Spire Healthcare

SPIRE HEALTHCARE	**Ref:**	**Clinical Policy 07**
	Issued By:	**Clinical Governance Director**
	Approved By:	**Policy Approval Group**
ADMISSION AND DISCHARGE POLICY	**Date:**	**January 2020**
	Applies to sites:	**All hospitals and clinical sites**
	Applies to staff groups:	**All relevant hospital staff**

ADMISSION AND DISCHARGE POLICY

CONTROLLED DOCUMENT

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1.0 INTRODUCTION

This policy sets out Spire Healthcare's requirements in relation to the admission and discharge of patients and should be used in conjunction with locally determined processes and work instructions. The standards for pre-operative assessment are outside the scope of this document and detailed in CLINI 81.

2.0 DUTIES AND RESPONSIBILITIES

The Hospital Director is ultimately responsible for ensuring that the hospital meets the required standards of clinical care, in many cases this is delegated to the Head of Clinical Services.

The Head of Clinical Services (Matron) is responsible for ensuring clinical standards in relation to the admission and discharge of patients, for ensuring staff are adequately skilled and for monitoring the effectiveness of care.

All registered practitioners must participate in the admission and discharge processes in line with care pathways and local protocols and ensure that patients are assessed, admissions are appropriate and discharge needs are considered and provided.

All staff are required to play their part in the patient journey, to ensure that hospital protocols are followed and report problems if they arise.

Admitting consultants are responsible for the admission and discharge of patients in their care in accordance with the standards defined in the Consultants' Handbook.

3.0 DEFINITIONS OF PATIENT GROUPS

Inpatient – a patient who is, or expected to stay overnight

Daycase – a patient undergoing a procedure who is expected to be discharged on the same day (i.e. without overnight admission)

Surgical – a patient undergoing primary surgical care, admitted under a surgeon with practising privileges

Medical – a patient undergoing primary medical care, admitted under a physician with practising privileges

Planned transfer – a patient transferred to another unit in a planned way in circumstances predictable on admission or being moved for reasons other than an escalation of treatment that cannot be provided by the admitting unit.

Emergency or unplanned transfer – a patient transferred to another unit at short notice for an escalated level of treatment that cannot be provided in the admitting unit.

Discharge – a patient undergoing planned discharge

Self discharge – a patient who wishes to be discharged despite medical advice to the contrary

4.0 BOOKINGS

Requests for admission (day case and in-patient) are accepted from doctors with practising privileges at the hospital or their secretaries. Alternatively, patients may be accepted as an NHS referral within agreed protocols. Bookings will only be accepted on presentation of a fully completed booking form sent to the admission office.

Bookings for patient admission to the hospital for theatre surgical procedures will be

provided with a minimum of 7 days' notice and will be processed by the admissions office.

Late bookings for admission for surgical procedures (less than 7 days) will be authorised by a member of the Theatre Senior Team and Senior Nurse on duty once due consideration has taken place regarding:

- the clinical urgency of the case
- the number of cases already booked for that session
- the complexity of the cases booked on that session
- the availability of theatre / ward staff and experience required
- the availability of instrumentation / equipment
- the availability of a bed / critical care provision
- the ability to undertake any necessary clinical and financial risk assessments
- the availability of a pre-operative assessment appointment
- the pre-operative testing requirements and the time taken to receive test results, ensuring that all necessary test results will be received prior to surgery

GPs who contact the hospital directly regarding a request for an immediate consultation and possible admission will discuss details with the Senior Nurse on duty.

If considered an appropriate admission for the hospital, the Senior Nurse on duty will contact a consultant to accept the patient's care.

Any emergency admission will not be accepted until an appropriate consultant has agreed to discuss the case directly with the GP prior to acceptance and be present to assess the patient on arrival at hospital.

Payor status needs to be established before **any** admission and insurance authorisation confirmed as appropriate. For Inclusive Care patients, payment is required in full prior to admission. Self-pay patients must pay an agreed sum as an initial deposit.

5.0 CLINICAL RISK ASSESSMENT

Each patient will be assessed clinically prior to admission and in consideration of the 'Elective Surgical Admission Criterion Policy. Patients will be assessed prior to surgery as detailed in the Pre-operative Assessment Standards, Policy and SOP. A Pre-Admission Medical Questionnaire PAMQ) will be completed for all patients ahead of admission and discharge planning should be considered at this stage, especially requirements for home care packages or periods of convalescence

A 'Weekly Planning Meeting' should be held to ensure that patients at increased risk have been assessed, optimised and a plan is in place and communicated to all relevant departments and the Head of Clinical Services (Matron) as appropriate.

Patients with a diagnosis of Cancer

- Evidence of a Cancer MDT recommendation must be available prior to any patient with a new or current diagnosis of cancer being admitted for treatment with surgery, chemotherapy or radiotherapy at a Spire facility

Process for confirming MDT prior to admission

- The new or recurrent cancer diagnosis and proposed treatment must be confirmed on the Booking form by the treating consultant
- All patients receiving curative treatment for a new or recurrent cancer diagnosis must attend for POA

- The POA RN must confirm that the MDT documentation relating to the treatment is available in the medical records
- In the event that the MDT documentation is not available the POA RN must complete a clinical incident report on Datix and alert the Head of Clinical Services (Matron)
- Where patients have been escalated to the Head of Clinical Services, the Head of Clinical Services should discuss this with the relevant MAC representative. The Head of Clinical Services may approve on an exceptional basis if they believe:
    - An MDT discussion as taken place and the documentation is not yet available. These cases must be followed up to ensure that this received post treatment or delaying treatment would place the patient at unacceptable clinical risk and the patient will subsequently be discussed at an appropriately configured MDT meeting following treatment and this evidence will be made available.
    - Approvals by exception should be detailed on a standard template as per the Cancer Standards Policy Appendix 4 and a copy added to the Datix report.

5.1 Financial Risk Assessment

A financial risk assessment will be undertaken for each patient (as detailed below). All insured, inclusive care and self-funding patients are required to sign a hospital registration form accepting financial liability. NHS patients are requested to complete a registration form to ensure all data is correct and the data protection notice is signed, but not for financial liability.

All non-NHS patients are requested to provide credit card or debit card details to cover any insurance excesses, take home drug costs and sundry charges not covered by their insurer or included within their package of care. Credit card details are acceptable from the patient or carer.

a) **Insured Patients – With the exception of oncology -** pre-authorisation checks will be carried out for insured patients. If authorisation is not provided by the insurer, the patient should be advised about Inclusive Care. Admission cannot take place without guaranteed payment by either the insurance company or advance payment of the inclusive care package.

b) **Inclusive Care Patients** - Full payment is required prior to admission. The procedure will be re-scheduled if the payment has not been received.

c) **Self-funding Patients** – An amount of money equivalent to inclusive care package is required prior to admission. The patient will be kept informed of costs throughout their stay and further monies requested as appropriate.

d) **NHS Patients - Credit or debit card information would only be suggested to patients on the day of admission to cover sundries or phone calls but not requested as a mandated requirement.** Patient journey details are maintained for management of potential breach dates

e) **Medico-Legal patients –** an inclusive care price is calculated with the understanding that a refund will be made if the full amount not used or if more funds are required. This can be guaranteed by a solicitor's letter as signed guarantor which is acceptable with the deposit of the inclusive care price.

f) **Immediate/Late Bookings** – Immediate/Late bookings (less than 72 hours) must be pre-authorised as a priority once the booking has been approved by the Senior Nurse and Theatre Manager. A deposit must always be requested for 'out of hours' bookings, this will be refunded to insured patients on confirmation of authorisation from the insurance company. If a patient needs admission 'out of hours' and claims to be covered by insurance, but this cannot be checked until a later date, they must be treated as self-pay patient until authorisation is confirmed by taking a deposit or guaranteed credit card payment in the interim.

6.0 PREPARATION FOR ADMISSION

Beds are allocated by the Senior Nurse on duty or via the bed management system.

On receipt of a booking form, availability of theatre time and bed/area should be assessed.

After pre-authorisation checks, care pathways and labels will be produced (showing full patient demographics) and the patients' medical record folder will be prepared for admission.

Theatre scheduling booking forms will be passed to the admissions office once a patient has been appropriately pre-operatively assessed. A theatre schedule will be built to the time slot available / allocated to the surgeon. Staff, bed availability and specialist equipment requirements will be assessed at the weekly bed management / scheduling meeting. Any proposed late additions to the theatre schedule will be discussed with the

theatre manager and senior ward nurse. Theatre scheduling will consider the complexity of procedure, patient condition, whether an in patient or day case procedure and the type of anaesthetic.

7.0 ADMISSION

A patient's admission will be conducted quietly and efficiently taking due care and attention of any religious and cultural beliefs maintaining privacy, dignity and confidentiality throughout. A sensitive approach will be maintained whilst gathering and imparting all the necessary information, ensuring that the patient is made to feel welcome and at ease.

7.1 Timing of Admission

It is recommended, whenever it is practical to do so, that admission times are split for morning, afternoon and evening operating lists. For example:

- 06:30 admission for a morning operating list beginning at 08:00
- 11:00 admission for an afternoon list beginning at 13:00
- 15:00 admission for an evening list beginning at 17:00

Splitting admission times allows better management of pre-operative fasting times and supports maximising bed occupancy. However, this must be balanced with the need for adequate time to complete admission processes (including consent) and for anaesthetists to assess patients prior to arrival in the anaesthetic room

For all day operating lists, split admission times must be in place

7.2 Administration

With the exception of emergency cases, all patients will receive an Admission Pack containing relevant details and information prior to admission.

Patients will be greeted on their arrival by reception staff. Details (including identity) of the patient will be confirmed by requesting the patient to state their full name, date of birth and current address. These should be checked against Spire's patient administration system.

Patient Reported Outcomes questionnaires will be issued as appropriate (if not already done so at pre-operative assessment) and any relevant payments requested (including credit card details) to cover sundry items and insurance excesses.

Registration forms must be reviewed by the patient and signed. Any changes to details must be amended on the system and will need to be communicated to the ward when care

pathways and labels have been produced prior to admission.

Reception is responsible for ensuring the patient is collected and escorted to their room without undue delay (typically within fifteen minutes of the patient making themselves known to the hospital unless circumstances dictate a longer waiting time)

The ward receptionist / HCA will collect the relevant notes from the ward station and escort the patient to their allocated room or clinical treatment area.

Once in the room or ward, it is the responsibility of the person escorting the patient to ensure they are familiar with all of the facilities available:

- Nurse call system
- Fire Procedure
- Hostess call system
- TV controls
- Lights
- Telephone
- Use of mobile phones
- Toilet facilities
- Lounge (if applicable)
- Visiting times
- Telephone number for ward / room for relatives to call in
- Confirm if patient has any electrical equipment. If yes, please follow work instruction – 'Procedure for patient and staff's own electrical equipment'.
- Safe storage of valuables in a safe with receipt (patients should be discouraged from bringing valuables into hospital)

The nursing staff must be informed that the patient has arrived and is in their room.

The admission details will be entered onto Spire's patient administration system.

7.3 Nursing

a) Prior to the admission, the admitting nurse will check the room / area to ensure the following:
   - The room or area is clean, warm and fit for purpose e.g. alcohol gels, gloves, towels tissues, vomit bowl, gown, disposable pants are available
   - Appropriate moving and handling equipment is in place (e.g. hoist)
   - Ensure relevant environmental risk assessment is carried out e.g. for paediatric admission or cot sides assessment
   - Ensure the nurse call system is in working order.
   - Ensure the oxygen and suction equipment is in working order and non-breathable mask, oxygen tubing and yankeur sucker are available.

b) The named nurse will greet the patient within fifteen minutes of their arrival into the room / area.

c) All information gained either verbally or written prior to admission must be included on the relevant hospital admission forms and Patient Record.

d) The nurse will complete/update the care-pathway with the patient, recording all details and identifying any changes to clinical condition since questionnaire completion or pre-admission assessment. Appropriate escalation of this information needs to be considered.

e) All patient risk assessments must be completed by a Registered Nurse

f) Allergies must be recorded on the patient Drug Prescription and Record and a warning sign placed on the front of the Patient Record folder. Relevant clinical and catering staff must be made aware of any problems highlighted including allergies.

g) VTE risk assessment is to be recorded on the Drug Prescription Chart and where a patient is identified at risk of VTE this must escalated to the admitting consultant.

h) Confirmation must be sought by the nurse that the patient has followed any pre-admission instruction e.g. 'no food/drink for a certain period'.

i) Legible ID bands recording the patient's full name, date of birth, hospital number and their consultant's name must be attached to all patients.

- **White** ID Band - All patients
- **Red** ID band when Allergies have been identified

j) Any medication brought into the hospital by the patient must be handed to the admitting nurse to liaise with the hospital pharmacist and then locked in a secured area. Their usual medications should be prescribed in a timely manner as appropriate. Self administration document must be completed for appropriate patients

k) The named nurse will ensure the patient has received all relevant information regarding their care.

l) A pregnancy test will be offered to all appropriate patients prior to treatment / surgery / investigation as per Spire policy.

m) If the pregnancy test is declined the consultant must be informed and course of action documented as a variance. Positive pregnancy tests must be reported to the consultant immediately and planned procedure suspended until reviewed by the consultant.

n) Any response to a relative's request for information must first be authorised by the patient.

o) Confirmation will be sought and documented by the nurse that discharge home arrangements made by the patient are suitable for their requirements e.g.:

1. Accompanied home by a responsible adult and for 24 hours following a general anaesthesia
2. Suitable transportation home
3. Carer arrangement made where relevant as per pathway.

8.0 PAEDIATRICS

The minimum age at which children will be admitted to a Spire hospital for all procedures is three years (with exception of Manchester Hospital and Leeds Hospital ONLY). Please refer to Clinical Policy 11 - Care of Children Policy which defines children as individuals between the ages of 0 and 15 years up to the day before their 16th birthday.

A pre-admission assessment must be arranged with the Registered Sick Children's Nurse (RSCN) for all children.

An appropriate risk assessment of patient, room and equipment must take place and be clearly documented within the patient's care pathway

Bookings for children cannot be confirmed without confirmation that an RSCN will be available throughout the duration of the child's stay.

Children will only be admitted under the care of a consultant who meets their practicing

privileges requirements for CYP patients.

9.0 DISCHARGE PLANNING - CLINICAL

The discharge plan will commence at the beginning of the patient episode of care. Liaison will take place between the consultant and other members of the clinical team. The discharge arrangements set out below apply whether within or outside normal working hours. Additional discharge arrangements for all patient groups are specified in the relevant treatment care pathways.

Community liaison and Occupational Therapy are contacted / involved when necessary as per the patient's care pathway.

The consultant and clinical team will identify the discharge date in line with the relevant care pathway; agree the expected clinical outcomes on discharge and any follow up care arrangements to be made.

The consultant will be notified of any variances that might affect the planned discharge date as they arise. If the patient does not achieve the expected clinical outcome this will be reviewed.

All inpatients will be discharged by 10:00am on the morning of their discharge if clinically appropriate. The discharge time for day-care patients will depend on the rate of their recovery and should take account of discharge criteria within the relevant care pathway.

Patients will not be routinely discharged after 22:00 unless the patient expresses otherwise; exception late evening discharges will be risk assessed to take account of carers at home and the patient signs to say they are happy to be discharged at thattime.

Patients that have been admitted as a day case and received sedation / general anaesthetic must only be discharged if they are accompanied home and have someone with them to stay overnight.

Patient information (including written information) and advice on follow up/wound care will be given to the patient and/or their carer on discharge together with relevant contact telephone numbers for 24 hour access. There should be a clear protocol in place for managing post-discharge calls (see appendix 8) and telephone enquiries from patients (or their carers) must be assessed by a nominated, qualified member of the nursing team.

Where required, an outpatient follow-up appointment will be made prior to discharge or sent to the patient's home address following discharge.

For ALL NHS patients there must either be a planned face to face out-patient follow up by a Clinician or a telephone review within 6 weeks of discharge, unless otherwise agreed with the relevant commissioner. A protocol for follow up telephone review for all patients has been developed and is included in appendix 4 and 5.

The discharge plan will be documented in the patient's hospital record and should include a record of any communication with community services.

A copy of the completed discharge summary must remain in the Patient Record with copies given to patient and faxed/sent to GPs.

ALL patients should be given their own personal copy of their Discharge Summary on the day of discharge which should be discussed with the patient face to face

Discharge medication should be explained and written information given to patient.

10.0 DISCHARGES BY WARD CLERK

All sundries and phone bills should be checked and ready for payment prior to discharge

Wherever possible, all out-patient follow ups should be arranged where indicated with written confirmation for patient

Once the nurse responsible for discharging the patient has completed her entries in the Patient Record, the Ward Clerk must ensure that the Patient Record is filed in correct order and details of discharge are entered on Spire's patient administration system.. See Clinical Policy 08 - Patient Records policy

All NHS contract patients managed under HRG4 at tariff must have their notes presented to the Clinical Coding Service immediately after discharge to ensure the episode is coded and the data entered into Spire's patient administration system for month end reporting and billing.

11.0 TRANSFERS

Transfers in – are processed as per the admission process but include a telephone nursing assessment with the hospital the patient is moving from, including a MRSA risk assessment and subsequent screening and isolation until it is confirmed that the patient is MRSA negative.

Internal transfers – conversion from day-case to unplanned inpatient – are arranged in accordance with the instruction of the consultant and senior nurse on duty and following liaison with the relevant departments.

External transfers – booked transfers are arranged as per the discharge process but include the arrangement of transport and escort as required. As appropriate, a copy of relevant documentation should be sent with the patient. The Patient Record must be updated to include details of the transfer and the reason for transfer must be recorded in the relevant section of Spire's patient administration system.

Emergency transfers – arranged following consultation with the attending consultant and senior ward/theatre nurse who will liaise with the accepting hospital as per the agreed local transfer policy. Relevant documentation will be photocopied and sent with the patient. Transport and accompanying clinical staff will be arranged as required as per UK Resuscitation Council Guidelines. An Serious Adverse Event Notification Form and datix form must be completed and the reason for transfer recorded in the relevant section of Spire's patient administration system.

All unplanned and emergency transfers to level 2 / 3 care - will be followed up on a daily basis by a designated member of the senior clinical staff who will contact the establishment where the patient has been transferred and document the details of the enquiry into the patient record. This daily contact must be continued until the patient is deemed 'safe' or 'out of critical danger'. A standard variance tracking sheet is available to support this process and is included at appendix 6. The Patient Record must be updated to include details of transfer.

Out of hours transfers

Hospitals must have out of hours transfer arrangements with local healthcare providers and local processes must be followed in the event that this is required.

Documentation

Documentation that accompanies a transfer should be adequate to ensure that the receiving unit have a history of treatment provided where this is relevant to the ongoing care. In many instances local transfer arrangements may require the completion of a transfer form and these should be completed where required.

A Serious Incident Requiring Investigation (SIRI) notification should be sent to IRWG following all transfers out.

12.0 EXTENDED STAYS

Any extended stay must be recorded as a variance in Care Pathway with the clinical reason

For insured patients, extended stays are monitored daily and communicated with the relevant insurance company where required to obtain authorisation for the extended stay.

For self pay patients, extended stays are monitored daily and hospital fees are secured appropriately.

The clinical governance team regularly audit extended stays to identify any developing trends.

NHS Patients – extended stays are monitored daily and information provided to the appropriate PCT according to the contractual agreement. All details of complications must be entered into Patient Record to ensure the Coding Administrator can record the cause of the extended stay.

13.0 MANAGING POST DISCHARGE ENQUIRIES

13.1 On discharge, patients must be provided with information on how to contact the hospital (24 hour number) and advised to do so if they have concerns regarding their recovery or discharge arrangements. Additionally consultants may also provide patients with direct contact information.

13.2 Telephone enquiries from patients (or their carers) must be assessed by a nominated, qualified member of the nursing team who has the appropriate competency for managing post discharge enquiries, available on the intranet. The purpose of this assessment (triage) is to signpost patients to the appropriate level of care, and **not** to make a clinical diagnosis. However, a qualified nurse may give the patient (or their carer) advice, provided the advice given is within their professional scope of practice and current knowledge.

13.3 The principles for effective post discharge call management are:

- Information gathering – actively hearing what the patient does and doesn't say
- Understanding – interpreting the main reason for the call amongst all the information the caller may give you
- Agreeing - reflecting back to the caller the main concern and agreeing the next course of action
- Appendix 7 must be used for all post-discharge enquires documenting the Situation, Background, Assessment and Response.

13.4 Possible Outcomes

The outcome of a call can be classified as:

A. Contact 999 for ambulance (to NHS Trust emergency department)

B. Immediate return to the Spire hospital - for review by RMO / Consultant

C. Advice given and patient to attend hospital tomorrow morning – for review by Nurse/RMO

D. Advice given and follow-up call to be made within 24 hours

E. Advice given and advice to be peer reviewed by senior nurse with 24 hours - may include attending a GP routinely, or attending next planned

out-patient appointment

F. Advice given and patient advised to call back if problem persists

G. Advice given and no further intervention required

H. Other disposal (not covered by categories A – E)

13.5 Assessment Criteria

A. If the patient is reported to be experiencing any of the following critical signs, the caller must be advised to dial 999 to request an emergency ambulance:

- Unconsciousness or altered consciousness
- Sudden onset chest pain suggesting an acute cardiac episode
- Facial weakness; arm weakness; slurred speech – symptoms suggesting a stroke
- Shortness of breath; difficulty breathing
- Acute and severe trauma, including head injury
- Heavy uncontrolled bleeding
- Sudden loss of vision following ophthalmic surgery
- Pain score of 4 or more despite prescribed analgesics
- Any other condition the nurse taking the call believes to be life threatening

B. If the patient is reported to be experiencing any of the following concerning signs the caller must be asked to attend the hospital as soon as they can for clinical assessment by a senor nurse or RMO:

- Any unwell child
- Pain score 2/3 despite prescribed analgesics (including severe headache)
- Calf pain; tenderness and swelling of the leg; skin discolouration that is pale, blue, or a reddish-purple colour – symptoms indicating a deep vein thrombosis
- Prolonged vomiting and / or diarrhoea
- Acute urinary symptoms including retention
- Unusual chest pain (not crushing chest pain)
- Persistent surgical site bleeding
- Abdominal pain not associated with primary surgery
- Escalating wound pain, swelling, inflammation or discharge
- Fever and/or escalating malaise
- Difficulty swallowing
- Confusion or disorientation; repeated episodes of dizziness
- Repeated falls
- Patients receiving chemotherapy treatment with an elevated temperature
- Any other condition the nurse taking the call believes to be particularly concerning

At the end of any call involving concerning signs, a "worsening statement" should be provided – e.g. *"if your symptoms worsen before you can attend the hospital, please call us back or contact 999"*

Once critical or concerning signs have been ruled out, there may be occasions when the nurse taking the call needs to contact the **treating Consultant** before providing advice to the caller. Examples include when the patient is experiencing:

- Elevated temperature

- Unrelenting cough
- Emotional distress

If this is the case, at the end of the call the nurse should take at least one, but preferably two telephone numbers to contact the patient back once advice has been received from the Consultant.

The Nurse should give an indication as to how long the caller will have to wait e.g. 20 minutes, and call the patient back even if it has not been possible to contact the Consultant within that timescale, to explain this.

Advice and reassurance by the Nurse taking the call can be provided in situations that would ordinarily be expected as a result of treatment, with no immediate concerns, and not requiring any immediate intervention, e.g.

- Discomfort controlled by pain relief
- Nausea
- Tiredness
- Bruising and or / swelling in the surgical area
- Constipation
- General queries relating to discharge arrangements (e.g. follow-up appointments)

The advice provided could include arranging a GP appointment or attending the next planned out-patient appointment.

At the end of any call involving advice and reassurance by a nurse, a "worsening statement" should be provided – e.g. if you continue to be concerned please do not hesitate to call us back"

NB: If someone calls post discharge for advice again within a 24 hour period, they must be invited to attend the hospital at their earliest convenience for clinical assessment by the senior Nurse or RMO.

14.0 POST DISCHARGE WARD/OUTPATIENT ATTENDANCE

N.B - it is rare that a patient will attend the hospital post-discharge without first calling for advice, but on these occasions please follow the same instructions as if the patient had been advised to attend the hospital.

Following a post-discharge phone call a patient maybe advised to visit the hospital for review. The patient must be advised which department to attend and inform the department and the RMO to expect the patient.

Prior to the patient's arrival ensure that the medical records are available. On the rare occasion where the medical records are unavailable there must be a local process in place to ensure that a temporary set must be made and merged as soon as possible with the original records.

All patients re-attending the hospital must be reviewed by the RMO. The patient must be fully assessed and documentation must include:

- Date and time
- Presenting symptoms
- Past medical history (recent admission and previous medical history)
- Examination and findings
- Impression
- Confirmation that the consultant has been notified and when
- Whether advice has been sought from the consultant, if it has, that advice should be documented. If advice has not been sought the reasons for not doing so should also be

documented.
- Plan for the patient
- Outcome

Any patient that has attended the hospital must be contacted within 24 hours of attendance by the RMO and the follow up call must be documented in the medical records.

Any patient that is seen at the hospital must be entered onto Datix in the following category

- Main category – Discharge
- Sub-Category – Re-attendance following discharge

15.0 EMERGENCY READMISSIONS

Priority should always be given to a re-admission i.e. a patient who has recently been discharged but needs to come back into Hospital urgently for further treatment. In the rare event that it is initially deemed that no beds are available, due consideration must be given to postponing future admissions to accommodate the patient. A member of the Senior Management Team must be consulted in any situation where beds are not immediately available for re-admissions.

The Nurse in Charge will be notified of the patient's needs by GP/Consultant

The Nurse in Charge assesses suitability of the patient's condition and staffing and bed availability

The Consultant will accept responsibility for the patient's admission

The Nurse in Charge completes a booking form, which is taken to Reservations / Bookings

If 'out of hours', the ward clerk will carry out the administrative admission.

The Patient's details are entered onto computer. The admission should be recorded as an "emergency" in the relevant section of Spire's patient administration system.

Patient records located.

The Patient (& GP if GP referral) are contacted with details of Admission/Transport and expected time of arrival

The Ward and relevant department are notified of re-admission.

All the appropriate pre-authorisation checks must be made and credit/debit card details secured unless reason for admission is covered by Inclusive Care Package.

Patient Assessment

All patients that are readmitted must be assessed and a plan of care agreed by their consultant no longer than 4 hours following admission.

16.0 MONITORING THE EFFECTIVENESS OF ADMISSIONS AND DISCHARGES

Local and national patient surveys, complaints, incidents reports and informal feedback all provide information on the effectiveness of admission and discharge arrangements. These are all monitored in line with the requirements of the Spire Healthcare Clinical Governance and Quality Manual (Clinical Policy 1)

Appendix 1

PATIENT SELF DISCHARGE AGAINST MEDICAL ADVICE PROCEDURE

In the event that a Patient wishes to be discharged against medical advice within a Spire Hospital the Senior Nurse on duty shall:

1. ensure that the patient is aware of the medical advice that he/she should not be discharged and the reasons for that opinion

2. inform the consultant responsible for the patient's care immediately

3. obtain the patient's written statement that they wish to be discharged against medical advice or, if the patient is unable or unwilling to sign such a statement, record all relevant details in the patient's medical record to be witnessed by two Healthcare Professionals one of whom should, if possible, be the consultant responsible for the patient's care

4. inform the patient's next of kin, carer or other appropriate person of the patient's discharge against medical advice providing the patient has signed his/her consent to this in the self-discharge form (Appendix 2). Details and reasons for patient's decision to self discharge should be left to the patient to explain to the next of kin if possible

5. take any steps to delay the patient's departure which are appropriate and are legally permitted

6. in the case of NHS patients, inform the NHS Contract's Manager as soon as reasonably practical of the patient's discharge against medical advice

7. in the case of a NHS patients, inform the patient's GP as the referring clinician, prior to, or immediately after, the patient's discharge

8. in the case of vulnerable patients, inform the police and/or other support agencies as appropriate

9. take all reasonable practicable steps to organise the discharge as if it were taking place with, rather than against, medical advice

10. update the discharge plan and patient record appropriately

11. where appropriate ensure that IV cannula is removed prior to departure with agreement of the patient

12. where appropriate ensure patient has essential medication prior to leaving as agreed by consultant

SPIRE HEALTHCARE

PATIENT SELF DISCHARGE FORM

I..... (Printed patient name) wish to take responsibility for my own discharge from this Spire Hospital, despite the medical and nursing advice I have been given.

I consent to my next of kin or carer being informed that I have taken my own discharge against medical and nursing advice (delete this section if consent withheld).

Date..... Time.....

Patient Signature .....

Patient Printed Name _____

State if Patient was unwilling or unable to sign this Form _____

Witness Signature _____

Printed Name _____

Nurse in Charge Witness Signature _____

Nurse in Charge Printed Name _____

Other Healthcare Professional Witness Signature _____

Other Healthcare Professional Witness Printed Name and Designation _____

Outpatient Telephone Consultations Form

Appendix 3

	Patient Number : **First Name :** **Last Name :** **Date of Birth :** **Sex :** **M / F** **Contact tel no. :**

Treatment / Operation :

Discharge Information (e.g. any relevant clinical findings, complications, pending investigations, advice given)

	Call date and time	Call made By	Completed	Unanswered	Patient unavailable / Voicemail	Patient declines telephone consultation
CALL 1			☐	☐	☐	☐
CALL 2			☐	☐	☐	☐
CALL 3			☐	☐	☐	☐

What is Patients current level of pain?

- ☐ 0 No pain
- ☐ 1 Mild pain
- ☐ 2 Unpleasant pain
- ☐ 3 Severe pain
- ☐ 4 Worst imaginable pain

How does the patient describe their surgical wound:

- ☐ Clean and dry
- ☐ Redness around wound no oozing of blood or other discharge
- ☐ Redness around wound and oozing of blood or other discharge
- ☐ N/A – no wound

Has the patient returned to normal activities such as driving, work and shopping yet? (Details)

Patient understanding of next steps (please state):

Outcome of Call

- ☐ No further action required
- ☐ Further action required (please state):

Call completed by:

Signature: ..... **Print Name :** .....

Date: ..... **Designation:**

SPIRE HEALTHCARE - FOLLOW UP ENQUIRY TELEPHONE PROTOCOL

Timing of consultations

4 weeks following discharge

Number of attempts at contact

If the first attempt at a follow-up phone consultation is unsuccessful (because the call is unanswered, the patient is unavailable or the time of the consultation is inconvenient), two more attempts at contact will be made (a maximum of three) within the period up to six weeks following discharge. Attempts to contact the patient must be made at different times of the day (e.g. am and pm on the same day) and the three attempts at contact must be spread across at least two consecutive days. However, if the patient declines a consultation at the first point of contact by telephone, no further attempts to conduct the consultation are required.

Escalation Procedures

Pain Score

0	No pain	No action required
1	Mild pain	No action required, if pain gets worse advised to contact hospital
2	Unpleasant pain	o/p review by health care professional
3	Severe pain	o/p review by health care professional
4	Worst imaginable pain	o/p review by health care professional

Wound Care

• Clean and dry	No action required
• Redness around wound no oozing of blood or other discharge	o/p review by health care professional
• Redness around wound and oozing of blood or other discharge	o/p review by health care professional

Return to normal activities

Any problems with return to normal activities	o/p review by health care professional

Telephone Consultation Format

a. Answer-phone

If the phone rings into answer phone, do not leave a message, but call back another time (if less than three attempts to conduct the consultation have been made).

b. Someone else answers

Hello, is it possible to speak to Mr/Mrs..... (include first name and surname)

If no: state name and inform that you will phone back at another time (if less than three attempts to conduct the consultation have been made). It is not appropriate to ask for a convenient time, as the person answering the phone may ask what the call is about and it is not in the patient's interest to discuss this. If the person who answers the phone presses for an explanation, ask them to inform the patient that {your name} called and that you will phone back at another time.

If yes: continue conversation with patient (see below)

c. When contact is made

Hello, is that Mr / Mrs..... (include just surname)

It's ....., a member of the nursing team at (hospital name), ringing as we agreed, is it all right to talk?

If no: negotiate a convenient time to call back

If yes: continue conversation

Please can you tell me your full name? And what is your date of birth?

- If either is NOT CONFIRMED: come out of assessment and check patients details against notes again and confirm address and telephone number.

Please can you confirm the password we agreed with you before your discharge.

- If NOT CONFIRMED: explain that in order to maintain patient confidentiality, you need to be sure of the identity of the person you are taking to and discontinue assessment. A face to face outpatient follow-up will need to be arranged for these instances.
- If CONFIRMED: (continue with assessment)

Pain score using 0 – 4 pain scale

Firstly, I would like to know if following your procedure you have been comfortable.

If the patient answers no then ask the detailed question below.

I need to ask you some questions about any current pain from your operation site. Would you describe your pain at the present time as:

0 No pain

1 Mild pain

2 Unpleasant paint

3 Severe pain

4 Worst imaginable pain

If the patient answers 0 (for example), there is no need to describe the scale in full.

Secondly, I need to ask you about your surgical wound. How would you describe it at the moment?

- Clean and dry
- Redness around wound no oozing of blood or other discharge
- Redness around wound and oozing of blood or other discharge

Finally, I need to ask you about returning to normal activities. Since your operation, have you been able to return to work, start driving again and undertake other everyday activities such as shopping?

Do you have any other concerns or questions?

That is the end of the consultation. I am happy to discharge you, if you have any problems in the future please contact your GP.

Or

Describe alternative next steps.

Thank you for your time.

{Patient Letter}

Dear

Re: Telephone Follow Up Appointment

As part of your ongoing care following your surgery at ..... Hospital you were to be contacted by telephone. On three separate occasions I have telephoned your number and have been unable to make contact with you.

Your Consultant and GP have been made aware of this.

From / / please contact your GP if you have any further queries. In the meantime, please contact me on the above number if you should wish to discuss this further.

Yours sincerely

{GP Letter}

Dear

Re: Patient Details

The above named patient was to be followed up by telephone following their ..... surgery at..... Hospital. I have been unable to contact this patient on three separate occasions, including the date and time we agreed with them. I have not made any further appointments and have sent a letter to the patient informing them of the above.

From / / the patient has been advised to contact you if they have any further queries.

Should you be aware of any changes in the patients circumstances or require any further information please do not hesitate to contact me on the above number.

Yours sincerely

Telephone Follow Up Appointment

As part of your care following your.....surgery, you will be followed up by telephone. The phone follow-up service has been set up for patients like you who require a follow-up appointment which does not need to be at the hospital outpatient department.

The follow up appointment has been made for you on .....(date) at..... (time).

The call will be made by a member of our nursing team. So that we can respect your right to privacy, we will provide you with a "password" before your discharge from hospital. Please keep this safe as we will need to confirm it with you at the time of the follow-up phonecall.

Examples of the questions you will be asked during the phone call include:

- How would you rate your level of pain (from your surgical site)?
- How would you describe your surgical wound?
- Have you been able to return to your normal activities such as driving, working and shopping?

Please think about your responses to these questions prior to the call to enable time to discuss any issues you may have.

If you, or the nurse, are worried about any problems, you may have to attend an outpatient appointment at the hospital to undergo further tests or treatment. If this is the case, we will inform your GP of the outcome of the call.

Should you have any problems prior to your telephone appointment please contact the hospital on tel: .....

Please inform the hospital of any changes in your personal details prior to your follow-up appointment, including changes to your telephone number.

If you are unavailable to talk at the time of your telephone appointment, we will contact you again (up to three times) to conduct the assessment.

PATIENT TRANSFER

Use one side per variance

Patient is to be transferred to another hospital due unplanned circumstances.

Date	Time	VARIANCE OR PROBLEM
		Give brief detail of reason for transfer here and continue to document below and over page as required.

ADDRESSOGRAPH

Please note: All patient unplanned transfers are reportable incidents. An adverse event/ near miss form must be completed.

In addition, a designated member of senior clinical staff must contact the establishment where the patient has been transferred on a daily basis and the enquiry must be documented in the patient record (see page 3). This contact must be continued until the patient is deemed "safe" or out of critical danger

The following detail is required for audit.

The patient is to be transferred to: ☐ the NHS ☐ Another independent provider

The patient is to transferred to:

☐ critical care level 2 ☐ critical level 3 ☐ other ward/unit (not level 2 or 3 care)

Please indicate the MAIN reason for the transfer:

☐ Unplanned transfer to ITU

☐ Unplanned transfer to HDU

☐ Unplanned transfer for Inpatient treatment

☐ Unplanned transfers due to Consultant request where no other reason is indicated

☐ Other (please state):

Time of actual transfer:

Who has authorised the transfer?

How is the patient being transferred:

☐ By 999 ambulance ☐ By private ambulance (paramedic crew)

☐ By private ambulance (non-paramedic crew) ☐ other (please give details)

Where is the patient being transferred to? (Give hospital and unit/ward)

Who is escorting the patient? (Name, profession and qualification)

Observations and vital signs recorded prior to transfer: (use space below if required)

PATIENT TRANSFER

Use one side per variance

Patient is to be transferred to another hospital due unplanned circumstances.

Name and signature of person completing this sheet:

Date	Time	Variance / Problem

Addressograph

Date & time	Report / Action	Sign	Outcome/Progress Evaluation	Sign	Date & time

Variance/ problem resolved: Yes / No (if no continue on another sheet)

PATIENT TRANSFER

Use one side per variance

Patient is to be transferred to another hospital due unplanned circumstances.

Date	Time	Variance / Problem
		Record of daily contact with accepting hospital to monitor patient progress

Addressograph

Date & time	Report / Action	Sign	Outcome/Progress Evaluation	Sign	Date & time
	Telephone call made to accepting hospital to monitor patient progress				
	Telephone call made to accepting hospital to monitor patient progress				
	Telephone call made to accepting hospital to monitor patient progress				

Variance/ problem resolved: Yes / No (if no continue on another sheet)

PATIENT TRANSFER

Use one side per variance

Patient is to be transferred to another hospital due unplanned circumstances.

Please continue overleaf if required

Date	Time	Variance / Problem

Addressograph

Date & time	Report / Action	Sign	Outcome/Progress Evaluation	Sign	Date & time

Variance/ problem resolved: Yes / No (if no continue on another sheet)

INTER-HEALTHCARE INFECTION CONTROL TRANSFER FORM

Patient/Client details: (insert label if available)

Name :

Address :

NHS Number :

Date of Birth :

Consultant :

GP :

Current patient / client location :

Transferring facility – hospital, ward, care home, other :

Contact No. :

Is the ICT aware of transfer? Yes / No

Receiving facility – hospital, ward, care home, district nurse

Contact no. :

Is the ICT / ambulance service aware of transfer? **Yes / No**

Is this patient / client an infection risk?

Please tick most appropriate box and give confirmed or suspected organism

☐ **Confirmed risk**	**Organism :**
☐ **Confirmed risk**	**Organism :**
☐ **Confirmed risk**	**Organism :**
☐ **No known risk**	

Patient / client exposed to others with infection e.g. D&V Yes / No

If patient / client has diarrhoeal illness, please indicate bowel history for last week :
(based on Bristol stool form scale)

Is the diarrhoea thought to be of an infectious nature? Yes / No

Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococcus SPP, C. difficile, multi resistant Acinetobacter SPP) and treatment information including antimicrobial therapy :

Specimen :				
Date :				
Result :				

Treatment information :

Other information :

Is the patient / client aware of their diagnosis / risk of infection? Yes / No

Does the patient / client require isolation? Yes / No

Should the patient / client require isolation, please phone the receiving unit in advance

Name of staff member completing form :

Print Name :

Contact No. :

For further advice, please contact your infection control team / adviser

Appendix 7

FRAMEWORK FOR MANAGING PHONE CALLS FROM CONCERNED PATIENTS

1. **Establish rapport with the caller**
   - Introduce yourself to the caller and advise them on the direction the call will take
   - Establish who is on the phone – patient, relative, third party, e.g. nursing home
   - Rule out any critical signs requiring immediate intervention

2. Once, critical signs have been ruled out, **establish reason for the call**
   - What has led the patient to call?
   - If the patient is not calling themselves, ask to speak to them in person
   - What has changed and what is their norm? What makes their symptoms better or worse?
   - Take a brief account of the enquiry, using the patient's reported words wherever possible.
   - Rule out any concerning signs requiring the patient to attend the hospital for clinical assessment by a senior nurse or RMO

3. Once concerning signs have been ruled out. **consider involving the RMO and the patient's consultant**
   - Reflect information gathered back to caller /patient to ensure that you have picked up the correct information

4. **Recommendations**
   - Involve caller/patient in your decision making:
   - Discuss outcome with caller/patient and gain agreement for decision.
   - Explain rationale for the decision you have reached

5. **Provide worsening statement**

6. **Complete the post-discharge call record sheet in full for each and every call where advice is provided. Sign, date and time.**

7. **Notify Consultant of contact from patient if advice has not already been sought.**

Appendix 7

POST-DISCHARGE CALL RECORD SHEET (Incoming Calls)

Please follow each step in order as it is set out in this form

Are you a qualified nurse with at least 6 months experience in post ☐ Yes ☐ No
Have you successfully completed a competency assessment in managing post-discharge calls ☐ Yes ☐ No

To proceed further you **must** have answered "Yes" to both of the questions above. You **must** otherwise pass the call to a more experienced colleague.

Date.....	Caller name:.....
Time	Patient ☐ Other ☐ *(please state relationship below)* .....

Patient's name:..... Date of Birth:.....

Telephone number:..... Consultant:.....

S

Why are you calling?

☐ Unconsciousness or altered consciousne

Is the patient reported to be experiencing any of these critical signs? You must specifically ask each question.	☐ Sudden onset chest pain suggesting an acute cardiac episode ☐ Facial weakness; arm weakness; slurred speech ☐ Shortness of breath; difficulty breathing – symptoms suggesting a stroke ☐ Acute and severe trauma, including head injury ☐ Heavy uncon ☐ Sudden loss of vision following ophthalmic surgery ☐ Pain score 4 despite prescribed analgesics *(please state below)* ☐ Other condition you believe is life threatening ..... **If any apply advise caller to dial 999 to request an emergency ambulance**

B

Date of admission: ..... Date of discharge: .....

Details of original admission *(e.g. procedure performed)*:

A

Please describe the enquiry in more detail using the patient's reported words wherever possible (e.g. "it's a sharp stabbing pain") *Please continue on a separate sheet if necessary, using a patient address label*:

.....

.....

.....

.....

Is the patient reported to be experiencing any of these concerning signs?	☐ Any unwell child ☐ Pain score 2/3 despite prescribed analgesics (including severe headache) ☐ Calf pain; tenderness and swelling of the leg; skin discolouration that is pale, blue, or a reddish-purple colour – symptoms indicating a deep vein thrombosis ☐ Prolonged vomiting and / or diarrhoea ☐ Acute urinary symptoms including retention ☐ Unusual chest pain but not crushing ☐ Persistent surgical site bleeding ☐ Abdominal pain not associated with primary surgery ☐ Escalating wound pain, swelling, inflammation or discharge ☐ Fever and/or escalating malaise ☐ Difficulty swallowing ☐ Confusion or disorientation; repeated episodes of dizziness ☐ Repeated falls ☐ Patients receiving chemotherapy treatment with an elevated temperature ☐ Other condition you believe is particularly concerning *(please state below)* ..... **If any apply advise please ask the patient to attend the hospital for clinical assessment by a senior nurse or RMO**
You may give the patient advice provided the advice you give is within your professional scope of practice and current knowledge. Please summarise the advice given:	
Was the Consultant contacted for advice BEFORE patient attends hospital? ☐ No ☐ Yes *(Please state below advice given by Consultant)*: Date and time of call to consultant:..... / ..... / 20..... ..... **If the Consultant was not contacted before advising the patient, please make sure the Consultant is notified that their patient has called and what advice has been given.**	
Final disposal	☐ 999 Ambulance ☐ Attend hospital immediately for review (attach records) ☐ Advice given and patient to attend hospital tomorrow morning for review (attach records) ☐ Advice given and follow-up call required within 24 hours ☐ Advice given and advice to be peer reviewed by senior nurse within 24 hours ☐ Advice given and patient advised to call back if problem persists ☐ Advice given and no further interventions required ☐ Other disposal (please state below)..... ....
	Date: ..... time: .....
Follow up call	☐ Have symptoms resolved ☐ Yes ☐ No ☐ Test results given ☐ Treatment advice given ☐ Advice given and patient to attend hospital for review ☐ Advice given and follow-up call within 24 hours ☐ Other .....

Signature:.....	Date: ..... time: .....

Spire Healthcare

SPIRE HEALTHCARE	**Ref:**	**Clinical Policy 18**
	Issued By:	**Clinical Governance Director**
	Approved By:	**Policy Approval Group**
	Date:	**January 2020**
RMO HANDBOOK	**Applies to sites:**	**All hospitals**
	Applies to staff groups:	**RMO's, SMT, Clinical HOD's**

RMO HANDBOOK

CONTROLLED DOCUMENT

1.0 INTRODUCTION

Welcome to Spire Healthcare. We hope that you will enjoy working as part of the multidisciplinary team. If you have any problems whilst you are here, please do not hesitate to bring them to Matron's / Clinical Service Managers attention.

The RMO handbook is intended to give a brief overview of the hospital and those policies and procedures which are the most relevant and essential to the role.

Our prime concern is for the safety of patients and the policies are in place to protect both patients and staff. Please familiarise yourself with them to avoid any compromise.

Matron or a senior member of the clinical team will greet you early in your first week to introduce you to all heads of departments

2.0 SPIRE HEALTHCARE THE ORGANISATION

Spire has 37 hospitals in the UK group and over 5000 of the UK's best consultants working in hospitals – this leads to 'centres for excellence' and specialties for different hospitals.

3.0 GENERAL INFORMATION

3.1 Appraisal / Mentor

You will be assigned a mentor who either is a member, or has been assigned by a member of the Medical Advisory Committee (MAC). The objectives of the MAC are:

- To provide a forum for members to discuss issues affecting the hospital and its facilities.
- To agree, implement and monitor measures designed to facilitate the delivery of appropriate and effective patient care.
- To monitor and review clinical services, providing advice to the hospital Matron as appropriate.
- To provide a forum for educational activities for members and to assist in ensuring compliance with the new regulatory environment.

You will meet with your mentor and Clinical Services Manager on a quarterly basis, i.e. every 3 months, regarding your progress and any issues or concerns. An appraisal document will be completed. One copy will be left in the hospital and another sent to the agency.

Monthly meetings will be held with Matron or a designated senior member of the clinical team to discuss incidents, accidents, clinical issues and concerns. At these meetings you can discuss opportunities for observing in theatre.

3.2 Induction

Using the checklists at appendix 1A and 1B, an induction will be completed and retained as a record of compliance.

3.3 Catering

The staff dining room is open at all times for tea and coffee. Please check with the Facilities Manager for usual times for serving meals

You will not be charged for meals whilst on duty. Therefore day duty includes lunch and dinner, night duty includes breakfast only. You may need to pre-book your meal order.

3.4 Do's and don'ts

- ✓ Do wear smart clothes.
- ✓ Hospital 'scrubs' (theatre clothing) may be worn outside of the theatre department (at local hospital management discretion). Night-shift RMO's may wear scrubs so that they can attend an emergency immediately
- ✓ Do wear a disposable apron if performing a clinical task
- ✓ Do wear identification
- ✓ Do always introduce yourself formally to patients.
- ✓ Do wear your bleep.
- ✓ Do answer your bleep promptly.
- ✓ Do always hand over to the next RMO all patient conditions and outstanding work.
- ✓ Do inform Matron of any anticipated personal visitors.
- ✓ Do liaise with Matron or designated senior member of the clinical team at least weekly - no appointment necessary.
- ✓ Do enter documentation in patient notes and remember to sign, date and time these entries
- × Don't keep problems to yourself – raise concerns with Matron or designated senior member of the clinical team.
- × Don't leave the hospital when on duty.

3.5 Housekeeping

The bedroom used by the night-duty RMO will be cleaned by housekeeping staff who will liaise to arrange a suitable time for this and this will probably be done twice weekly.

Please note that all private telephone calls are logged as you are liable for any calls you have made. Calls relating to patient care should be made via the ward telephone.

3.6 Mail

Mail will be left at main reception for you to collect or within a designated mail box / 'pigeon-hole'

3.7 Operational Policies

You must familiarise yourself with all operational policies which will be made available via Matron. It is essential that you read and become familiar with the following without delay:

- Clinical 02 Control of Infection Manual
- Clinical 08 Patient Records
- Clinical 12 Resuscitation Policy
- Clinical 13 Management of Medicines
- Clinical 42 Chaperone Guidelines
- FIN 03 Policy for Risk Assessment
- FIN 05 Duty of Candour Policy
- HOP 03 Health and Safety Policy
- HR 04 Confidential reporting of concerns by staff in the workplace – 'Whistle blowing'

In addition, the RMO section of the clinical intranet contains other guidelines which you must also read within your first 48 hours:

- Spire Healthcare Confidentiality Policy and Guidelines
- Spire Healthcare Data Protection Guidelines
- NES Complaints Policy (For RMO's contracted by NES)

3.8 Training / Teaching

If you would like to participate in teaching, please liaise with Matron / Clinical Services Manager.

4.0 RMO DUTIES

This is a demanding position responding to many requests from different areas. This is expected throughout the 24hour period. Although activity is obviously quieter by night it should be noted that night shift is a working shift and you are required to respond to requests in professional and timely manner.

4.1 Cardiac arrest / Emergency

- You must carry your pager at all times.
- If an arrest / emergency occur within the hospital, you and the emergency team will be contacted via the bleep system.
- The emergency tone will sound and the location of the arrest will be displayed or the pager will speak the location.
- Crash trolleys are located in various areas of the hospital. You must be aware of the location of these trolleys.
- Please note that the nursing staff will request that the RMO makes a medical assessment of any patient scoring 4 or above.

4.2 Medical Certificates

You may be requested to sign a medical certificate for patients on discharge.

4.3 Pain Control

Pain control is vital to good patient care. You need to be aware of PCA pumps and Epidural protocols – recovery staff can assist you with any training issues.

4.4 Documentation

- Please ensure you are familiar with the GMC's guidelines for good record keeping
- An entry must be made into the medical records of each patient every time an assessment is made or a procedure undertaken. This would include for example changing a venous cannula, inserting a catheter or attending the ward round
- The notes should be accompanied by date, time, signature, printed name and designation in black ink
- Each inpatient must, as a minimum, be visited once a day and a medical record entry made. A patient list can be obtained from the ward clerk
- Please inform the Duty Sister or the patient's nurse when changes are made to treatment
- Patients with comorbidities and abnormal blood results must have a referral for anaesthetic review prior to admission fully documented in the medical records
- All call backs to the hospital post discharge and advice given must be documented in full in line with policy
- All clinical patient reviews must be documented in the patient's medical records
- Consultants must be informed of patients if any concerns and this fully documented in the medical records

- Where the clinical notes of the patient are unavailable the documentation is held in a designated folder / temp set of notes and sent to medical records to be included in the medical file of the patient

Death Notification

- The Consultant will usually complete this and the documentation is available on the ward

Clinical Incident/Accident form

- If an accident or clinical incident occurs with a patient or member of staff and you are called to assist then you will need to participate in the completion of the online Datix form. Please ensure you meet with the Clinical Governance Lead during your induction to familiarise yourself with the system

4.5 Pharmacy

Your duties may involve dispensing of drugs from Pharmacy out of hours (before 9.00am and after 5.00pm Monday to Friday, Saturday after 1.00pm and all day Sunday). The presence of the pharmacist may not be required to enter the pharmacy out of hours, but you must ensure that you have a member of the nursing team with you when entering pharmacy during these times.

On your first visit to the hospital you will be given the alarm code for Pharmacy. Please ensure that you call into the department when it opens at 9.00am to learn the alarm system or in the case of starting at the weekend, then telephone the on-call Pharmacist for any queries you may have. The nursing staff will hold the door code to Pharmacy and a Registered Nurse must accompany you when you go to Pharmacy as above.

All drugs removed from Pharmacy must be double-checked for dosage, route of administration, frequency and expiry date against a prescription and must be recorded in the pharmacy department record.

Prescribing Guidelines:

- Drugs must be prescribed by generic name
- Please ensure that start dates, completion dates (if applicable), route, code etc are correctly filled in
- Please make a **NEW ENTRY** for **ANY CHANGE** in dose or route

If a drug is discontinued, cross through the blank areas on the chart with one clear line and fill in the stop date. Do not obliterate or deface any records of doses given.

Once a chart is full, start a new one clearly denoting that it is chart 2, 3 and so on and indicate on the first that is no longer in use.

Before any IV administration the following must be checked:

- The name on the prescription must match the patient's arm band, and the patient must be asked verbally for their name;
- The drug route, dose and amount by you and a nurse.

4.6 Phlebotomy

You will undertake phlebotomy, as required.

4.7 Pre-admission Assessment

You may be required to assess and review ECGs on request, and take appropriate action where clinically indicated e.g. referral to anaesthetist

The patient for surgery may need to be assessed. The nurses in pre-admission will help you with this.

4.8 Venepuncture

- You are required to do routine ward bloods and may be called in the outpatient environment.
- Names and patient details on blood bottles and request forms must be checked against the patient verbally and with a wristband if possible.
- All blood sample bottle labels must be hand-written. The laboratory will not accept any sample with pre-printed labels attached to the sample bottle. Specimen bottles must not be pre-labelled but must be labelled in the presence of the patient following venepuncture.
- Pre-printed labels can only be used on the general Spire Healthcare pathology form and must be attached to each copy.
- Any transfusion / cross match forms must be hand-written and the section on the previous transfusion completed.
- All samples must be completed including the full name of the patient, date of birth, hospital number, gender, the time blood was taken and the date.
- All Group and Save / Cross match blood sample bottles must include the first line of the patients address.
- If you are not sure of the correct bottle to use for a test, each clinical department has a list of the correct bottles available.
- The vacutainer system is not designed to be used with a syringe and needle unless in difficult circumstances or unless clinically indicated.

4.9 Taking Blood Cultures

The procedure for taking blood cultures is documented in Clinical policy 02 section 3.6

If taking a blood culture please consider contacting your local Infection Control Doctor to discuss the patient concerned especially with regards antibiotic prescribing guidance.

4.10 Xray / Imaging

All request forms must be signed and completed with relevant clinical information prior to examination. You may be required to give contrast injections for MRI or CT. All Ionising Radiation Medical Exposure Regulations (IRMER) must be met and understood by you, following induction with the Radiology Department.

4.11 Post Discharge Ward/Outpatient Attendance

N.B - it is rare that a patient will attend the hospital post-discharge without first calling for advice, but on these occasions please follow the same instructions as if the patient had been advised to attend the hospital.

Following a post-discharge phone call a patient maybe advised to visit the hospital for review.

Prior to the patient's arrival ensure that the medical records are available. On the rare occasion where the medical records are unavailable a temporary set must be made and merged as soon as possible with the original records.

All patients re-attending the hospital must be reviewed by the RMO. The patient must be fully assessed and documentation must include:

- Date and time
- Presenting symptoms
- Past medical history (recent admission and previous medical history)
- Examination and findings
- Impression
- Advice from consultant
- Plan for the patient
- Outcome

Any patient that has attended the hospital must be contacted within 24 hours of attendance by the RMO and the follow up call must be documented in the medical records.

5.0 CONTACTING CONSULTANTS

You are professionally accountable to the Consultants. The Consultant will decide on a patient's treatment regime and on-going medical interventions. Try to familiarise yourself with every Consultant's regime, e.g., duration of Enoxaparin treatment after discharge, commencing analgesia and laxatives post op, instructions for commencing anti-hypertensive drugs.

If a patient becomes unwell or you need advice at any time, you must contact the Consultant concerned. If you are unable to contact this Consultant, then please seek advice from the nurse in charge as to an alternative Consultant. Your role is to provide medical support for the Consultants and not to take charge of medical decisions unless in an emergency situation. Most Consultants like to be consulted before a patient is catheterised post operatively.

Following discharge if a patient calls the hospital for advice or re-attends the hospital the admitting consultant MUST be made aware of the reasons advice given or contacted for further management.

6.0 COMPLAINTS PROCEDURE

In the event of Spire Healthcare having to raise an issue with you about delivery of service, a pre agreed complaints procedure must be pursued.

6.1 Duty of Candour

Where an incident during a patient's care or treatment in a Spire hospital appears to have resulted in or required treatment to prevent death or specified types of injury, you will be expected to work with the Matron, the Duty of Candour Lead, to assist Spire in complying with its statutory and contractual Duties of Candour and the procedures in Spire's Duty of Candour Policy (FIN 05). Nothing in Spire's Duty of Candour Policy restricts a doctor's existing ethical duties to be open and honest with patients as set out in "Good Medical Practice".

7.0 CARE PATHWAYS

Care Pathways are used throughout Spire Healthcare when caring for patients. A care pathway is a clinical record that documents the care given to patients. They define what

is expected to happen for either a group of patients or for a particular surgical procedure. All care pathways are made up of two main elements:

- The tasks and interventions (such as assessments and types of treatment) that help patients to progress along the pathway
- The goals and outcomes the patient is expected to achieve together with milestones (key indicators) to help measure their progress

Care Pathways are used for three main reasons:

- To support day-to-day delivery of quality care
- To promote accurate and complete documentation To help to meet the requirements of Clinical Governance and other standards

Care Pathways are to be completed by those responsible for providing care to the patient. The interventions and goals included within the pathway must be signed off as completed. This will generally be done by nurses or physiotherapists. However, there is also space – multidisciplinary progress notes – for you to record their care as part of the pathway.

Each hospital has a nominated co-ordinator, responsible for local management of care pathways. If you have any questions or comments, or if you want to see some examples of care pathways, please contact them in the first instance.

Appendix 1A

RMO INDUCTION CHECKLIST

To be completed within 48 hours

New Starter (full name): _____

Date Started _____

RMO's Designated Body / RO _____

	Inducted by	Signature	Date	RMO sign as complete
RMO Handbook received and read				
CNST Staff Letter signed and copy sent to the CNST Coordinating Commissioner (CNST CoC) in the normal way. http://intranet.spirehealthcare.net/Left-Menu/Legal/CNST-Letter-/Letter-1/				
On Arrival • Bleep System / Cardiac Pagers • Post Tray • RMO Accommodation • Hospital Tour • Location of crash trolleys	Present RMO			
Introduction to Matron	Matron			
General Overview • Hospital • Job Description – summarise • Health and Safety and Fire Procedures • Pathology (if on site)	Ward Manager			
Pharmacy (1st Working Day) • Procedures • Out of Hours Arrangements • Alarms and Keys • TTO Management and Controlled Drugs	Pharmacy Manager			
Imaging (1st Working Day) • IV Contrast Injection • Out of Hours Arrangements • Documentation Requirements • MRI • IRMER Regulations and Requirements	Imaging Manager			
ITU/HDU/Theatres (1st Working Day) • Layout and equipment • Emergency Procedure	ITU/HDU Co-ord Theatre Mgr			
Pathology (1st Woking Day) • Specimens • Process and Procedures • Bottles and Forms to be Used and Where This Information is Available • Out of Hours Arrangements	Pathology Manager			
Equipment Demonstration • Epidural Pumps • Patient Controlled Analgesia Pumps • Syringe Drivers • Resuscitation Trolleys / Guidelines	Theatre Department			

Appendix 1A

RMO INDUCTION CHECKLIST

Name : _____

Date : _____

Completed induction for the following	RMO Signature	Date	HOD Signature
Cardiac Arrest Trolley The RMO is familiar with the contents and layout (including drug box defib) of trolleys and their location. Reiteration of resuscitation procedures taken place with hospital resuscitation trainer.			
Cardiac Arrest Alarm Call and Team The RMO recognises the cardiac alarm and what to do in its event. The RMO is the clinical lead in the Cardiac Arrest Team			
Broselow Bag The RMO is familiar with the location and use of the Brose Low Bag.			
Fire Procedure The RMO has read and understands the Fire Policy and what to do in the event of a fire alarm of finding a fire.			
Pharmacy Layout The RMO is aware of the physical layout of the Pharmacy, including the location of injections, tablets, capsules, eye and ear drops, drugs for inhalations, creams and extra cardiac arrest drug boxes. TTO Management. RMO is aware of how to work alarm system.			
On-Call Pharmacist The RMO is aware of how to contact the on-call Pharmacist out of hours			
Pharmacy Policy The RMO is made aware of Clinical policies 13 -Management of Medicines and 14 - Safe management of Controlled Drugs			
Bleep System The RMO knows how to use the bleep system			
Orientation to the Hospital The RMO is familiar with the hospital layout, location of departments and room numbers and location of clinical equipment			
Orientation to Wards The RMO has met with Clinical Services Manager and Senior Nurses. RMO is aware that their dayshift start time matches that of the handover time of wards and should attend handover			
Pathology The RMO has been orientated to the department. Procedures for out-of-hours requests have been discussed. Phlebotomy technique observed Assessment of cannulation skills Aware of taking blood culture guidance section 3.6 Clinical policy 02			

Appendix 1A

Completed induction for the following	RMO Signature	Date	HOD Signature
Infection Prevention and Control The RMO has met the local Infection Control Doctor The RMO has full contact details for the ICD and is able to discuss any patients management The RMO has received a full induction regards key aspects of the IPC policy - Hand hygiene; Standard precautions; Care of invasive devices			
Outpatients The RMO has met with the Outpatients Manager			
Imaging Department The RMO has met with the Diagnostic Imaging Manager.			
Hotel Services The RMO is aware of arrangements for laundry, housekeeping, restaurant times and ordering of meals			
Nursing Levels The RMO is aware of the emergency admissions procedure, Consultants contacts, the 09.00 handover, and the crash call procedures.			
Spire Policies Clinical 02 Control of Infection Manual Clinical 08 Patient Records Clinical 12 Resuscitation Policy Clinical 13 Management of Medicines Clinical 18 RMO Handbook Clinical 42 Chaperone Guidelines Fin 03 Policy for Risk Assessment HOP 03 Health and Safety Policy HR 04 Confidential reporting of concerns by staff in the work place- 'Whistle Blowing'			
Clinical intranet RMO section Confidentiality policy & guidelines Data Protection Guidelines NES complaints Policy (for RMOs contracted by NES)			

Next Fire Lecture :

Date to Attend :

Next Resuscitation Update :

Date to Attend :

RMO Signature :

Date :

HOD Signature :

Date :

Spire Healthcare

NES SPIRE RMO NIGHT DUTY

RMO's will ensure first ward rounds at 08:30 in the morning and last round at 23:00 at night.

Criteria for calling the RMO between 23:00 – 08:00

- EWS 4 or more
- Uncontrolled pain
- Cannulation
- Male catheterisation
- Following patient fall or accident
- Medical emergency e.g. Cardiac arrest, transfer out to Level 3 care

The RMO will visit the wards every 2 hours until 23:00.

Nursing staff will review all drug charts to ensure night sedation, analgesia and intravenous fluids are prescribed prior to this.

All TTA's will be requested before 23:00.

All post-operative patients who have not passed urine to have bladder scan performed before 23:00. Male patients' not passing urine will be alerted to RMO for possible catheterisation.

Nursing staff will not bleep the RMO unless the patient meets the above criteria or in exceptional circumstance.

Appendix 3

1:1 ROTATIONS

Frequently Asked Questions

Is this legal from the perspective of the European Working Time Directive?

Yes, provided that all doctors employed on these shifts have voluntarily signed the Opt-Out. This enables them to work longer hours than those laid out by the EWTD.

NES Healthcare gives its doctors the freedom to choose the rotation they wish to work and provides them with the information to allow their decisions to be well informed.

Do the doctors really want to work like this?

Many doctors prefer working the full week as it provides free accommodation and meals. They are also paid a higher salary for being on duty for the longer hours.

Evidence suggests that doctors working on a 1:1 rotation are more likely to stay long term, with 75% choosing to extend their initial contract. This is in contrast with the 12 hour rotations, where only 42% of doctors stay on. The main negatives in the WTR compliant rotations that are cited by the doctors are the salary and the need to source their own accommodation.

Don't the doctors get tired?

Hospitals that routinely work the 1:1 rotation have adopted procedures that ensure that where possible the RMO's rest periods are protected. Whilst the RMO remains on call throughout the week, protocols can be put in place to make sure that they are not called every night.

This is a change in approach from the hospitals that have operated 12 hour shifts with doctors on night duty who are up and working. For this reason Spire and NES are working in partnership to establish criteria for night calls, which will be based around the EWS scores.

What if a doctor does feel overworked?

Obviously this situation can arise if there are one or two very poorly patients in the hospital. This is one of the reasons for NES having up to 6 standby doctors available in any given week to attend in place of the duty RMO.

In the event that an RMO feels unfit for work then a replacement can be sent within hours so that they can take a break.

Are there benefits to the hospital resulting from working a 1:1 rotation?

The hospital may well benefit in terms of continuity for a number of reasons. As explained already, this is the preferred option for doctors, with the majority of those approaching NES for work requesting this rotation.

They are also more likely to extend their contract, which enables a stronger working relationship to be established between the consultants and the RMOs across the length of their tenure.

There is also the issue of continuity of care for the patients throughout the week, with the same doctor attending them at night as during the days.

How to be an excellent RMO

1. Always wear your name badge.

2. Only leave the hospital once you have completed a written and verbal handover to the incoming RMO. Remember to provide your incoming colleague with the bleep/phone/keys/codes etc.

3. Whilst on duty you are responsible for all first aid and resuscitation. You are therefore not able to leave the premises until your relief arrives. To do so will certainly result in a disciplinary and a referral to the GMC. If you are unwell or you need to leave the hospital due to an emergency please contact the NES office (01296 746140) or the emergency line (07920 045175) and we will do our best to support your request.

4. Always follow the GMC's Good Medical Practice guidance and only work within your scope of practice. Please see http://www.gmc-uk.org/guidance/index.asp.

5. Medical notes should be in clear handwriting, dated and signed and be available as soon as possible after every procedure or interaction with a patient. This includes telephone conversations with consultants, the cannulation of a patient, blood taking and performing an ECG. If you are asked to see a relative of a patient you also need to make notes and it is always good to note that you have instructed the patient to visit the nearest A+E. **No Note = No Defence!**

6. Keep the Consultant and Nursing team in the loop when you find any abnormalities or an increase in the Early Warning Score (EWS) of a patient. When called to see a deteriorating patient please follow the ABCDE approach. Call for help early when you are dealing with any deteriorating patient. Do not delay using the emergency call and act sooner rather than later getting the team and emergency equipment close to the patient. You might need to contact the patient's Consultant and the Anaesthetist on call. All hospitals will have an escalation policy and a back up telephone call list for each Consultant.

7. Consultants have practicing privileges and can therefore admit patients to a hospital. The RMO cannot admit patients and when a patient returns after surgery you will need to inform the Consultant. RMOs will frequently need to deal with post operative complications and wound dressings. Remember a "quick look" should never be without a short note about your observation and findings.

8. RMOs will be supporting nurses with TTOs (To Take Out of hospital medication) and discharge summaries to GPs. Please carefully include a summary of the procedure and further treatment/follow up information with or without prophylaxis for DVTs (deep vein thrombosis) on the discharge letter or discharge summary.

9. In the event of a patient transfer you should speak and write to the receiving clinician. Please ensure all notes/results and prescription charts are given to the receiving team. Please make detailed notes about the transfer as in many cases this will result in a request

for a statement. Please note that statements must be completed on the NES template (available from your MSM) and will need to be reviewed by the NES legal and medical team prior to being released to anybody. **Never provide a statement directly to the hospital without letting NES review it first.**

10. Patients will expect to see you as part of the hospital team, and they will form a judgement based on your presentation. Make sure you follow the dress code and look smart. Always introduce yourself, explain what you need to do and take care to smile and put the patient at their ease. They will want to see that your hands have been cleaned before any procedure or examination. It helps to think of patients and nurses as customers. Customer care is at the heart of what we do as clinicians and a professional relationship will result in accolades.

11. Nurses will be responsible for the daily care of the patients and each of them will have several to look after. From their experience they will suggest treatment which they are familiar with and it is good to listen to their suggestions. Remember however that it will be your signature on the prescription chart so check with the patient and Pharmacist as necessary. Always check the identity of the patient prior to prescribing or performing a procedure.

12. Be visible and stop frequently at the ward(s) making sure that there is no work waiting in the RMO book. If the Nursing team are short of numbers and you have extra time please ask if they need help. Being part of the team and advising them when you will be able to be there when bleeped all help to foster good relationships.

13. Always give due attention to calls about patients at night. Make good notes and never give any verbal orders. If you have a particularly busy night and cannot fulfil your duties during the day please call the office to request a standby doctor to take over from you. If you are tired you are not performing at your best and as clinicians we need to be aware of the human factors. Watch this video, which has been viewed by over 250,000 clinicians: https://www.youtube.com/watch?v=JzIvgtPIof4

14. Try to enjoy your time as an RMO and be ready for at all times for adult or paediatric scenarios where you will be expected to act as team leader. During these there is no excuse for not following UKRC protocols and guidance, which you can review at: https://www.resus.org.uk/. Keep NES, as your employer, informed of any important or work-related issues and remember that we are on your side with offering training, medical and other support.

15. Point-of-Care Testing (PoCT) such as the "iStat" of other machines will allow you to get instant blood results. Ensure you use the correct sample tube and do not use any other ID card but the one issued to you following your training at the hospital.

16. All hospitals should now have the EZ-IO available for resuscitation. Please refer to your ALS/EPALS book and have a look at the following : https://www.youtube.com/watch?v=KHXSfh2ZRDM

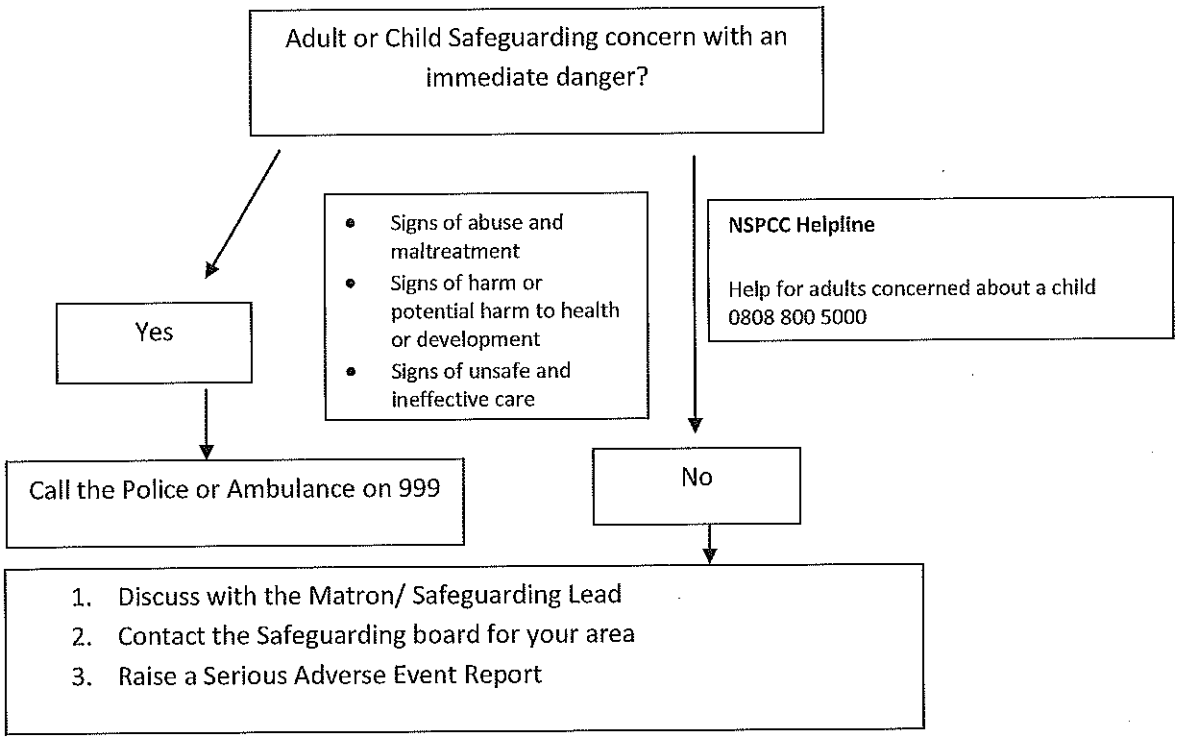
17. Fitness for work notes or sick notes should be written as per the Consultant's advice. Most Consultants will have a standard time period for their patients to be away from work. If unsure please check and refrain from writing such notes for Nurses or other members of staff. Be careful not to sign any forms in advance (the night before) as it will put you at risk of potential fraud.

18. Should you be asked to complete a Death or Cremation Certificate please use your GMC registered names and qualification as printed on your degree. Please double-check the form for completeness as incomplete forms will cause unnecessary delays for the grieving family.

19. To assist you with the UK Hospital's regulator the Care Quality Commission's (CQC) or the local Clinical Commissioning Group visits at your hospital you will need to be well aware of the terminology used in the Mandatory training.

Mandatory Training Update

1. Safeguarding



My Hospital Adult Safeguarding Lead is .....

My Hospital Paediatric Safeguarding Lead is .....

My Local Safeguarding Board contact number is .....

2. Deprivation of Liberty (DoLS) and the "Acid test" questions

- Does the individual lack the capacity to consent?

- Is the person subject to continuous supervision and control?
- Is the person free to leave? Focus on those who support this person and how they will react if this person does not leave.

All parts must apply: If a person is subjected to a level of supervision that is continuous and he/she is not free to leave then it is likely that this person is deprived of their liberty.

3. **Common Symptoms of Dementia**

- Memory loss
- Communication (dysphasia/aphasia)
- Carrying out Tasks (dyspraxia/apraxia)
- Lack of Concentration
- Recognition difficulty
- Orientation difficulty
- Perception difficulty
- Psychological changes

4. **Seek assistance from the Caldicott Guardian if:**

- Police requests access to patient records
- Patients request to delete records
- Actual or alleged breaches of confidentiality

5. **Duty of Candour principles**

- Openness: enable complaints and concerns to be raised freely without fear of questions asked to be answered
- Transparency: Allowing information about the Truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour: Any patient harmed is informed of the facts and an appropriate remedy is offered regardless of whether a complaint has been made or a question asked about it.

6. **Whistle blowing**: A confidential way to raise concerns at work. Speak with the Matron or Hospital Director. There should be confidential email and contact numbers available for us at the Hospital for when the matter is not resolved.

7. **Riskman/Datix**: a system for reporting Incidents, near misses and accidents.

8. **Prevent**: protect vulnerable people against radicalisation. My local contact number is .....

9. **Mental capacity Act**: protects and empowers all individuals 16 years and older who may lack the mental capacity to make their own decisions about their care and treatment.

10. My Infection Prevention Lead is.....

A Case Study

December 2019

A patient that had been discharged from hospital 6 days previously attended a private hospital without an appointment with symptoms of bruising around their wound site, mild confusion and jaundice. The patient was reviewed by a nurse and the RMO (not from NES) and a urine test was taken. The patient was reassured and no further treatment was provided. The following day the patient attended the local Accident and Emergency department with chest pains and ECG changes were noted. He was diagnosed with a myocardial infarction and became acutely unwell. Tragically the patient died the following day.

Concerns were raised by the Coroner that there was no formal system in place at the hospital for patients that attended unexpectedly after discharge; that there was a lack of comprehensive record keeping and the consultant was not informed immediately.

Although this happened outside of NES Healthcare we all have a duty to learn from the concerns raised.

10 lessons for all doctors

1. A full clinical assessment is undertaken of the patient and documented.
2. For unexpected reviews there is a process in place and documented to follow up with the patient.
3. Always make good notes in the patients care records. Please ensure that if the medical records are not immediately available that a temporary folder is made and all documentation is then merged with the full record.
4. Inform the Consultant of all patients that return to the hospital for a review by the RMO. The patient's consultant should be immediately contacted and guidance/attendance documented.
5. Your role is to ensure the patient is in a facility that can treat the patient well.
6. Please review the hospital's action plan and undertake a review of processes at your site.
7. If the NEWS2 is 7 or more, insist on a clinical review from the Consultant. Make a note of this to protect you against counter arguments later.

8. If the consultant is unavailable or there is a considerable delay, an NES doctor can transfer the patient. Many hospitals' policies around the deteriorating patient provide such authority. Please always keep good notes and keep the Consultant informed. Make sure you read the local policy on deteriorating patients, where one exists.
9. Do not delay taking action with any deteriorating patient.
10. Make sure you send all statements to NES for support from our legal team and do not create extra medical insurance risks to yourself or NES by providing them direct to hospital management.

Spire Healthcare

SPIRE HEALTHCARE	**Ref:**	**Clinical Policy 08**
	Issued By:	**Group Clinical Director**
	Approved By:	**Safety, Quality and Risk Committee**
PATIENT RECORDS POLICY	**Date:**	**September 2019**
	Applies to sites:	**All hospitals and clinics**
	Applies to staff groups:	**All staff making entries in the patient record**

PATIENT RECORDS POLICY

CONTROLLED DOCUMENT

TABLE OF CONTENTS

1. INTRODUCTION

This policy relates to the documentation of patient records by clinicians, and related issues of confidentiality. Spire Healthcare has adopted this policy to cover its use of patient records in line with the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA).

This policy also provides best practice guidance in order to meet:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The National Care Standards for Independent Hospitals in Scotland (Outcome 4)
- The National Minimum Standards for Independent Health Care Services in Wales (2011) (standard 20: records management)

2. SCOPE AND DEFINITIONS

For the purpose of this policy, the term 'patient record' includes all documentation of care provided to a patient by a clinician or healthcare professional and may be in any medium, including:

- Paper (e.g. the patient's care pathway, operation note, medication chart and copies of correspondence between clinicians and GPs, other healthcare professionals and patients.
- Electronic (e.g. images and reports held on RIS/PACS)
- Photographs, slides and other images (e.g. photographs taken by clinicians before and after surgery)
- E-mails (e.g. Clinical advice sent by a clinician or Healthcare Professional to a patient via e-mail)

It also includes relevant operational records required to deliver patient care including the Registration Form and the episode Booking Form.

Single Patient Record Definition
Spire must have in its physical possession and control at all times (in the hospital or at the NDC) either the **original or a copy** of:

- all **outpatient and inpatient/day case notes**
- from **all departments**
- from **all consultants**
- for **all patients** who attend the hospital

3. DUTIES AND RESPONSIBILITES

3.1 Chief Operating Officer
The Chief Operating Officer has overall responsibility for records management in Spire Healthcare.

3.2 Caldicott Guardian
The Group Medical Director for Spire Healthcare acts as the overall Caldicott Guardian to oversee the use and sharing of clinical information.

The key responsibilities of the Caldicott Guardian are:

- **Strategy & Governance**: the Caldicott Guardian must champion confidentiality issues at Board/management team level, will sit on an organisation's Information Governance Board/Group and act as both the 'conscience' of the organisation and as an enabler for appropriate information sharing.
- **Confidentiality & Data Protection Expertise**: the Caldicott Guardian must develop knowledge of confidentiality and data protection matters, drawing upon support staff working within an organisation's Caldicott function but also on external sources of advice and guidance where available.
- **Internal Information Processing:** the Caldicott Guardian must ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff.
- **Information Sharing:** the Caldicott Guardian must oversee all arrangements, protocols and procedures where confidential patient information may be shared

Other responsibilities include the need to establish process to review the content of patient records to ensure compliance with national guidelines.

3.4 Hospital Matrons
In each Spire Healthcare hospital, the Matron/Head of Clinical Services will act in the capacity of the local Caldicott Guardian to ensure records are kept securely and treated in confidence at all times.

3.3 Hospital Director
In each Spire Healthcare hospital, patient records are the responsibility of the hospital Director.

3.5 All Clinicians and Healthcare professionals
All staff that make entries in patient records are responsible for the quality, content of those records in line with their own professional codes of practice.

See appendix 2 for the Caldicott Committee good practice principles and summary of recommendations.

4. DOCUMENTATION BY CLINICIANS

All hospitals must maintain securely accurate, complete and contemporaneous records in respect of each patient including a record of the care and treatment provided to them and of decisions taken in relation to the care and treatment provided. Patient records include all data made by or on behalf of a health professional in connection with the diagnosis, care or treatment of a patient at Spire and can be in any form i.e. paper based, electronic, photographic, imaging, emails and also includes operational records required to deliver patient care including the Registration Form and the episode Booking Form.

It is a condition of being granted and maintaining practising privileges at a Spire Healthcare hospital that consultants and clinicians ensure that a copy (or the original) of their outpatient notes and all relevant medical records are provided to the hospital so they can be included in the patient record. Without this access, a single patient record cannot be maintained. Further guidance is outlined within the Consultants' Handbook (Clinical Policy 16).

Information must be recorded legibly, using blue or black ink or biro within paper records, unless a specific requirement to use other colours (such as green ink for pharmacy charts) exists. Any alterations made must also be legible and deletions ruled through using a single line. Correction fluid must not be used and no entries should be permanently deleted. Abbreviations must be avoided and only those professionally acceptable and recognisable must be used.

All entries, including deletions or alterations, must include the time and date the entry was made and be signed. Initials must not be used as a signature unless the name and designation of the signatory is known and recorded in a 'signature-bank' or equivalent system. A signature bank is provided in each care pathway for this purpose.

Wherever possible, records must be written with the involvement of the patient and their guardian or carers. The record must be written in terms that the patient can understand and must avoid comments that may cause patients or their carers any offence.

An entry should be made in the healthcare record whenever a patient is seen by a clinician or member of staff. All clinicians and healthcare professionals must make clear, accurate and contemporaneous records relating to their patients. The record must contain regular and timely progress notes, observations and consultation reports made by such professionals. In addition to Spire Healthcare's requirements, clinicians and healthcare professionals may formally be required to do so by their professional regulatory body. Clinicians are reminded that failure to keep suitable clinical records may be regarded as professional misconduct by their professional bodies and may also be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (and any Regulations made thereunder); The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011 (and any regulations made thereunder); and the Care Standards Act 2000 (and any regulations made thereunder in Wales).

There must be a system of "alert" notation in place to ensure that any allergies or sensitivities are immediately noticeable in the patient record.

Hospital departments can keep active records but they must be stored securely and returned to the Hospital's medical records department on discharge to be filed in line with the single patient record. For example, Physiotherapy and Chemotherapy records

The contents of the patient record must be filed in the correct order, according to the design of the record and its dividers and securely fastened within the folder. Guidance regarding the specific minimum content is outlined in Appendix 1 of this policy.

The same principles apply when entries are made into an electronic health record. For example, arrangements must include the date and time of any entry, the person who made the entry, and must ensure that any changes or additions to entries are made in such a way that the original information is still visible and accessible.

Records can be held electronically, as part of the single patient record, provided that they are available to authorised people in a timely and accessible way in order to review and deliver patient care in a way that meets their needs and are held securely in line with the requirements of the Data Protection Act 2018. As part of this requirement, all Consultants must have access to clinical IT systems in order to evaluate electronically held results. Consultant access can be requested via the Spire IT services self-service order form on the intranet.

A Medico-legal report does not form part of the single patient record as the legal basis for processing is not the provision of healthcare. Such reports should be stored separately from a patients medical records or clinic notes as they will need to be deleted manually. Spire will not store medico-legal reports produced by a consultant unless they are processed by a Spire Medical Secretary. In such cases the reports must be stored separately and for a period of 10 years from the time the report was last accessed. However, Spire's requirement for single patient record will apply to any diagnostic tests imaging/reports undertaken as part of a medico-legal report process must be held by Spire in line with our patient record retention policy. Medico-legal patients should complete a registration form, as should anyone attending the hospital for any type of appointment

Records of individuals attending information only and marketing events do not need to be filed as part of the single patient record. These are offered at the consultant's discretion and are an

opportunity for prospective patients to explore general questions about cosmetic surgery. Any record of advice given or a discussion with a patient about their diagnosis, care or treatment must form part of the Spire single patient record.

Spire's patient records should never be taken off site by consultants. For more information, please see the consultant data sharing agreement in the consultant handbook.

All patient notes (other than the exceptions detailed above) should be filed as part of the single patient record and must under no circumstances be stored in non-med boxes at the NDC.

5. PATIENT RECORDS ON DISCHARGE, TRANSFER OR DEATH OF THE PATIENT

The original full set of medical records must be retained by the hospital (or the NDC once the record has been transferred for storage there). A duplicate copy of the patient's notes must be sent (or accompany a patient) when ongoing patient care is required elsewhere (e.g. following a planned or unplanned transfer of care to another hospital), or where the notes have been requested for inspection by the coroner or are required for pre-action disclosure. The duplicate copy must be readable and photocopying must be undertaken with due care to ensure suitable quality, completeness and confidentiality.

The notes must ideally be kept in a sealed envelope/document wallet and marked 'confidential'. Where the notes are being posted, a secure transit method, such as courier or special delivery, is strongly advised. For further information, please refer to IT02 – Information Management & Handling Policy.

When a patient is transferred to another hospital (including the NHS), the record must state the date of transfer, the time of transfer, the reason for transfer, the name of the receiving hospital and ward or department of the receiving hospital.

Following discharge, the record must contain a copy of the immediate discharge notice and a copy of the clinicians discharge letter to the patient's GP, unless the patient has indicated (which should be recorded Spire Healthcare's patient administraion system (SAP)) that they do not wish this to be sent to their GP.

If the patient has died, the record must contain the cause of death (if known), the date and time of death, and copies of the notification to the GP and to the Care Quality Commission, Healthcare Inspectorate Wales or Health Improvement Scotland as appropriate (made within 24 hours of death). The patient's record on SAP must also be updated accordingly.

If a post mortem is conducted, the record must contain an anatomical diagnosis and a copy of the post mortem report which must also be sent to the GP. (A provisional anatomical diagnosis is made within 72 hours of death, and a completed diagnosis is made within one month.) There must be evidence of review of the clinical diagnosis in the light of the findings of the post mortem examination.

6. CONFIDENTIALITY OF PATIENT RECORDS

Each hospital must ensure that patient identifiable information is maintained in confidence with access on a strict need-to-know basis, and is disclosed for justifiable purposes only. This includes disclosure amongst healthcare professionals. If patient records are disclosed, only the minimum records necessary for the purpose must be disclosed. Every attempt must be made to safeguard information, to prevent unauthorised access, alteration, disclosure or destruction of patient records.

It is essential that patient identifiable information is not disclosed without consent / lawful reason and that if it is disclosed patient identifiable information must be removed wherever possible.

When copies of records are transferred between Spire hospitals and associates satellite clinics:

- All patient records or other items including patient identifiable information must be placed in either tamper proof bags or boxes locked with tags
- A document detailing what is included in each bag/box should be produced and signed at the receiving end, then returned to the sender of the records

It is also strongly recommended that any partner health agencies or insurers that send or are sent patient information adhere to the Caldicott Committee principles (Appendix 2).

6.1 Termination of Pregnancy

Termination of pregnancy and sexual health records should be kept separately from the single patient record. They must be kept strictly within the establishment (i.e. not sent to the NDC). In addition the Care Quality Commission (Registration) Regulations 2009 state that the registered person under these regulations must maintain a register of patients undergoing termination of pregnancy. This register must be:

- completed in respect of each patient at the time the termination is undertaken; and
- retained for a period of not less than three years beginning on the date of the last entry

6.2 Psychiatric and Psychology records

Psychiatric and Psychology records should be kept separately from the single patient record. They must be kept strictly within the establishment (i.e. not sent to the NDC). A Psychiatric or Psychological assessment tracker form must be filed as part of the single patient record (appendix 3).

7. DISCLOSURE AND ACCESS

For further information on disclosure of patient records, please see IT 21 - Data Protection Policy For information about the rights of access by Data Subjects (i.e. patients) please see IT 19 - SAR Policy.

8. MANAGEMENT ARRANGEMENTS

Hospitals are required to use all current corporate care pathways (available through the care pathways printing tool) and related documentation including the operation note, medication chart, booking form, registration form and discharge summary.

In addition, each hospital must ensure that:

- there are suitably trained staff to complete patient records in line with this policy and their own clinical professional codes of practice;
- it undertakes a review of patient record issues at the relevant localcommittee;
- it audits the contents of patient records for completion, accuracy, legibility and misfiling;
- it carries out a appropriate annual patient record audit to include a cross-section of records and clinicians in the hospital and to close out problems identified in previous audits; this includes completing the patient record audits required by Spire Healthcare's national clincial audit plan;

- it maintains a patient record folder that complies with Spire Healthcare policy;it maintains a filing system for paper-held records that enables rapid retrieval of records, prevents misfiling and incorporates an effective tracing system. It is also essential that where manual and electronic health records exist together, that both are managed consistently to ensure that a complete record is available at the point of need.

9. TRAINING

All Spire Healthcare staff must be reminded of their responsibilities for record-keeping through induction, awareness programmes and guidance. It is the responsibility of each member of staff to ensure they have completed any annual refresher training relating to records management mandated by Spire Healthcare (including completing the required information governance training modules).

10. MONITORING ARRANGEMENTS

Relevant patient record audits will be included in Spire Healthcare's national clinical audit programme and the results will be reported to the National Quality Committee.

11. RELATED POLICIES

- IT02 – Information Management & Handling Policy
- IT19 - SAR Policy
- Clinical Policy 16 – Consultant Handbook
- IT 21 - Data Protection Policy

APPENDIX 1- SPECIFIC MINIMUM CONTENT OF PATIENT RECORD

The initial and summary entry must contain full demographic details of the patient. The patient's name (in full) and the hospital number must be recorded on every page of the patient record. Details of any legal orders to which the patient may be subject must be recorded.

Other records (such as administrative records), including those held electronically, may be required to support patient management. Whilst there is no requirement for them to be stored within the patient record itself, a system must be in place to ensure they can be retrieved as required

1. Demographic Details

Must include:

- Full name
- Marital status
- Address, postcode and telephone number
- Date of birth and gender
- Name, address and telephone number of the patient's GP
- Name of the admitting clinician and date on which the patient was admitted or first received treatment
- Hospital number
- First language, if not English
- Contact details of the next-of-kin or other person to notify in an emergency
- Where the patient is a child, the name and address of the school which he/she attends or attended before admission
- Ethnic origin or nationality
- Religion, if the patient consents

2. Initial Record

Must include:

- Clinical reason for admission or referral with the date and time of the initial consultation
- Source of referral
- Present and past medical history
- Relevant family history
- Details of medication
- Details of any allergies or sensitivities
- Details of the initial physical examination of the patient
- Proposed care and treatment plan

3. Progress Record

Must include:

- Assessment and treatment of the patient as directed by the care pathway and the patient's clinical condition, including all observations (e.g. temperature)
- Details of any problems including the action taken to resolve them and its outcome
- All therapeutic orders with reasons
- All orders for diagnostic tests and all results of investigations
- All drug therapy records, including intravenous fluids and blood transfusion records
- All drug records must be signed and include the name of the medicine, the dose, the route of administration and the frequency and time for administering the dose
- Details of verbal instructions and documented information given to staff, patients or relatives
- Details of valid consent, including a written consent form for every episode of surgery or invasive procedure under general or regional anaesthesia or under sedation
- Information on the pre-operative diagnosis or indication given by a suitably qualified medical practitioner for patients undergoing surgery or an invasive procedure
- Information confirming that common complications, including the possible requirement for transfusion of blood, and rare complications which may cause serious harm have been discussed prior to starting any medical treatment, or to the procedure for patients undergoing surgery or an invasive procedure
- If the patient has been transferred to a hospital (including an NHS hospital), the date of the transfer, the reasons for it and the name of the hospital to which the patient was transferred

4. Operation Record

Must be written by the main operator and include:

- Date
- Name and signature of the operating surgeon and assistant
- Name of the clinician responsible
- Confirmation of valid consent
- Diagnosis and procedure performed
- Description of findings
- Details of tissue removed, altered or added and destination of tissue removed
- Details of sutures used
- Details of blood loss and blood components transfused
- An accurate description of any difficulties encountered
- Immediate post-operative instructions
- Name and signature of the person responsible for checking that all needles, swabs and equipment used during the operation have been recovered from the patient
- Details and serial numbers of all implanted medical devices, including pharmaceutical products, except where this would entail the disclosure of information contrary to the provisions of s33(5) of the Human Fertilisation and Embryology Act 1990 (restrictions on disclosure of information)

- Drugs applied directly to the operative site, eg prep solutions, infiltration, irrigation etc.

5. Anaesthetic Record

Must include:

- Name of the anaesthetist
- The operation planned and performed
- Pre-operative assessment, including risk factors
- Patient checks carried out
- Checks of apparatus carried out
- Details of anaesthetic technique
- Monitoring data, including both patient and equipment
- Details of drugs administered, with doses and route of administration
- Details of venous cannulation
- Fluid loss; intravenous fluids and blood transfusion administered
- Use of specialised equipment
- Method used to secure airway and any difficulties encountered
- Patient position and attachments
- Temperature control and limb position
- Details of any untoward events
- Postoperative instructions and pain relief

6. Discharge Summary

Must contain:

- Dates of admission and discharge of the patient
- Clinician in charge
- Summary of the history
- Any abnormalities found on examination
- All significant test results
- All diagnoses and procedures undertaken
- Inclusion of the most current diagnostic and procedure coding
- Current ongoing medication
- Arrangements for wound management, if applicable
- Arrangements for any continuing care
- Recommendations for follow-up
- Any information given to the patient
- If the patient dies whilst in hospital or during treatment , the date, time and cause of death (if known) and a record of any notification given to the Care Quality Commission, Healthcare Inspectorate Wales and Scottish Commission for the Regulation of Care e.g. Coroner

7. Filing order within the patient record

The filing order specified within the patient record must be followed.

Filing Order - filed in reverse chronological order i.e. the most recent at the top

- In front of the first blue divider
  - Patient Alert stickers
  - Registration Form

- Episode (blue divider)
  - Clinician correspondence to and from referrers
  - Discharge Summary
  - Patient History & Continuation Sheet
  - Episode care pathway, ward & theatre
  - Variance Tracking Sheet
  - Pre-admission questionnaires
  - Physiotherapy assessment documents
  - Episode booking form

- Ward Data (pink divider)
  - Early Warning System observation and fluids charts
  - Drug charts, including daily drug charts, intravenous fluids, PCA

- Theatre Data (green divider)
  - Operation & treatment notes
  - Consent Form
  - Theatre Records
  - Pre-op, peri-op and post-op, including anaesthetic records
  - MediTrax records

- Results X-ray and pathology (blue divider)
  - Radiology and pathology reports (on mount sheet for <A4 sized reports)
  - Imaging referral form

- Tracer Card

APPENDIX 2- CALDICOTT COMMITTEE: GOOD PRACTICE PRINCIPLES

1. Justify the purpose(s)

Every proposed use or transfer of person-identifiable information within or from an organisation must be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don't use person-identifiable information unless it is absolutely necessary

Person-identifiable information items must not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified must be considered at each stage of satisfying the purpose(s).

3. Use the minimum necessary person-identifiable information

Where use of person-identifiable information is considered to be essential, the inclusion of each individual item of information must be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

4. Access to person-identifiable information must be on a strict need-to-know basis.

Only those individuals who need access to person-identifiable information must have access to it, and they must only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

5. Everyone with access to person-identifiable information must be aware of their responsibilities.

Action must be taken to ensure that those handling person-identifiable information – both clinical and non-clinical staff – are made aware of their responsibilities and obligations to respect confidentiality.

6. Understand and comply with the law

Every use of person-identifiable information must be lawful. Someone in each organisation handling confidential information must be responsible for ensuring that the organisation complies with legal requirements.

Appendix 2

CALDICOTT COMMITTEE: SUMMARY OF RECOMMENDATIONS

1. Every dataflow, current or proposed, must be tested against basic principles of good practice. Continuing flows must be re-tested regularly.

2. A programme of work must be established to reinforce awareness of confidentiality and information security requirements amongst all staff within the NHS.

3. A senior person, preferably a health professional, must be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information.

4. Clear guidance must be provided for those individuals/bodies responsible for approving uses of patient-identifiable information.

5. Protocols must be developed to protect the exchange of patient-identifiable information between NHS and non-NHS bodies.

6. The identity of those responsible for monitoring the sharing and transfer of information within agreed local protocols must be clearly communicated.

7. An accreditation system which recognises those organisations following good practice with respect to confidentiality must be considered.

8. The NHS number must replace other identifiers wherever practicable, taking account of the consequences of errors and particular requirements for other specific identifiers.

9. Strict protocols must define who is authorised to gain access to patient identity where the NHS number or other coded identifier is used.

10. Where particularly sensitive information is transferred, privacy enhancing technologies (e.g. encrypting identifiers or "of patient identifying information") must be explored.

11. Those involved in developing health information systems must ensure that best practice principles are incorporated during the design stage.

12. Where practicable, the internal structure and administration of databases holding of patient-identifiable information must reflect the principles developed in this report.

13. The NHS number must replace the patient's name on Items of Service Claims made by General Practitioners as soon as practically possible.

14. The design of new systems for the transfer of prescription data must incorporate the principles developed in this report.

15. Future negotiations on pay and conditions for General Practitioners must, where possible, avoid systems of payment which require patient-identifying details to be transmitted.

16. Consideration must be given to procedures for General Practice claims and payments which do not require patient-identifying information to be transferred, which can then be piloted.

APPENDIX 3 – SINGLE PATIENT RECORD PSYCHIATRIST/ PSYCHOLOGIST REVIEW PROFORMA

Spire Healthcare

Affix Patient label

Date: _____

Clinician: _____ (please print)

I confirm that I have seen the above patient in clinic today.

Due to the particularly sensitive nature of the consultation, I have not provided any clinic notes/letters in regards to this consultation to form part of the patient's centrally held Spire Healthcare record.

However, if for any medical reason, and where it is in the best interests of the patient, Spire Healthcare believes that further input from me would be beneficial in regards to this patient's care, please feel free to contact me directly and I will be happy to offer any assistance that I am legally able to provide (including, where indicated and lawful, provision of the notes relating to this consultation).

Tel: _____

Signed: _____

Spire Healthcare

Resident Medical Officer Induction Pack

Looking after you.

Welcome to XXXXX Hospital

The following information has been put together in the hope that you will find it useful while you settle into your new role here.

The team at XXXXX Hospital are all very helpful; please don't be afraid to ask for their help and advice. They are careful to make sure the RMO becomes a valued member of the team here at the Hospital.

We are a key hospital in the Spire Healthcare portfolio of 39 hospitals. We have a broad range of modern acute facilities which include:

- XX en-suite bedrooms
- An operating department with X laminar flow theatre plus X other theatres and a X bay recovery area.
- An Endoscopy Unit
- A X bed Enhanced Recovery Unit (ERU) Level 1
- Day Care with XX beds
- An Outpatient Department with XX consulting rooms.
- Pathology department
- Pharmacy
- Diagnostic Imaging with an MRI & CT facility
- BUPA Health Screening
- Physiotherapy Department

These are supported by a number of other departments. Our radiology department offers all imaging services on site. In addition Spire XXX Hospital is a partnership site for BUPA Wellness offering a variety of health screening. We are also a partner hospital for Breast Health UK and are accredited for both bowel and breast cancer. We employ over XXX staff including nurses, radiographers, physiotherapists, medical secretaries, administrators, housekeepers and porters.

Our commitment is to quality and value, providing facilities for advanced surgical procedure together with friendly, professional care.

The Hospital is situated XXXXXXXXXXX

Medical Management

Each Consultant is required to apply to the Hospital Director for 'Practice Privileges'. The application is taken to the Medical Advisory Committee (MAC). At this meeting, upon advice of the MAC, individual consultants are granted their 'practice privileges'. If the application is accepted, then the Consultant can 'admit' patients to the hospital and commence practice, covering both in and outpatient care.

Medical Advisory Committee

This is a meeting of representatives from every major user in the surgical and medical field practicing within the hospital, chaired by a senior Consultant (XXXXXXXXXXXX). The MAC meets quarterly.

In addition to vetting new applicants for 'practice privileges'; the committee also receives reports on patient activity, finance, and Clinical Governance issues affecting the organisation.

Clinical Governance

The hospital meets quarterly as a committee to review the governance standards within the hospital. You will be invited to attend this meeting and will be expected to attend if practicable.

Hospital Management

☐ Hospital Director .....

☐ Director of Clinical Services.....

☐ Finance and Commercial Manager .....

☐ Theatre Manager .....

☐ Business Development Manager .....

If there any concerns these should, in the first instance, be directed to the Director of Clinical Services, but any member of staff will be happy to assist.

Patients Finance

As you will appreciate, private healthcare is open to all members of the population therefore we receive a broad spectrum of patients.

Patients financially are covered in the following ways:

Medical Insurance – Some patients are admitted under some form of Medical Insurance scheme. It is important that patients contact their insurance company prior to admission to ensure cover.

Self pay – This is where patients pay for the treatment themselves.

NHS Patients – Hospitals aim to have a strong partnership with the local NHS Trust and we may admit NHS patients for surgery.

Admissions

Admissions during normal working hours are coordinated by the Bookings Dept, who liaise directly with the Consultants.

Emergency admissions, outside of these hours, are accepted by the Duty Sister in Charge of that shift who will have spoken to the patients Consultant and will discuss with the RMO the patient's needs.

The RMO is expected to clerk patients on arrival and to agree a treatment plan with the Consultant.

Pre-op Assessment

The majority of our patients who are to have surgery undergo a pre-operative assessment, which is arranged and performed through the outpatient department.

You may be called on occasionally to take blood and to review ECG recordings. In these circumstances it is possible to contact a Consultant Anaesthetist for advice. Please ensure you sign and date all blood results and ECGs with required action.

Emergency Pager System

The RMO pager will be automatically be set off if an emergency bell is activated.

You must respond immediately. The Bleep will let you know which room/department has been activated.

There is a backup resus system which is XXXXX if the emergency bell system is down.

Bleeps will be tested daily and you will be required to attend the daily resus huddle in a timely manner.

Please keep your bleep with you at all times and respond immediately in an emergency.

Fire

The Engineer in charge of Fire Management, will discuss the fire policy with you and give you basic fire instruction, please see them as soon as possible on starting as part of your induction.

RMO is required to go to the nearest Ward/Department area and await advice.

Ward visits

You are expected to attend the ward handovers when practicable.

The handover times are:

There is a ward round at XXXX: the XXXXXXXX and you will attend.

Notations of the ward round must be documented in patient medical records.

Last thing at night, you must do a ward round to ensure all patients have sufficient pain relief, antiemetic and have passed urine.

Please attend the ward safety huddles so that you are informed of the plan for the day ahead and any potential issues. The safety huddle is at XXXXXX

If you have not had sufficient rest overnight please inform the Nurse in Charge so that cover can be arranged if required.

Blood Tests

Please arrange to see the Pathology Department (including the Blood Transfusion Lead) as soon as possible. Outpatient nurses and some ward nurses perform venepuncture. However, the RMO is expected to carry out routine phlebotomy on request.

You will need to check for blood tests requested from previous days surgery and these should be taken early in the morning so that they can be processed and acted upon.
Samples you may need to do:

☐ Any tests which are required urgently, which cannot be performed with POC

☐ Urgent blood transfusion

☐ Tests that will directly affect the treatment of a patient that evening/night

☐ Blood cultures

There is a Point of Care (POC) system in the XXXXX department where certain blood tests can be performed. These include; XXXXXXXX. The POC system is used when blood tests are requested out-of-hours (including weekends). You are expected to be trained on how to use these machines and fill in the necessary documents (bottles, request forms, charge sheets) by the Pathology Department/Ward staff.

Pathology Results

The RMO is expected to review all pathology results at least three times daily or when they are received onto the ward.

These will be placed in the XXXXX which you must look for every time you move through the ward.

- **It is your responsibility to contact the consultant if the results are abnormal, and you should also inform the nurse in charge of that patient.**
- All pathology results must be initialed and dated by the RMO when they have been read.

Contacting Consultants

You are professionally accountable to the Consultants. The Consultant will decide on a patient's treatment regime and on-going medical interventions. Try to familiarise yourself with every Consultant's regime, e.g., duration of Enoxaparin treatment after discharge, commencing analgesia and laxatives post op, instructions for commencing anti-hypertensive drugs.

If a patient becomes unwell or you need advice at any time, you must contact the Consultant concerned. If you are unable to contact this Consultant, then please seek advice from the nurse in charge as to an alternative Consultant. Your role is to provide medical support for the Consultants and not to take charge of medical decisions unless in an emergency situation. All Consultants to be informed prior to a patient being catheterised post operatively.

Pharmacy

XXXXX Hospital Pharmacy is managed by a qualified Pharmacist with support from the Pharmacy Team.

As part of your induction it is important for you to meet with them to discuss issues surrounding the prescribing and dispensing of medicines with you and it is advisable to arrange to see them as soon as possible after your arrival.

You should make yourself familiar with all policies relating to medications. You should also make yourself familiar with proper labelling of dispensed drugs.

If drugs are required out of hours, it is part of the RMO's role to dispense the prescription, most of commonly require TTOs are kept in the RMOs TTO cupboard. Should you require something that is not stocked here you will need to access the pharmacy department; access is on a secure basis and you will need to have a member of the ward/outpatient nursing staff to accompany you.

Points to note:

- Do not split pre-packs of TTO medication as they have already been checked by pharmacy
- Ensure all TTOs are second checked by a registered nurse
- Patients own drugs should be prescribed on admission and stored securely

The Nursing Staff are not allowed to take verbal orders either over the phone or directly, for medicines.

These will be placed in the XXXXX which you must look for every time you move through the ward.

- It is your responsibility to contact the consultant if the results are abnormal, and you should also inform the nurse in charge of that patient.
- All pathology results must be initialed and dated by the RMO when they have been read.

Resuscitation

On arrival please ensure you are familiar with the resuscitation equipment and location of the anaphylaxis box. The Resuscitation Lead for the hospital will show this to you. Trolleys are checked once week, please ensure you familiarise yourself with the contents of each drawer. There are simulated cardiac arrest scenarios taking place regularly to audit staff competencies and system problems, you are required to attend these.

Please also familiarise yourself with the location of the sepsis kit, second line drugs, emergency alert buttons in patients rooms and the sound of the emergency alarms.

Documentation

- Please ensure you are familiar with the GMC's guidelines for good record keeping
- An entry must be made into the medical records of each patient every time an assessment is made or a procedure undertaken. This would include for example changing a venous cannula, inserting a catheter or attending the ward round
- The notes should be accompanied by date, time, signature, printed name and designation in black ink
- Each inpatient must, as a minimum, be visited once a day and a medical record entry made. A patient list can be obtained from the ward clerk
- Please inform the Duty Sister or the patient's nurse when changes are made to treatment
- Patients with comorbidities and abnormal blood results must have a referral for anaesthetic review prior to admission fully documented in the medical records

- All call backs to the hospital post discharge and advice given must be documented in full in line with policy
- All clinical patient reviews must be documented in the patient's medical records
- Consultants must be informed of patients if any concerns and this fully documented in the medical records
- Where the clinical notes of the patient are unavailable the documentation is held in a designated folder / temp set of notes and sent to medical records to be included in the medical file of the patient
  - *Death Notification*
- The Consultant will usually complete this and the documentation is available on the ward
  - Clinical Incident/Accident form
- If an accident or clinical incident occurs with a patient or member of staff and you are called to assist then you will need to participate in the completion of the online Datix form. Please ensure you meet with the Clinical Governance Lead during your induction to familiarise yourself with the system

Dress Code

- We expect all RMO's to dress appropriately while on duty.
- Scrubs are provided for your comfort and are to be changed daily.
- Footwear should be appropriate and protect the wearer from potential injury. Therefore no sandals or trainers will be worn.
- A name badge should be worn at all times. One should be available for you on commencement here.
- Full compliance with Bare Below the Elbow in clinical areas

Health & Safety

You are expected to comply with the Health and Safety at Work Act. A copy of the Health and Safety policies are available for your information.

Infection Control

The hospital has an Infection Control Team and national and local policies to support good practice. Please familiarise yourself with the local 'Management of Sharp injuries' as soon as possible as the RMO plays a significant role in the management of sharps/needlestick injuries in the hospital Please ensure you meet with the Infection Prevention and Control Lead nurse during your induction
Our infection rate is very small and you are asked to abide by good practice and universal precautions. Please ensure you familiarise yourself with clinical waste procedures e.g. dealing with pharmacy waste, and that procedures for sharps and the treatment in the event of sharps injuries are followed.

Accommodation

If you have visitors please inform reception.

Room Cleaning

Please try and keep the room as tidy as possible. The room is fully cleaned every week; some equipment is available if you need cleaning more frequently than this. Please contact Housekeeping for any assistance.

Meals

Meals are complimentary for you only.

Please discuss ordering requirements with the Chef.

Facilities for making hot drinks and warming up of food are available in the restaurant. Snacks are available from the kitchen throughout the day and the vending machine is available.

Phone Calls

To make an outside call, first dial 9. You will be charged for all calls made. Ask at main reception to set this up for you

Internet Access

Internet and e-mail access is available to you.

Smoking

The Hospital operates a 'No Smoking Policy'. All smoking must take place off site.

Sleep & Rest

Please ensure the Senior Ward Nurse is aware if your sleep was disturbed or if you require cover due to fatigue.

Diagnostic Imaging

The Diagnostic Imaging Department is open XXXX Monday – Friday, with a Radiographer on duty into the evenings if appropriate clinics are scheduled late in Outpatients.

There is an on–call service available. A rota is maintained and held at XXXXXXXXXXXXXXXXX Any

request for imaging must be made on an imaging request form by a doctor. This form must be completed fully with all patient details and a clear, complete clinical history to justify the examination.

The Imaging department undertakes XXXXXXXXXXXXXXXXXXXXXXXX.

Routine request forms can be placed in XXXXXXXXXXXXX but urgent requests must be made directly with the department.

Outpatients Department

The outpatients department accommodates a wide variety of clinics and health screening.

The RMO may be required to assist the nurses in the department with venepuncture. You might also be asked to assess a patient's surgical wound post operatively (e.g. for signs of infection, inflammation, allergic reactions). Always document any assessment made and inform the Consultant if necessary.

Support for Doctors

Working in hospitals can be very challenging. It is vital that all doctors support one another by providing an environment that encourages and enables us to make choices that promote healthy lives and wellbeing. We need well doctors so that patients receive the best care and management possible.

The hospital is usually the first place to seek advice and support. Staff here will understand specific problems and be in a position to provide solutions and support. Please speak to the Director of Clinical Services if support is required. Each hospital also has a Freedom to Speak up Guardian who you can speak to if you have any concerns. The Ward Manager will inform you of who this is.

If you or a colleague is looking for additional support there are a range of organisations, services and websites which can offer help. Please search http://www.aomrc.org.uk/supportfordoctors/
You will find a host of important information to help support healthy lives and wellbeing of our doctors.

Some of the links include:

Workforce http://www.aomrc.org.uk/supportfordoctors/#1465861183058-32a10695-e1e5
Medical Royal Colleges http://www.aomrc.org.uk/supportfordoctors/#1465858571595-d681c205-74ae
British Medical Association http://www.aomrc.org.uk/supportfordoctors/#1465858640552-4ee2b70e-5fbe
Medical Defence Unions http://www.aomrc.org.uk/supportfordoctors/#1465858804711-d7056b6c-44ea
General Medical Council http://www.aomrc.org.uk/supportfordoctors/#1465858708734-6354a7b0-8f27
Mental Health Support http://www.aomrc.org.uk/supportfordoctors/#1465858914205-3cac3324-6baf

Alcohol and drug addiction support http://www.aomrc.org.uk/supportfordoctors/#1465858992939-b1fa4622-26f0

Counselling and psychotherapy http://www.aomrc.org.uk/supportfordoctors/#1465859070012-ef7e41c7-e252

Financial support http://www.aomrc.org.uk/supportfordoctors/#1466638394592-dd37f360-1

Other support services http://www.aomrc.org.uk/supportfordoctors/#1466638581922-94eb3690-4118

Signed: .....

Date: .....

*Copy to be photocopied and provided to Ward Manager

We hope that this covers all the information you need but if you have any other questions, please ask our Director of Clinical Services.

Approved by:

NES Healthcare

Spire Healthcare

Looking after you.

NES Healthcare UK
First Floor, Barclays House
1 Gatehouse Way
Aylesbury, Bucks, HP19 8DB
01296 746140
admin@neshealthcare.co.uk
www.neshealthcare.com

NES Healthcare UK Mandatory Training

The current Mandatory training consists of Blood transfusion through Scottish National Blood Transfusion Service (SNBTS) and Educare mandatory training.

Blood Transfusion (3 yearly)

Haemovigilance, Blood group and Sampling

Haemovigilance

Blood Group Serology

Sampling Procedures

Requesting to Management

Administration Procedure

Requesting Procedure

Collection Procedure

Management of the Transfused Patient

Safe practice and Platelets

Safe and Appropriate Transfusion Practice

Blood Group Serology

Red blood cells

Platelets

NES Healthcare UK
First Floor, Barclays House
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Plasma and Adverse effects

Plasma Components

Massive Transfusion

Plasma Derivatives

Adverse effects of transfusion

Paeds Blood Transfusion

Paeds Haemovigilance

Paeds Blood Group Serology

Paeds Requesting Procedure

Paeds Sampling Procedures

Paeds Collection Procedure

Paeds Administration Procedure

Paeds Management of the Transfused Patient

Video

Blood Transfusion Video

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First Floor, Barclays House
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www.neshealthcare.com

Educare modules

3 Yearly
Mental Health, Dementia and Learning Disabilities
Food Hygiene Essentials in Health and Social Care
Personal Safety
An Introduction to the General Data Protection Regulation
An Introduction to Effective Teamwork
An Introduction to Risk Assessment
An Introduction to Leadership
How to be an Effective Fire Warden or Fire Marshal
Food Hygiene and Safety 2018
The Prevent Duty
Fire Safety (2018)
Raising Awareness of Honour-Based Abuse and Forced Marriage
Female Genital Mutilation Awareness (June 2018)
Safer Recruitment
Communication Skills and Handling Information (Feb 2019)
Raising Awareness of Trafficking and Modern Slavery
Domestic Abuse: Children and Young People
Your Personal Development in Health and Social Care
Person-Centred Care Approaches in Health and Social Care
Understand Your Role
Adverse Childhood Experiences (ACEs)
First Aid Essentials in Health & Social Care
Conflict Resolution in Health and Social Care
Fluids and Nutrition

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11 Annual Modules
Safeguarding Children in Health and Social Care
Health and Safety in Health and Social Care
Mental Capacity
Manual Handling
Duty of Care, Privacy & Dignity
Information Governance & Data Security in Health and Social Care
Equality and Diversity in Health and Social Care
Infection Prevention and Control in Health and Social Care
Safeguarding Adults in Health & Social Care
Child Neglect
Child Protection Advanced