Affix Patient label

Name ....

Reg No ....

Inpatient SBART Transfer Checklist

NHS University Hospitals Birmingham NHS Foundation Trust

To be completed by transferring ward/department and transferred on the front of the notes then filed.

S — Situation

Date ....   Time of transfer ....

Consultant ....   Provisional diagnosis ....

RN Handing over ....   Transferring ward/dept ....

RN Receiving handover ....   Receiving ward/dept ....

B — Background

Relevant medical history ....   ID wristband ....

Treatment Escalation and Limitation (TEAL) decision

Allergies ....   RESPECT / DNACPR (please circle) Yes / No

A — Assessment

Infection risk: (please circle) None / Vomiting / Diarrhoea / Previous / MRSA / Other ....

MRSA screen ☐   Communication issue ☐

Wound/pressure Ulcer: None / Yes (area ....   Grade ....

Datix ref no ....   Waterlow score ....   Mattress ....

PVC ☐   CVAD ☐   Epidural ☐   Tracheostomy ☐   Dysphagia ☐   NBM ☐   Urinary catheter ☐

Chest drain ☐   Wound drain ☐   Continence ☐   IV Drugs/infusion / IV Insulin ☐   Diabetic ☐

Falls risk: Yes / No   Fallen this admission: Yes / No   Enhanced care required: Yes / No

Confusion Yes / No   If yes give details ....

R — Recommendation

Diagnostics still outstanding ....

Management / discharge plan ....

Special instructions (e.g. cardiac monitoring) ....

Referrals made: (please circle) Safeguarding / Dementia / Learning disability / Social work / RAID /

Other (detail) ....

T — Transfer

(Observations must be taken within 30 mins of transfer) If not required please tick ☐

Current SEWS/NEWS ....   Has SEWS/NEWS escalation been followed Yes / No

Capillary blood glucose ....   Pain score ....   Does the patient have sepsis? Yes / No

Has the Sepsis Six been followed? Yes / No

Oxygen required: (please circle)   2 litres / 4 litres / Other (detail) ....

Oxygen cylinder sufficient for transfer ☐   Oxygen valve turned to on position ☐   No property ☐

Property / cash / valuables checked / disclaimer signed ☐   Transferred with patient ☐   Wristband in situ ☐

Relatives informed of transfer ☐   Medication with patient/locker emptied ☐   No medication ☐

Medication sent home ☐   Escort required ☐   Level of escort ....   Equipment checked ☐

RN:	Print name:	Signature:	Date:	Time:

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Emergency Department Safety Checklist

Date: **Time of arrival:**

	Action	Time	Initials	Comments
First hour Completion Time	Initial Assessment/Triage/RAT			
	Vital signs measured & NEWS recorded			
	ECG recorded & reviewed (within 10 mins)			
	Undressed & gown			
	Wristband			
	Pain score assessed			
	Analgesia administered (if appropriate)			
	Infection control screening			
	Falls assessment			
	Sepsis screen			
	IV access (if appropriate) and IVAD form completed			
	Imaging (#NOF within 1 hour)			
	Specific Pathway Triggered (see box 1)			
	Pathway commenced (e.g. Sepsis, DKA, NOF, GI bleed)			
2nd hour Completion Time	Vital signs measured & SEWS/NEWS recorded			
	Pain Score Assessed			
	Analgesia administered (if appropriate)			
	Next of kin aware			
	Refreshments offered (if not NBM)			
	Falls:			
	Assessment (Is patient at risk of falls?)			
	Falls assessment completed			
	Absconding/Violence & aggression			
	Assessment (Is patient high risk of absconding or violence aggression?)			
	Documentation/TAG completed, flagged on OCEANO			
	Pressure Area Care:			
	Assessment (Full Waterlow completed if at clinical risk)			
	PICS Waterlow chart completed			
	Patient good to go:			
	Ensure patients own medicines transferred to ward			
	Patient property documentation complete			
	Patient ready for transfer			
	Specialty bed confirmed			
3rd hour Completion Time	Vital signs measured & SEWS/NEWS recorded			
	Pain Score Assessed			
	Analgesia administered (if appropriate)			
	Refreshments offered (if not NBM)			
	Review by senior Doctor			
	Regular medication administered (If appropriate)			
4th hour Completion Time	Vital signs measured & SEWS/NEWS recorded			
	Pain Score Assessed			
	Analgesia administered (if appropriate)			
	Refreshments offered (if not NBM)			
	Regular medication administered (If appropriate)			
	Reposition patient (If required/appropriate)			
CONTINUE ANY ADDITIONAL HOURS SAME AS 4TH HOUR COMPLETION AND DOCUMENT ON THE NEXT PAGE				
Referrals & Pathway/ Specialty Triggers	Adult safeguarding referral			Box 1 - Specialty Trigger:
	Child safeguarding referral			
	Mental health proforma completed			Liaison Psychiatry ☐
	Mental health team referral			Trauma ☐ Use Trauma Proforma
	Youth violence NO/YES - REDTHREAD referral			OPAL ☐

ENSURE O2 LEVELS ARE REGULARLY CHECKED ON TROLLEYS - REQUEST REPLACEMENT CYLINDERS FROM PORTERING STAFF

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Emergency Department Nursing Care Record

NHS
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NHS Foundation Trust

Time/Date	Assessment & Care	Sign Print Designation

Safety Checklist - Notes

Pressure Area Care:
In your clinical judgement is the patient at risk of pressure ulcers?
If YES - Complete full Waterlow risk assessment on PICS, document interventions.

Absconding or Violence & Aggression risk:
If YES - inform NIC immediately. Nurse in an area that can be observed. Write a full description of the patient on their TAG form or in the notes.

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Patient Property Record

Has patient retained their own property? YES/NO

Signature ______________________ Witness Name ______________________

Has patient's relative retained their property/valuables? YES/NO

Signature ______________________ Witness Name ______________________

Are the patient's valuables in the A&E safe? YES/NO

Receipt Number ______________________

Please list patient's property below

Has the Police seized patient's property YES/NO

Receipt/Police shoulder number ______________________

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Date and Time	PVC No.	Number of days PVC in situ	PVC Indicated	VIP Score	Dressing Clean, Dry, Intact	ANTT used	Assessment / Intervention / Comments	Sign and Print name and Designation
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		
			Yes / No		Yes / No	Yes / No		

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Emergency Department Nursing Care Record

University Hospitals Birmingham
NHS Foundation Trust

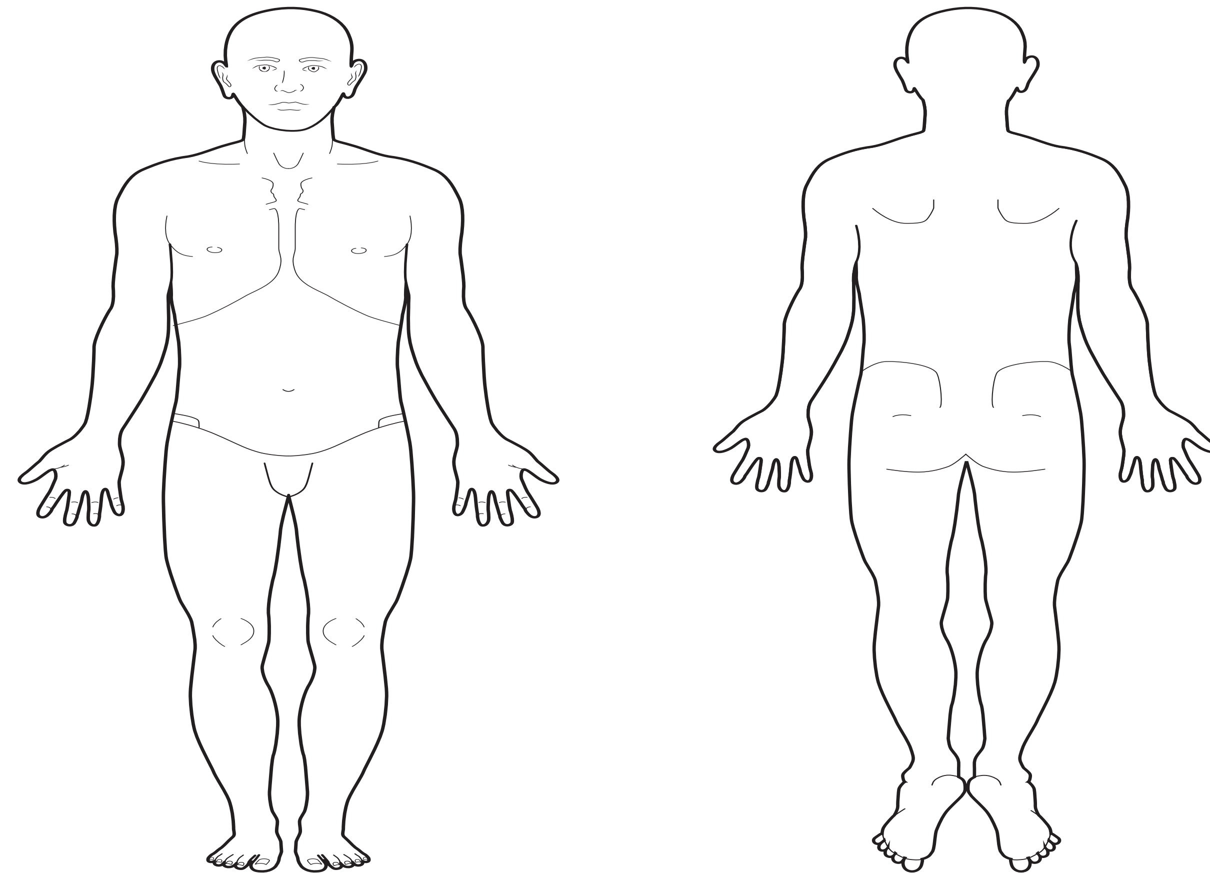
Time/Date	Assessment & Care	Sign Print Designation

Safety Checklist - Notes

Pressure Area Care:
In your clinical judgement is the patient at risk of pressure ulcers?
If YES - Complete full Waterlow risk assessment on PICS, document interventions.

Absconding or Violence & Aggression risk:
If YES - inform NIC immediately. Nurse in an area that can be observed. Write a full description of the patient on their TAG form or in the notes.

Circle damaged areas:



Waterlow Score =

Datix Reference =

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

• 1 mm ● 2 mm ● 3 mm ● 4 mm ● 5 mm ● 6 mm ● 7 mm ● 8 mm ● 9 mm ● 10 mm

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Peripheral Venous Cannula (PVC) Insertion and Ongoing Care Record

The Aseptic Non Touch Technique must be used for all aspects of care

PVC INSERTION AND REMOVAL RECORD

Insertion PVC 1

Date and Time:	Gauge:	Lot No:
Reason for Insertion:		Skin prep used YES NO Chlorhexidine Other....................
Site of Insertion: Left Right Hand Forearm ACF Other..................................		Inserted by (sign and print name and designation):

Removal PVC 1

Date and Time:	State if unsuccessful attempt or reason for removal:	Removed by (sign and print name and designation):

Insertion PVC 2

Date and Time:	Gauge:	Lot No:
Reason for Insertion:		Skin prep used YES NO Chlorhexidine Other....................
Site of Insertion: Left Right Hand Forearm ACF Other..................................		Inserted by (sign and print name and designation):

Removal PVC 2

Date and Time:	State if unsuccessful attempt or reason for removal:	Removed by (sign and print name and designation):

Insertion PVC 3

Date and Time:	Gauge:	Lot No:
Reason for Insertion:		Skin prep used YES NO Chlorhexidine Other....................
Site of Insertion: Left Right Hand Forearm ACF Other..................................		Inserted by (sign and print name and designation):

Removal PVC 3

Date and Time:	State if unsuccessful attempt or reason for removal:	Removed by (sign and print name and designation):

PVC ONGOING CARE RECORD

(with reference to Trust PVC Guidelines)

V.I.P SCORE (Visual Infusion Phlebitis Score)

IV site appears healthy	0	No signs of Phlebitis • OBSERVE CANNULA
1 of the following is evident: • Slight pain near IV site or redness near IV site	1	Possible first signs of Phlebitis • OBSERVE CANNULA
2 of the following are evident: • Pain near IV site or along the path of the PVC • Erythema • Swelling	2	Phlebitis • RE-SITE CANNULA • REVIEW FOR TREATMENT

- Assess PVC for signs of Phlebitis each time it is used
- Record VIP score at least every 8 hours
- Remove PVC if no longer indicated
- Remove PVC if VIP score is 2
- Change dressing if soiled / no longer securing PVC

Any variance from Trust PVC Guidelines must be risk assessed and clearly documented