Somerset Partnership NHS
NHS Foundation Trust

BLOOD INVESTIGATIONS POLICY - NON-MEDICAL PROFESSIONALS REQUESTING PATHOLOGICAL SAMPLES

To be read in conjunction with the Venepuncture Policy

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Ratified by:	Senior Managers Operational Group
Date Ratified:	August 2015
Title of Originator/Author:	Clinical Skills Facilitator Senior Nurse for Clinical Practice
Title of Responsible Committee/group:	Director of Nursing and Patient Safety
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Relevant Staff Groups:	All trust staff who order blood investigations

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DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
NV/Aug12/BIP	4	Final	Senior Nurse for Clinical Practice
Amendments	Revised Document Post Acquisition of Somerset Community Health		
Document objectives: To enable selected non-medical staff to request diagnostic pathological investigations namely, blood investigations, in accordance with organisation policy, and locally agreed protocols, following appropriate training and demonstration of competence.			
Intended recipients: Somerset Partnership NHS Foundation Trust Health Staff			
Committee/Group Consulted: Community Hospital Best Practice Group, Dental Service, Prison Manager, Clinical Policy Review Group, Clinical Governance.			
Monitoring arrangements and indicators: This policy will be reviewed on a three yearly basis or more often in order to maintain best practice.			
Training/resource implications: Training already provided for venepuncture via the training department. Competency assessed by assessors in practice.			
Approval	Clinical Governance Group	Date: August 2015	
Formal Impact Assessment	Yes	Date: August 2015	
Ratification Body and date	Senior Managers Operational Group	Date: August 2015	
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Contact for review	Senior Nurse for Clinical Practice		
Lead Director	Director of Nursing and Patient Safety		

CONTRIBUTION LIST Key individuals involved in developing the document

Name	Designation or Group
Carrie Butcher	CPN
Lucy Hornshaw	Prison Healthcare Manager
Claire Marks	District Nurse Lead
Andy Sprod	Clinical Director Dental Service
Group Members	Community Hospital Best Practice Group
Andrew Sinclair	Trust Equality and Diversity Lead
Dawn Holloway	Staff Nurse
Heads of Division	(2015)
Dawn Dawson	Head of General Nursing and Clinical Governance (2015)
Liz Berry	Senior Nurse for Clinical Practice (2015)
Liz Harewood	Deputy Chief Pharmacist (2015)
Rhiannon Morris	Team Manager for Point of Care Testing, Southwest Pathology Services (2015)
David James	Clinical Director, Southwest Pathology Services (2015)

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1. INTRODUCTION

1.1 Pathology services are an integral part of the care that patients receive. Demand for these services has increased dramatically in recent years and this increasing demand is likely to continue in the future. Unavailability of diagnostic and clinical support services is seen as a significant bottleneck in delivering the NHS Plan (DH, 2000).

1.2 The NHS plan (DH, 2000) also included the Chief Nursing Officer's (CNO) (DH 2000; DH 2001) 10 key roles for nurses, with "ordering diagnostic investigations such as pathology tests and X-rays" being at the forefront.

1.3 The NHS Plan (DH, 2000) states, 'it is about working smarter to make the maximum use of the talents of the entire NHS workforce.' As a result, nurses and midwives are being empowered to undertake a wider range of clinical tasks including the requesting of investigations and diagnostic tests.

1.4 The link between having the personal knowledge of the medical indication for a test and requesting the test is being weakened (Howard, 2003). Completing request forms and collecting samples are seen as routine tasks that can be performed by many people. Different sets of skills, knowledge and competencies, including clinical expertise, are required to decide on which investigations are indicated for a particular patient. The distinction between these two very different aspects of requesting pathology tests has become blurred (The Royal College of Pathologists, 2003).

2. PURPOSE AND SCOPE

2.1 The purpose of this policy is to enable selected non-medical staff to safely and appropriately request pathological blood investigations in accordance with the organisation's policy and to locally agreed protocols, by:

- ensuring best practice in the use of diagnostic services
- ensure that test results are communicated and reviewed by an appropriate clinician, in a timely manner
- to avoid duplication of requests
- ensuring maximum use of the talents of all the NHS workforce as stated by CNO in the NHS Plan (2000)
- ensuring appropriate training is received and demonstration of competence achieved

3. DUTIES AND RESPONSIBILITIES

The **Trust Board, via the Chief Executive** is responsible for ensuring the Trust has a policy to promote safe and effective practice in relation to blood investigations and there are effective and adequately resourced arrangements for the fulfilment these policy requirements.

The **Director of Nursing and Patient Safety** is responsible for overseeing the local control of and the implementation of this policy.

The **Clinical Practice Team** is responsible for ensuring there is defined process for training and competency assessment relating to this policy within the Trust.

The **Learning and Development Team** is responsible for provision of Trust training programmes and maintaining the electronic staff record of training.

Ward Managers and Team Leaders are responsible for ensuring that staff who request blood investigations are competent and compliant with the policy. This skill, along with other competencies, must be reviewed at staff members' annual appraisal and following any related incident.

Staff members undertaking this skill are responsible for demonstrating to their line manager that they have received the formal training and that they are competent to request blood investigations whilst acting within local policy**.**

4. EXPLANATIONS OF TERMS USED

A request

4.1 A request may be for one or more investigation within a pathology specialty, from a single sample, or group of related samples, taken from a patient or other human or non-human source and sent to a pathology laboratory at one time. A request can be summarised as 'a sample, plus appropriate clinical and identifying / demographic details for one or more investigations.

Delegation

4.2 'Delegation' is when an individual asks another individual to undertake a duty. The person delegating the task must ensure the person undertaking the task is competent and confident to do so.

The GMC's publication, Delegation and Referral (2013), states "Delegation involves asking a colleague to provide care or treatment on your behalf. When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised. When you delegate care you are still responsible for the overall management of the patient."

Point Of Care Testing (POCT)

This encompasses a range of testing many analytes across pathology. POCT is capable of delivering results in a timely manner that allows clinical decisions to occur quickly, thus potentially allowing better clinical

(and/or economic) outcomes. For further information please refer to the Point Of Care Testing Policy.

Blood investigations

The blood investigations are abbreviated as follows;

- FBC – Full Blood Count;
- U+E – Urea and Electrolytes;
- INR – International Ratio;
- TFT – Thyroid Function Test;
- LFT – Liver Function Test;
- CS - Clotting Screen.

5. STATEMENT OF POLICY

5.1 Requests should be prompted by the clinical circumstances and some knowledge of the relevance of the investigation and result to that clinical circumstance. This process will be formalised within the protocol.

5.2 Staff must not accept requests made directly by the patient/relatives/carers. Confirmation must be obtained from either the acute Trust or patient's GP prior to taking any action.

5.3 When delegating requests for tests, or review of results, there must be a clear line of accountability. Pathologists should be informed of whom they should contact in the event of a significant result.

5.4 Through local agreement with the medical lead, and within clearly defined criteria, ordering pathology requests may be delegated to non-medical personnel. The medical practitioner retains the responsibility for requesting the investigation.

5.5 When non-medical staff sign a pathology form, they must include the name of the medical practitioner to whom they are responsible and who has overall care of the patient

5.6 Autonomous practitioners, such as midwives and dentists who request diagnostic tests and require advice on interpretation of results, are responsible for taking action on the results and are clearly bound by their professional accountability.

Patient Consent

Staff must ensure they have received informed consent from the patient at all times and that the patient is aware of the reason for request and subsequent actions. Refer to the Policy for Consent and Capacity for actions to be taken in relation to patients with incapacity. Staff must ensure the correct action and communication process is followed and documented at all times.

Results

The pathologist's duty of care is to ensure that the results are communicated to someone who will act on that information as expeditiously as is appropriate.

Results must be checked when available, and communicated to an appropriate practitioner, such as a senior clinician, who is responsible for taking action.

All results must be clearly communicated and clearly documented. Any action taken must be recorded in the evaluation record and must be included in handover.

Permitted Investigations

Suspected Clinical Condition	Point of care testing	Blood Investigations
Chest Infection	Urinalysis, Capillary blood glucose	FBC, U+E, Creatinine
Urinary Tract Infection	Urinalysis	U+E , FBC, Creatinine
Jaundice	Urinalysis, Capillary blood glucose	LFT
Cellulitis	Capillary blood glucose	FBC, U+E, Creatinine
Confusion	Urinalysis, Capillary blood glucose	FBC, U+E, Creatinine, TFT
Suspected Diabetes	Urinalysis, capillary blood glucose	Fasting Glucose
Warfarin Monitoring	Coagulometer	INR
Anaemia		FBC
Chest Pain	Urinalysis, capillary blood glucose	FBC, U+E, Creatinine Troponin, Cholesterol, CS,
Nausea & Vomiting	Urinalysis, capillary blood glucose	FBC, U+E, Creatinine
Diarrhoea	Urinalysis, capillary blood glucose	FBC, U+E, Creatinine
Shortness of Breath	Capillary blood glucose	FBC, U+E, Creatinine,
Chemotherapy	N/A	FBC
Suspected hypo and hyper-glycaemia	Capillary blood glucose	

It is important that when assessing the deteriorating patient, that basic forms of investigations at the patient's bedside, are not overlooked. They should be used in conjunction with other blood investigations as listed in the table above. These tests can be used to determine the need for further pathological investigations required from venous blood.

There are certain blood investigations that can ONLY be requested by non-medical practitioners who have undergone further specialist training, for example, Occupational Health Nurses, Sexual Health Nurses,

Community Matrons and Emergency Nurse Practitioners. These groups will follow specific national and local guidelines and protocols outside of this policy.

6. TRAINING REQUIREMENTS

6.1 Staff wishing to request pathological investigations, will be identified by their line manager and must complete relevant training and assessment of competence, according to the requirements of their role.

6.2 In addition staff must be able to demonstrate the correct process of action and communication to be followed and documented.

6.3 Initial training will be delivered by the Clinical Practice Team and cascaded to appropriate members of the team, as identified by line managers.

6.4 Non-medical staff requesting tests should undertake a period of supervised practice to achieve competence.

6.5 Non-medical staff should competently undertake ordering tests under supervision, across a range of patient situations, using this policy. The period of working under supervision should be determined by the professional lead for the service.

6.6 It may be necessary for a practitioner to undertake a further period of supervised practice if he/she does not undertake the role of ordering tests for a period of time for example, six months, or of he/she moves to work in a different clinical area where different protocols are in use. This area of competency should be discussed during the appraisal process.

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

8. MONITORING, COMPLIANCE AND EFFECTIVENESS

8.1 Any issues relating blood samples sent to Somerset Pathology Services, such as problems with the sample, labelling or the testing, will be discussed with the appropriate staff at the time the sample has been received. Somerset Pathology Services will also provide a monthly report to feedback any issues that have arisen relating to blood samples sent by Somerset Partnership. This will be disseminated to the appropriate Best Practice Groups.

These clinical guidelines will be reviewed every three years or updated sooner following the release of new guidance.

Any incidents, patient complaints or feedback will be investigated by the clinical service providing the patients care, and reported via the appropriate best practice group.

9 COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18:	Notification of other incidents

10.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

11.1 **References**

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Department of Health (2002). Developing Key Roles for Nurses and Midwives: A Guide for Managers. www.doh.gov.uk/newrolesfornurses/index.htm

Department of Health (2003) *Freedom to Practice: dispelling the myths*.

Department of Health (2000) *The NHS Plan: a plan for investment, A plan for reform.* DH, London.

General Medical Council. Delegation and referral . London: GMC, 2013. http://www.gmc-uk.org/guidance/ethical_guidance /21187.asp#ask _a_colleague

Hayward R (2003) VOMIT (Victims of modern imaging technology) – an acronym for our times. *British Medical Journal:* 326:1273.

MHRA (2010) "Device Bulletin. Management and use Of IVD Point of Care Test Devices" DB2010902), Department of Health.

Nursing and Midwifery Council (NMC) (2015) *The Code. Professional standards of practice and behaviour for nurses and midwives*

The Royal College of Pathologists (2003) *Who can request a test. Draft guidelines* (Unpublished)

11.2 Cross reference to other procedural documents

Consent and Capacity to Consent for Treatment Policy

Learning Development and Mandatory Training Policy

Point of Care Testing Devices Policy

Risk Management Policy and Procedure

Staff Mandatory Training Matrix (Training Needs Analysis)

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

12. APPENDICIES

For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Process of action and communication when requesting pathological samples by non-medical health professionals

APPENDIX A

Somerset Partnership NHS
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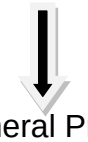
PROCESS OF ACTION AND COMMUNICATION WHEN REQUESTING PATHOLOGICAL SAMPLES BY NON-MEDICAL HEALTH PROFESSIONALS (COMMUNITY HEALTH DIRECTORATE)

Registered Nurse (trained and competent) assesses patient clinical condition



Named Doctor/ General Practitioner identified

Investigations discussed with patient and informed consent gained

Patient clinical history and previous recent investigations scrutinised to ensure avoidance of duplication of requests

Investigations requested in accordance with Organisation's Policy

Results are communicated back to the Named Doctor for action

Urgent abnormal results must be reviewed, in a timely manner, as directed by the pathologist, to the Named Doctor

All communication and action(s) taken or omitted must be clearly documented at all times and signed and dated by the health care professional