NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Junior Doctors' Induction- Administration Processes & Out of Hours Provision

1st August 2018

Pride in our care

Useful Information

- Study leave
- Relocation expenses
- Annual leave
- Travel claims
- Sickness absence
- Mandatory Training
- On Call Systems
- Medical Services Team

Study Leave

- Study leave entitlements vary depending on the stage of your training.
- Exam leave must be applied for on a Study Leave application form and any required service cover identified.
- Premature, repeated or simultaneous attempts at exams, especially in quick succession, should be discouraged.
- Trainees should demonstrate attendance at feedback sessions where provided, after two or more unsuccessful examination attempts.
- Examination failures will be considered under the ARCP/RITA process.
- Full policy is available at https://heeoe.hee.nhs.uk/study_leave_policy

Study Leave cont....

- All applications must be signed by Consultant and sent to Medical Services before final authorisation by DME.
- Retrospective applications will not be accepted.
- For honorary placements you will be required to forward authorised, signed copy of your study application to your Lead Employer who will manage the funding aspects.
- For full details relating to applications and claims, contact Nicholas Morgan, PGME Administrator.

Relocation Expenses.

- Relocation is administered in line with HEEoE policy, available on line at https://heeoe.hee.nhs.uk/policies_and_procedures
- Applications must be made electronically in line with the policy and submitted to Medical Staffing for review and processing.
- Claim forms (P20) are available from Medical Services and should be returned for processing.
- Claims submitted via CPFT e-expenses system will be rejected.

Annual Leave

- Leave requests should be submitted six weeks prior to requirement.
- Ensure daytime emergency cover in place and application signed by your Consultant. Email notification acceptable.
- When rostered on nights you are able to swap with the consent of your Consultant and the Consultant of the colleague you are swapping with.
- Take your full entitlement during each rotation, anything not taken can not be carried forward to another placement or Trust.
- Annual leave is administered on behalf of Medical Services by james.smy@cpft.nhs.uk

Travel Expenses

- Work related travel is paid in accordance with the Terms and Conditions of Service (TCS).
- P9 Standard Car User Form, copy driving licence and MOT if applicable are required to register your vehicle.
- Submit claims on a monthly basis using the e-expenses system.
- Insurance with "Business Use", must be in place and evidenced on your Certificate of Insurance. Expenses will not be reimbursed without this. Failure to do so may invalidate your insurance.
- Mileage relating to attendance at external courses must be claimed separately through the e-expenses system.
- Claims made when insurance is not valid will not be paid.

Sickness Absence

- Report all absences to Medical Services on 01223 884252 and your supervising Consultant. If you are rostered on call you **must** telephone and not just email to enable time to source cover.
- Medical Services will complete a P6 sickness form and your Consultant will undertake a 'return to work interview' with you when appropriate in all instances.
- Any absences relating to Mental Health or Muscoskeletal require an Occupational Health referral as standard practice.
- Ensure Medical Services are notified when you are fit for duty. Not doing so may impact on your pay.
- We are required to reported all absences of 10 days or more to HEEoE who will assess any impact on training.

Mandatory Training.

- Mandatory training must be up to date.
- E-Learning account will be set up for you by CPFT Learning and Development Department via the e-academy.
- Recent, up to date, mandatory training may be considered and evidence should be submitted to Nicholas Morgan.

DATIX REPORTING SYSTEM

- The Trust uses an online system for reporting all risks and incidents.
- It does not require a log in and is available through a link on the home page on the Intranet.
- Every member of staff is encouraged to use the Datix system to report any incidents, risks or near misses which could include gaps on the rota, other staff gaps, poor or no responses from telephone calls to on call staff etc.
- Online training for the Datix system is also available from the links on the homepage.
- The link to Datix is https://nww.riskreporting.cpft.nhs.uk/index.php and if any one has any questions about using the system please contact James Claydon, Medical Workforce Lead, 01223 884240 or james.claydon@cpft.nhs.uk

Your hours – expectations.

- *Duty hours* are the total average hours that a doctor is available to work, including any rest period (contracted hours).
- *Actual hours* reflect the total hours that a doctor spends performing tasks for the Trust, excluding any rest periods.
- CPFT does not expect you to work beyond your contracted hours, but acknowledges there may be exceptions when you are required to do so.
- You are required to take natural breaks of 30 mins for shifts rostered more than 5 hours and further 30 mins break more than 9 hours which can be taken flexibly. This is in addition to any rest required for working pattern. **A break = period away from clinical duties.**
- You have the opportunity to submit an exception report.
- Keep to the designated duty times:
  - handover within duty hours
  - hours only exceeded in extraordinary circumstances necessitated by a clinical emergency

Emergency Out of Hours cover – an overview.

- The Trust is split into 2 geographical areas.
- 3 Tier emergency on call system.
- Tier1 rota (CT level) in each locality supported by a Consultant rota.
- Tier2 provide Trust wide cover and support to Tier1.
- Child and Adolescent Services (CAMHS) have a Trust wide Consultant rota and may be contacted directly without referral to Tier2.
- Foundation Doctors do not participate in rotas but can provide emergency cover during normal working hours to inpatient units where appropriate.
- FY2s may undertake locum late shifts after a period of shadowing.

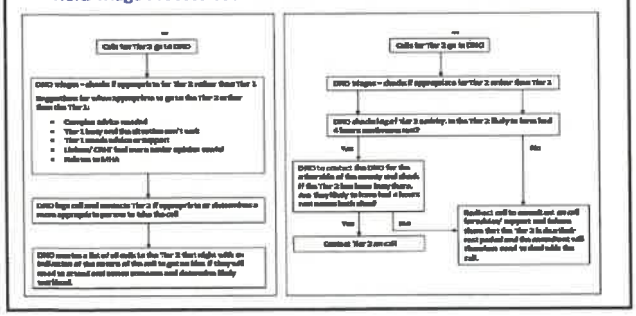
Shift Working Pattern – Tier1

- Normal Working Day 09:00 to 17:00
- Late 09:00 to 21:30
- Night 21:15 to 09:15
- Allows a 15 minutes handover period for on call/out of hours working.
- Duty bleeps and/ or mobiles are available for emergency purposes.
- There may be local mechanisms in place for day time emergency cover. Your Junior Doctor Representatives will advise.
- **Tier2 and Consultant always available if you require advice or assistance and attendance when necessary.**
- **YOU ARE NOT ALONE...**

On Call – Tier2

- Normal Working day 09:00 to 17:00
- On call 09:00 Day1 to 09:00 Day2
- If it is known Tier2 are unable to obtain 5 hours continuous rest between 22:00 and 07:00 there may still be occasions when it would be appropriate to contact them.
- There is no 'protected' time and Tier2 **must** be available throughout the contracted duty.
- Expected to attend if required to do so, not just telephone advice.
- Tier2 Triage Process applies.
- **Consultant on call is always available for advice and support and attendance when necessary.**

Tier2 Triage Process between 22:00 and 07:00 – DNA role



Swapping rostered duties.

- All on calls **must** be swapped when planning leave or other absences.
- Tier1 Nights must be swapped in blocks to minimise service impact. Rest swaps with the duty.
- Tier1 Late can be swapped individually if preferred.
- Tier2 – consider impact on next day commitments. Swaps to include duty and associated rest.
- OOHs swaps **must** be notified to Medical Services either using the 'Swap Form' or by email including all concerned.
- Short notice swaps may be considered in exceptional circumstances.
- All normal day cover is for emergency situations only. Team first contact regardless of grade.

Further Information.

- Please remember to hand in all outstanding starter paperwork.
- HMRC Checklist all including Honorary placements.
- Checklist or P45/P60 for CPFT employees if available.
- P2 applies to all, even Honorary placements.
- Cash Floor certificates are required for all paid under Schedule 14, Section 1.
- Evidence of previous pay required for all paid under Schedule 14, Section 2.
- CPFT Bank forms are available on request if you wish to join.
- If in doubt ask a member of the Team.

01223 884252

Medical Services Team

First point of contact 01223 884252			
James Claydon	Medical Workforce Lead	01223 884240	james.claydon@cpft.nhs.uk
Jan Hazell	Medical Services Advisor	01223 885817	jan.hazell@cpft.nhs.uk
John Ward	Medical Services Advisor	01223 885716	john.ward@cpft.nhs.uk
Sandra Cooper	Medical Services Officer	01223 884402	sandra.cooper@cpft.nhs.uk
Nicholas Morgan	PGME Administrator	01223 884024	nicholas.morgan@cpft.nhs.uk
Gergely Kristo	Medical Services Administrator	01223 884152	gergely.kristo@cpft.nhs.uk
Holly Porter	Medical Services Administration Assistant	01223 884252	holly.porter@cpft.nhs.uk

Jorge.Zimbron@cpft.nhs.uk

www.Exceptionreports.com

- **Other Resources**

  The Cochrane Library: a *collection of systematic reviews of clinical trials continually reviewed & updated. Go to* http://www.cochranelibrary.com/

NICE Information Suite

The National Institute for Health and Care Excellence (NICE) provides an information suite of evidence services, which includes:

- Healthcare Databases (HDAS)
- Journal A-Z list
- Evidence Search (Athens not required)
- BNF/BNFC (Athens not required)
- Clinical Knowledge Summaries (CKS) (Athens not required)

Go to https://www.evidence.nhs.uk/ to access any of the above.

Local Athens Administrator

If you have any questions about using Athens, please contact your Athens on-site administrator who will be more than happy to answer your questions.

Contact: Ian Rennie or Trish Moore

Email: fulbourn.library@cpft.nhs.uk

Phone: 01223 884 440 **OR** 01733 218601

Other Useful Websites

East of England Library Resources:

http://www.eel.nhs.uk

Library website:

www.academy.cpft.nhs.uk/library.htm

Library Book/eBook Catalogue:

www.elms.nhs.uk

Updated April 2018

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Your Athens Account

Making the most of electronic resources

CPFT LIBRARY

NHS

Email: fulbourn.library@cpft.nhs.uk
Website: www.academy.cpft.nhs.uk/library.htm

Follow us @CpftLibrary

What is Athens?

Your Athens account gives you access to all electronic resources purchased by CPFT Libraries.

There are thousands of journal titles, over a hundred e-Books, point of care tools and clinical skills guidance.

Who has access to Athens?

All staff and students within CPFT and Health Education East of England staff are entitled to an Athens account through this Trust.

How do I apply for an account?

Applying for an Athens account is simple and self-serving. We advise you use a NHS computer to apply, as approval is much quicker.

- Go to https://openathens.nice.org.uk
- Enter your details, including work or personal email and choose CPFT as your Organisation.

Once you have filled out the form, you will be sent an activation email with a link, to set up a password.

Where can I use it?

Once set up, you can access CPFT resources via your Athens account at your place of work, and on your home PC/laptop as well as mobile devices like phones and tablets.

Which e-Resources are available via Athens?

- **Healthcare Databases Advanced Search (HDAS):**

  PsychoInfo, Medline, Embase, CINAHL & AMED (and others). Go to https://hdas.nice.org.uk

- **The Royal Marsden Manual Online**

  The premier manual for clinical nursing procedures. Go to www.rmmonline.co.uk

- **Clinical Skills**

280 fully illustrated step-by-step guidelines on Clinical Skills. Reviewed & updated continually. Ideal for practice, revision or assessment. Go to www.clinicalskills.net

Clinical Skills.net
a unique resource at your fingertips

- **BNF apps**

The British National Formulary (BNF) is now available as an app for smartphones and tablets.

BNF
BNFC

Immediate prescribing at point of care for both IOS & Android. Go to www.bnf.org/products/apps

- **EBSCO eBooks**

A wide range of e-Books on all areas of Health & Social Care inc a focus on Community & Mental health. Go to www.elms.nhs.uk

EBSCOhost

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DETERIORATING PATIENT STRATEGY

SBAR COMMUNICATION TOOL

S SITUATION
B BACKGROUND
A ASSESSMENT – ABCDE
R RESPONSE/RECOMMENDATION

AWAYS USE YOUR COMPETENT CLINICAL ASSESSMENT AND JUDGEMENT

LOOK AT THE PATIENT, LISTEN TO THE PATIENT/RELATIVES

PATIENTS CAN BE SICK BUT NOT TRIGGERING A NEWS SCORE OR NO OBVIOUS SYMPTOMS MAY BE PRESENT

NON-TOUCH OBSERVATIONS – ABC

- **A** AIRWAY IS THE PATIENT TALKING NORMALLY? RESPONDING AS NORMAL?
- **B** BREATHING DOES THE PATIENT APPEAR TO BE BREATHING NORMALLY? (12–20 RESPS/MINUTE)
- **C** CIRCULATION DOES THE PATIENT LOOK A NORMAL COLOUR? MOVING ABOUT NORMALLY?

ASSESSMENT OF CONSCIOUSNESS – AVPU

- **A** = ALERT FULLY AWAKE AND RESPONSIVE
- **V** = RESPONDS TO VOICE BUT NOT FULLY AWAKE
- **P** = RESPONDS TO PAINFUL STIMULI
- **U** = UNRESPONSIVE – DOES NOT RESPOND TO VOICE OR PAINFUL STIMULI

RESPONDING TO VOICE PAIN OR UNRESPONSIVE – VPU

UNRESPONSIVE
OPEN MOUTH CHECK IF CLEAR
IF NOT CLEAR TURN PATIENTS HEAD TO SIDE AND SHAKE JAW TO EXPEL CONTENTS
OPEN AIRWAY USE HEAD TILT CHIN LIFT
IS THE PATIENT BREATHING?
LOOK
LISTEN } 10 Seconds
FEEL
NOT BREATHING – NO SIGNS OF LIFE, CHECK CAROTID PULSE (IF COMPETENT)
CALL FOR HELP – PULL/PRESS ALARM – SHOUT
CALL (9)999/112 STATE CARDIAC ARREST
COMMENCE – CPR – COMPRESSIONS, RATIO 30 : 2
PUT AED ON TO CLEAR DRY CHEST – ATTACH PADS
GIVE OXYGEN 15 LITRES/MIN VIA BVM (Bag Valve Mask)
AIRWAYS – NASAL AND ORAL
HAVE SUCTION READY
CONTINUE WITH RESUSCITATION – CPR
WHEN PARAMEDICS ARRIVE GIVE PATIENT HANDOVER
CONTINUE CPR UNTIL THEY ADVISE

FOR TRANSFER OF PATIENT TO HOSPITAL
PATIENTS MEDICATION CHART
MEDICATION
DOCTORS LETTER IF POSSIBLE
PERSONAL BELONGINGS

NEW ONSET OF CONFUSION – RESPONDING TO VOICE RESPONDING TO PAIN – UNRESPONSIVE

IS THE PATIENT BREATHING? YES – ASSESS USING ABCDE

AIRWAY
CHECK MOUTH TO SEE IF CLEAR – CONSIDER SUCTION
OPEN AIRWAY HEAD TILT CHIN LIFT
CONSDER AIRWAYS TO SECURE – NASAL/ORAL
MAINTAIN AIRWAY

BREATHING
> 20 RESPS/MIN (NORMAL 12–20)
GIVE OXYGEN VIA NON REBREATHING MASK 15 LITRES/MIN – TO MAINTAIN OXYGEN SATURATIONS AT > 96%

BREATHING
< 10 RESPS/MIN – GIVE OXYGEN VENTILATE USING BVM (Bag Valve Mask)
2 PERSON TECHNIQUE 15 LITRES/MIN – 1 BREATH EVERY 6 SECONDS = 10 BREATHS/MIN

CIRCULATION
CHECK PULSE RADIAL OR CAROTID MANUALLY FOR 30 SECONDS x 2 (NORMAL 50–90 PER MIN)
CHECK COLOUR – PALE, GREY, MOTTLED, CYANOSIS
CAPILLARY REFIL TIME – CRT NORMAL = < 2 SECONDS
CHECK B/P MANUALLY (IF COMPETENT) SYSTOLIC < 90 MMHG ELEVATE LEGS

DISABILITY
CHECK TEMPERATURE (NORMAL 36–38°C)
BLOOD GLUCOSE (NORMAL 4–7 MMOLS)
PEARL (PUPILS EQUAL AND REACTING TO LIGHT)

EXPOSURE
LOOK FOR BLEEDING, RASH, SWELLING, LIGATURES, FRACTURES, BRUISING,

IS THE PATIENT ALERT? ORIENTATED? – YES ARE YOU CONCERNED? – YES USE ABCDE TO ASSESS

Assessment:

A Airway	Is the patient talking? Any airway noises; e.g. gurgling / stridor	
B Breathing	Respiratory Rate (RR?) Any respiratory noises e.g. wheeze? Is breathing laboured?	Oxygen saturation levels (SpO_2)?
C Circulation	Heart Rate (HR)? Capillary Refill Time (CRT)?	Blood Pressure (BP)? Temperature?
D Disability	Level of consciousness (AVPU)? Blood sugar levels?	Pupil reactions?
E Exposure	Any other abnormal signs? Exposure & environment	Bleeding / rashes, etc.?

IS THE PATIENT TRIGGERING A NEWS SCORE – NO
HAS THE PATIENT'S BASELINE NEWS SCORE INCREASED – NO
ARE YOU CONCERNED – YES
ESCALATE THE SITUATION TO NURSE IN CHARGE/DOCTOR/OR CALL (9)999/112
ALWAYS USE YOUR CLINICAL ASSESSMENT/CLINICAL JUDGEMENT – LISTEN TO THE PATIENT – LOOK AT THE PATIENT

FOLLOW UP – DOCUMENTATION/ACTIONS

1. COMPLETE PATIENT NOTES USE SBAR FORMAT TO RECORD INFORMATION.
2. DATIX USE SAME INFORMATION FROM PATIENTS NOTES IN SBAR FORMAT
3. INFORM NEXT OF KIN.
4. DEBRIEF WITH ALL STAFF INVOLVED (THEY MAY HAVE RESPONDED FROM OTHER WARDS). ASK FOR STAFF FROM RESUSCITATION TEAM TO ATTEND. DEBRIEF IF REQUIRED.
5. CHECK AND REPLACE EQUIPMENT USED.
6. UPDATE MONTHLY RESUS CHECK LIST.

SEPSIS IN ADULTS IS A SERIOUS CONDITION

that can initially look like flu, gastroenteritis or a chest infection. Sepsis affects more than 250,000 people every year in the UK.

The UK Sepsis Trust is a registered charity number (England & Wales) 1159043

Seek medical help urgently if you develop any or one of the following

- **S** lurred speech or confusion
- **E** xtreme shivering or muscle pain
- **P** assing no urine (in a day)
- **S** evere breathlessness
- **I** t feels like you're going to die
- **S** kin mottled or discoloured

JUST ASK
"COULD IT BE SEPSIS?"
IT'S A SIMPLE QUESTION, BUT IT COULD SAVE A LIFE.

INFORMATION FOR HEALTH PROFESSIONALS

Sepsis is when the body's response to infection injures its own tissues and organs. If left untreated, sepsis can lead to shock, multi-organ failure and death.

THINK SEPSIS IF THE PATIENT:

- Is triggering an early warning score
- Looks ill
- Has any signs of infection

SEPSIS TRUST
www.sepsistrust.org

Email info@sepsistrust.org for more information

IF PATIENT SCORING 5 ON NEWS AND HAS HISTORY OF INFECTION THINK SEPSIS

IS THERE 1 RED FLAG PRESENT?

CALL (9)999/112

PATIENT HAS RED FLAG SEPSIS

RED FLAG SEPSIS

Are there signs/symptoms of infection?

	Yes
Yes, but source not obvious	☐
Pneumonia likely chest source	☐
Urinary Tract Infection	☐
Abdominal Pain or distension	☐
Cellulitis/septic arthritis/infected wound	☐
Device-related infection	☐
Meningitis	☐
Other (specify):	☐

Perform a full set of observations

Is ONE Red Flag present?

	Yes
New deterioration in GCS/AVPU or acute confusion	☐
Systolic B.P. ≤90 mmHG (or ≥40 mmHg below normal	☐
Heart rate ≥130 per minute	☐
Respiratory rate ≥25 per minute	☐
Needs oxygen to keep SpO_2 92% (88% – COPD)	☐
Non-blanching rash or mottled/ashen/cyanotic	☐
Not passed urine in last 18 hours	☐
Urine output less than 0.5 ml/kg/hr if catheterised	☐
Recent chemotherapy (within last 6 weeks)	☐

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Reasons for Observations

Care Plan to Support

NEWS Observation Chart – Inpatient Mental Health

CHART NO

Obs Freq.	Obs Freq.	Obs Freq.
Date	Date	Date
Time	Time	Time

NEWS KEY	NAME	D.O.B.	Hosp no.:
0 1 2 3			

MONTH: | MONTH:

DATE

TIME

BASELINE

Parameter	Value	Score
RESP. RATE (>20 consider sepsis)	≥25	3
	21–24	2
	12–20	
	9–11	1
	≤8	3
SpO_2	≥96	
	94–95	1
	92–93	2
	≤91	3
O2 therapy	%	2
TEMP (Consider Sepsis if Temp <36°C or >38.3°C)	≥39°	2
	38°	1
	37°	
	36°	1
	≤35°	3
BLOOD PRESSURE (NEW SCORE uses Systolic BP; Consider Sepsis if BP Systolic <90mmhg)	230	3
	220	
	210	
	200	
	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	1
	100	2
	90	
	80	
	70	3
	60	
	50	
HEART RATE (Consider Sepsis if Heart Rate >90)	>140	3
	130	2
	120	
	110	
	100	1
	90	
	80	
	70	
	60	
	50	
	40	1
	30	3
Level of Consciousness	Alert	
	V / P / U	3
BLOOD SUGAR (Bl'd Sugar)		
TOTAL NEW SCORE (TOTAL SCORE)		
Additional Parameters	GCS Score	
	1–10 Pain Score (Pain Score)	
Has the patient passed urine? (Passed urine?)		
Escalation Plan Y/N n/a (Escal. Plan)		
Initials		

NEWS SCORE TO BE USED IN CONJUNCTION WITH CLINICAL ASSESSMENT AND JUDGEMENT DO NOT PUT REFUSED ON THE CHART UTILISE NON-TOUCH OBSERVATIONS AND DOCUMENT IN PATIENTS CLINICAL NOTES.

NEWS score	0	1–4
Frequency of Monitoring and Clinical Response.	**NORMAL MONITORING ACCORDING TO CARE PLAN ARE YOU CONCERNED?** **IF YES HAVE YOU ESCALATED THIS TO THE NURSE IN CHARGE?**	**IF NO CHANGE TO PATIENT BASE LINE SCORE, CONTINUE MONITORING OF OBSERVATIONS ACCORDING TO OBSERVATION FREQUENCY SUPPORTED BY CARE PLAN.** **ARE YOU CONCERNED?** **IF YES HAVE YOU ESCALATED THIS TO THE NURSE IN CHARGE?**
3 in any one observation	**5–6 SICK**	**7+**
CALL NURSE IN CHARGE IMMEDIATELY PATIENT MAY BE SICK. **NURSE IN CHARGE TO REVIEW PATIENT AND TO DECIDE WHAT THE ESCALATON OF CLINICAL CARE WILL BE.**	**SICK** **ESCALATE TO NURSE IN CHARGE IMMEDIATELY, INCREASE FREQUENCY OF OBSERVATIONS MINIMUM HOURLY OR MORE FREQUENT NURSE IN CHARGE TO ESCALATE THE SITUATION 999/112.**	**ACT NOW** **CONTINUOUS MONITORING 999/112 CALL FOR AMBULANCE TO TRANSFER TO ACUTE HOSPITAL, IF SEPSIS PRE ALERT RED FLAG SEPSIS.** **IF PATIENT GOES INTO CARDIAC ARREST COMMENCE RESUSCITATION.**

RAPID TRANQUILISATION AND PHYSICAL RESTRAINT OBS (WITHOUT RT)

MONITOR THE PATIENT EVERY 15 MINS FOR 1 HOUR, USING CLINICAL JUDGEMENT CONTINUE TO MONITOR THE PATIENT UNTIL THERE ARE NO CONCERN'S ABOUT THE PATIENTS PHYSICAL HEALTH STATUS.

OBSERVATIONS:

- USE THE NEWS CHART TO RECORD PHYSIOLOGICAL OBSERVATIONS.
- IMPLEMENT NON-TOUCH OBSERVATIONS WHEN NECESSARY I.E. DURING RESTRAINT.
- IF PATIENT IS ASLEEP RESPIRATION RATE AND OXYGEN SATURATIONS ARE TO BE MONITORED AND RECORDED.
- PUT NEWS SCORE ON RIO.
- ENSURE THAT THE PATIENT IS ADEQUATELY HYDRATED OFFER FLUIDS, CONSIDER USING A FLUID CHART TO MONITOR FLUID INTAKE IF NECESSARY.
- IF PATIENT DETERIORATES ENSURE BLOOD GLUCOSE IS CHECKED (NORMAL LEVEL SHOULD BE 4–7 MMOL).
- USE THE CLINICAL RESPONSE ON THE REVERSE OF THE NEWS CHART TO MAKE THE CORRECT EMERGENCY CALL FOR HELP.

S – Situation:

Your name / designation / ward

The patient's name

I am concerned because — The NEWScore trigger is

B – Background:

Brief History — Admission Date — Treatment Date

MHA Status — Medication / therapy

A – Assessment:

A Airway	Is the patient talking? Any airway noises; e.g. gurgling / stridor	
B Breathing	Respiratory Rate (RR?) Any respiratory noises e.g. wheeze? Is breathing laboured?	Oxygen saturation levels (SpO_2)?
C Circulation	Heart Rate (HR)? Capillary Refill Time (CRT)?	Blood Pressure (BP)? Temperature?
D Disability	Level of consciousness (AVPU)? Blood sugar levels?	Pupil reactions?
E Exposure	Any other abnormal signs? Exposure & environment	Bleeding / rashes, etc.?

R – Recommendation:

I would like you to do

What would you like me to do?

NON-TOUCH OBSERVATIONS

AVPU – Alert = responsive — Circulation – colour normal

Respiration Rate (12–20 breathing normally)

Assessment of consciousness – AVPU

A (alert)	Fully awake and responsive
V (responds to voice) but not fully awake	Responds (e.g. by opening eyes, speaking, or moving) when spoken to
P (responds to pain) but not to voice	Responds (e.g. by opening eyes, moaning, or moving) when given painful stimulus: Press on eyebrow, when given Trapezium (shoulder) squeeze, Pressure between jawbone and ear
U (unresponsive)	Does not respond to voice or painful stimulus

Consider possible causes of reduced consciousness:
e.g. Hypoglycaemia, overdose, head injury

RED FLAG SEPSIS

Are there signs/symptoms of infection?

	Tick
Yes, but source not obvious	☐
Pneumonia likely chest source	☐
Urinary Tract infection	☐
Abdominal Pain or distension	☐
Cellulitis/septic arthritis/infected wound	☐
Device-related infection	☐
Meningitis	☐
Other (specify):	☐

↓ Y

Perform a full set of observations

↓

Is ONE Red Flag present?

	Tick
New deterioration in GCS/AVPU or acute confusion	☐
Systolic B.P. ≤90 mmHG (or ≥40 mmHg below normal)	☐
Heart rate ≥130 per minute	☐
Respiratory rate ≥25 per minute	☐
Needs oxygen to keep SpO_2 92% (88% in COPD)	☐
Non-blanching rash or mottled/ashen/cyanotic)	☐
Not passed urine in last 18 hours	☐
Urine output less than 0.5 ml/kg/hr if catheterised	☐
Recent chemotherapy (within last 6 weeks)	☐

Use in conjunction with AVPU

Glasgow Coma Scale

Behaviour	Response	Score
Eye opening response	Spontaneously To speech To pain No response	4 3 2 1
Best verbal response	Orientated to time, place and person Confused Inappropriate words Incomprehensible sounds No response	5 4 3 2 1
Best motor response	Obeys commands Moves to localized pain Flexion withdrawal from pain Abnormal flexion (decorticate) Abnormal extension (decerebrate) No response	6 5 4 3 2 1
Total score	*Best response* *Comatose client* *Totally unresponsive*	15 8 or less 3