</td>
<td></td>
</tr>
<tr>
<td>FY2:</td>
<td></td>
</tr>
<tr>
<td>Ward Cover:</td>
<td></td>
</tr>
<tr>
<td>On Call:</td>
<td></td>
</tr>
<tr>
<td><strong>Critical Care:</strong></td>
<td></td>
</tr>
<tr>
<td>ITU Consultant:</td>
<td></td>
</tr>
<tr>
<td>CCOS Practitioner:</td>
<td></td>
</tr>
<tr>
<td>CCOS Clinical Assistant:</td>
<td></td>
</tr>
<tr>
<td>FoC Anaesthetist:</td>
<td></td>
</tr>
<tr>
<td>ODP:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical:</strong></td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
<tr>
<td>SpR:</td>
<td></td>
</tr>
<tr>
<td>FY1:</td>
<td></td>
</tr>
<tr>
<td>FY2:</td>
<td></td>
</tr>
<tr>
<td>Ward Cover:</td>
<td></td>
</tr>
<tr>
<td>On Call:</td>
<td></td>
</tr>
<tr>
<td>SOG:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td><strong>Other Specialities:</strong></td>
<td></td>
</tr>
<tr>
<td>Bed Management:</td>
<td></td>
</tr>
<tr>
<td>Resus Officer:</td>
<td></td>
</tr>
<tr>
<td>Transfer Practitioner:</td>
<td></td>
</tr>
</tbody>
</table>

*Set Start time: 08.00*

*Actual start time:*

*Reason why:*
Hospital @Night Clinical Coordinator (bleep 086)

To act as one central coordination point to ensure all calls and alerts are allocated to the most appropriate team member. This will mean the right person at the right place undertaking the right task to ensure patient safety out of hours.

Hospital at Night Clinical Coordinator (H@N CC - bleep 086)

Coordinator will chair the H@N meetings and provide structured leadership to ensure appropriate completion of the meeting.

ALL bleeps to be made to the H@N CC who will allocate the task to the most appropriate team member.

2222 calls will continue to go direct to switchboard.

The coordinator should be contacted for all clinical concerns and requests, some of which are described below but not limited to:

- Amendments to prescriptions
- Clinical Equipment issues
- Blood results reported by labs
- Verification of death
- Transfer co-ordination if required off Island
- Escalation of deteriorating patient
- Fails
- Referrals for palliative care Input / Wellow ward

Critical Care Outreach
Clinical Assistant can be bleeped directly on 044 for:
- Cannulation
- Bloods

The H@N Clinical Coordinator will triage the bleep and refer on if appropriate to either:

Critical Care Outreach (006)

Medical / Surgical Team
(bleeps from ED to med reg for referrals will be direct)

Site Coordinator (bleep 200)

The site coordinator will maintain responsibility for all other areas of site safety:

- Patient flow
- Staffing allocation and ward issues / concerns
- Fire and security
- Estates issues
- Generation of SMOC report
Appendix F

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

| Document title | Clinical Review, Hospital at Night and Handover Policy |

<table>
<thead>
<tr>
<th>Totals</th>
<th>WTE</th>
<th>Recurring £</th>
<th>Non Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manpower Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Training Staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equipment &amp; Provision of resources</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Summary of Impact: This policy sets the expectations of how patients are managed and handed over with the acute hospital.

Risk Management Issues: None

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

<table>
<thead>
<tr>
<th>Manpower</th>
<th>WTE</th>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational running costs</td>
<td>Post already in place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals:</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Staff Training Impact

<table>
<thead>
<tr>
<th>Recurring £</th>
<th>Non-Recurring £</th>
</tr>
</thead>
</table>
### Equipment and Provision of Resources

<table>
<thead>
<tr>
<th></th>
<th>Recurring £ *</th>
<th>Non-Recurring £ *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation / facilities needed</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Building alterations (extensions/new)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IT Hardware / software / licences</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stationery / publicity</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Travel costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Utilities e.g. telephones</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Process change</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rolling replacement of equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Marketing – booklets/posters/handouts, etc</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

- Capital implications £5,000 with life expectancy of more than one year.

<table>
<thead>
<tr>
<th>Funding /costs checked &amp; agreed by finance:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature &amp; date of financial accountant:</td>
<td></td>
</tr>
<tr>
<td>Funding / costs have been agreed and are in place:</td>
<td></td>
</tr>
<tr>
<td>Signature of appropriate Executive or Associate Director:</td>
<td></td>
</tr>
</tbody>
</table>

---

**Appendix F**

Title Clinical Review, Hospital at Night and Handover Policy
Version No. 2.0

Page 27 of 30
**Equality Impact Assessment (EIA) Screening Tool**

1. To be completed and attached to all procedural/policy documents created within individual services.

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Clinical Review, Hospital at Night and Handover Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of document</td>
<td>Setting a process for medical team clinical handover and review and H@N</td>
</tr>
<tr>
<td>Target Audience</td>
<td>BMT, Consultant led team, H@N team, CCOS team</td>
</tr>
<tr>
<td>Person or Committee undertaken the Equality Impact Assessment</td>
<td>H@N working group</td>
</tr>
</tbody>
</table>

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British People</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Black or Black British People</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Chinese people</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>People of Mixed Race</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>White people (including Irish people)</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>People with Physical Disabilities, Learning</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Disabilities or Mental Health Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Lesbian, Gay men and bisexual</td>
<td></td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Age</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Older People (60+)</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Younger People (17 to 25 yrs)</td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Faith Group</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pregnancy &amp; Maternity</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Equal Opportunities and/or improved relations</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

**3. Level of Impact**

<table>
<thead>
<tr>
<th>Legal (it is not discriminatory under anti-discriminatory law)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

**3.1 Could you minimise or remove any negative impact that is of low significance?** Explain how below:

N/A

**3.2 Could you improve the strategy, function or policy positive impact? Explain how below:**

N/A

**3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?**

N/A

**Scheduled for Full Impact Assessment Date:** 21st September 2016
| Name of persons/group completing the full assessment |  
|--------------------------------------------------|---|
| Date Initial Screening completed                 | 21st September 2016 |