POLICY DOCUMENT

Burton Hospitals

NHS Foundation Trust

Emergency Department Operational Policy

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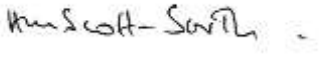
Signature:	
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Burton Hospitals NHS Foundation Trust

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POLICY INDEX SHEET

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
1	Addendum	10/10/16	Addition to highlight agreed process of referral direct to speciality when presenting at the Emergency Department having already been seen in Primary Care
2	Addendum	10/10/16	Addition to highlight Paediatric assessments in ED when a safeguarding concern has been raised

Emergency Department Operational Policy

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Burton Hospitals NHS Foundation Trust

Emergency Department Operational Policy

To give an overview of the processes and service provided within the Emergency Department, within the division of Emergency Care. The policy will detail how the Emergency Department will run and the expectations for users of the facility.

Abbreviations:

AAC Acute Assessment Centre
ED Emergency Department
AEC Ambulatory Emergency Care
GP General Practitioner CDU
Clinical Decisions Unit
SAU Surgical Assessment Unit
IPS Internal Professional Standards
RN Registered Nurse

1. Function of ED

1.1 Overview

The ED is recognised nationally as a type 1 Emergency Department offering full unscheduled emergency care services 24 hours per day, 365 days per year, based at Queen's hospital site, Burton Hospital NHS Foundation Trust.

This document outlines the operational policy for the ED and facilities based within or in close liaison to the department. The facility is located on the main Queen's hospital site with direct access from Belvedere road and offers emergency ambulance and walk in access. It outlines how the ED will operate and the expectations of patients of this facility and the clinical care pathways that are in association to the ED through regional care networking arrangements and/ or specialist services.

The facility offers a dedicated minor injuries unit that includes a triage area, 5 assessments cubicles, 4 bedded treatment room, 1 eye assessment room and 1 plaster room. These are all accessible via the main entrance and waiting room. A separate paediatric waiting room and dedicated treatment cubicle is also part of this area, but not inclusive of the outlined accommodation.

The majors area comprises of 12 trolley areas, inclusive of 1 isolation room and 6 monitored spaces. 1 rapid assessment room is available off the main ambulance entrance corridor.

The resuscitation room includes 3 multi functional trolley spaces, principally dedicating 2 adult and 1 paediatric area, however are fully interchangeable as to patient need. This facility is directly accessed from the emergency ambulance entrance and has a dedicated relatives room.

The ED provides urgent assessment, observation, diagnostics and treatment for all presenting patients, inclusive of speciality referrals to the Trust.

The teams working in the ED will predominantly be the from within the Emergency Medicine team although other specialities including specially doctors and critical care teams will provide care to patients as required.

1.2 Service Scope

The ED is operational 24 hours per day, 365 days a year providing emergency and urgent care for any patients regardless of age.

Patients will attend the ED on their own accord, via an emergency services partner or via a primary care provider. Every patient presenting to the ED will be registered and assessed equally inline with the agreed protocols ensuring a systematic provision of care is offered to all.

Confidentially is to be upheld at all times inline with Trust policy and no clinical information should be handed over or shared in patient facing areas at any time.

1.3 Internal Professional Standards

The function and ability to deliver quality care, ensuring flow is maintained within the ED at all times requires **ALL** users to be achieving their outlined Internal Professional Standards (IPS). The agreed IPS's of all specialities utilising the ED, will be in operation at all times. Monitoring/audit utilising KPI's will be undertaken to ensure these are being followed. This is critical to the success of the centre.

1.3.1 Escalation

To ensure that appropriate action is taken to prevent the delay of safe treatment and maintain operational flow for all patients visiting the ED

Objectives:

1. The ED should be adequately staffed with correct number and skill levels in accordance with the established template.
2. Patient flow through waiting, initial assessment, treatment and plan of care should be maintained
3. Ambulance crews should be off loaded and CAD released within 15 minutes of arrival, CAD system updated by ward clerks.
4. Potential areas of blockages throughout the ED are anticipated and appropriate action will be taken to minimise through a 2 hourly board round process
5. Clinical and Managerial colleagues will be informed of projected and current pressures that may result in unsafe patient care and poor patient experience.
6. To maintain high quality care and achieve the clinical quality standards set for ED.

Escalation involves:

1. The implementation of those prearranged actions (Appendix) that are within the control of the ED team
2. Seeking support from the operational management team is necessary to ensure actions within the wider Trust are taken.

Escalation is the responsibility of the nurse coordinator in conjunction with the doctor in charge on the floor, usually the Consultant or the Senior Registrar. These names will be

clearly displayed and updated as part of the ward board process to ensure efficient escalation.

Key decisions
Key decisions during the day will be made by the following personnel over the 24hr period. The manager who will be either the ED lead nurse, Matron or Operational Lead, they will be available from 7am to 5pm. Out of standard working hours the hospital on site on call manager will assume this responsibility between 5pm to 7.30pm. Out of these hours and at weekends the Clinical Site Practitioner responsible for ED and operational flow will assume this role. Weekend cover is across the long days on Saturday and Sunday and will be via the on site Clinical Site Practitioner who will handover to the Night CSP'S.

2. Workforce

2.1 Medical Model

Overall ownership of the ED is the responsibility of Emergency Care, day to day management and leadership will be provided by the ED consultants. Speciality teams will also be in operation within the ED as per patient need and/or practice guidelines.

2.1.1 Consultants / Middle Grades

ED Consultants will not attend, whilst on call to minimise waiting times outside of their sessional requirements. They will attend for all trauma calls or if the department is deemed to be clinically unsafe by either the middle grade/ Nurse in Charge of the department

Patients will be seen in order of clinical need

All majors patients should be seen by a senior doctor within 30 minutes of arrival.

A clear management plan should be created on assessment of the patient.

- Appropriate disposal/placement of patient should be considered and any beds at this stage which are required should be discussed with the nurse looking after the patient so as to facilitate a timely admission – speciality doctor may discharge

Completion of first line drug therapy and fluid prescriptions

Responsible for referral to speciality team (as appropriate)

Doctors working in the ED should work as a team under the direction of the supervising ED consultant..

During the night the middle grade doctor is in charge of the shop floor and is responsible for escalating any issues which they are unable to resolve to either the ED consultant on call or the on call manager.

2.1.2 Emergency Medicine Speciality Trainee and Speciality Doctors in Emergency Medicine

Duties to be carried out as per the rota.

All swaps must be communicated through medical staffing.

Annual leave requests must be 6 weeks in advance of the start date of your holiday.

In the event of sickness, inform the ED consultant in charge and medical staffing.

2.1.3 Patient Management Standards

Doctors are under the direct management of the consultant on the shop floor.

Whilst the consultant is present, he/she is in-charge of the ED and CDU areas.

- When the consultant-on-call is at home, you will be the medical lead on the 'shop floor'.

Doctors will be expected to:

Ensure patients are seen in a timely fashion, with quality and safety being a priority.

Assist the junior medical staff in patient assessment, treatment and disposal as and when required.

You must ensure that patients continue to be assessed in line with the A+E quality indicator targets, in particular:

Monitoring of patient flow/assessment and treatment is essential to ensure the EM quality indicators are met.

All patients arriving by ambulance must be assessed within 15 minutes of arrival by a senior nurse or doctor.

All patients must be assessed by a decision making clinician within 1 hour of arrival. An appropriate management plan must be in place for each patient.

The 95th percentile of patients must be discharged or admitted within 4 hours of arrival

No patient must be in the ED longer than 6 hours.

2.1.4 Referral Standards

Aim to have a management plan for every ED patient by 2 hours of arrival

If at this point, or beforehand, the patient requires admission, refer to the appropriate on-call speciality

Update the Medical Tracker for all patients being referred to Medics

If that doctor is failing to answer in a prompt fashion, or if repeated efforts are made to bleep them

- PHONE THE NEXT DOCTOR IN ORDER OF SENIORITY
- THIS MAY BE THE REGISTRAR OR CONSULTANT

This will reduce the possibility of breaching and prompt appropriate speciality assessment

2.2 Clinical Decisions Unit

When the consultant on-call is at home, Middle Grade Doctors will be responsible for the management of emergency medicine patients in CDU.

For a patient to enter a bed on CDU, the middle grade must be informed and agree the management plan provided by the assessing doctor.

All patients entering CDU require a proforma.

NO PROFORMA = NO ADMISSION

The middle grade starting at 0800 at the weekend will review CDU patients at the start of their shift (if appropriate), or at a suitable time before midday.

2.2.1 Contacting a consultant out-of-hours

The NIC or middle grade can contact the consultant out-of-hours for advice.

Consultants will return to the ED in the following circumstances:

- *Trauma call (as defined by the Trauma Call alerting policy)*
- *Major Incident*
- *A clinically unsafe department*

2.2.2 Senior/Speciality Assessment

Timely decisions will be required to aid the steady flow of the department. If not already completed at the 2-hour stage, decisions will be sought from the senior/speciality clinical team on future treatment/care of the patient.

Request and organise or sanction request for radiological investigations (e.g. U/S, CT)

These doctors must be of a grade consistent with the ability to make admission, discharge and definitive treatment decisions.

Within a 2-hour period the patient will be transferred to the most appropriate area/place.

2.2.3 Breach Analysis and Board Rounds

Each consultant and NIC will review breaches as and when they occur whilst the consultant is on the shop-floor, including a 2 hourly board round.

Outside these times you will be expected to carry out a 2 hourly board round and breach review, if required.

Information required will be intentionally brief to enable you to treat, assess and manage patients on your shift.

Documentation must be completed at the time and then this information is collated by the nurse manager of the week.

Issues or problems need to be tackled and solved as soon as they are identified.

Issues that are unable to be resolved at the time must be reviewed within 24 hours, or when the consultant is next on duty.

The analysis can then be directed to the ED clinical lead and the ED matron to act upon.

Other Specialities

The other speciality teams will have on-call doctors to assess/treat/admit/discharge patients.

This structure will not change in the foreseeable future.

2.3 Nursing Model

The Nursing Team will provide cover across 24 hours per day, 365 days per year. The minimum staffing numbers take into consideration the bed base, acuity and dependency expected into the area. This may however fluctuate. As part of the board round process and live patient tracker, patients will be prioritised and staff allocated to move for clinical need and dependency. Referrals to out reach and the Surgical Assessment Nurse may be required to support care delivery and patient placement. Where highly dependent immobile patients are nursed within the area the patients will be prioritised to be nursed on a bed until on-going care is arranged.

Staffing template
DAY (LD 07.00-19.30)
1 RN Shift in Charge
1 RN Triage
1 RN Minors
3 RN Across Majors
1 RN Resuscitation

Supported by 1 Nursing Assistant in Majors

TWI (LL 11.45-00.15)
1 RN Resuscitation plus RAT
1 RN Minors

Supported by 1 Nursing Assistant in Minors

Night (LN 19.00-17.30)
1 RN Shift in Charge
3 RN across Majors
1 RN Resuscitation
1 RN Triage
1 RN Minors

Supported by 1 Nursing Assistant in Majors

Minimum staffing identifies 7 RN on duty at any point of 24 hour period. 9 RN on duty in line with peak actvity pattern between 11.30 am and midnight.

Nursing allocation sheet for staff coverage required for each area (Appendix)

The nursing staff will be responsible for the patients care in collaboration with medical colleagues, ensuring that regular observations are recorded, frequent vital signs are undertaken, medications are administered and that patients ongoing care needs are met.

Nurses will assess, plan, implement and evaluate the patients care through a recognised trust format (acutely ill assessment) utilising the HISS Meditec patient care system and complete ED nursing care documentation.

Nurses Role

Introduce self
Base line observations
Weigh Patient
Undress patient if necessary
Wristband
Cannulate, take bloods, ECG, urinalysis as required
Nursing documentation
Commence treatments
Request bed or potential bed required

2.4 Nurse in Charge

The Charge Nurse will be responsible for the initial assessment of patients and the planning and evaluation of care without supervision. The post holder will be responsible for the effective function of ED ensuring efficient delivery of specialist care by all team members adhering to existing protocols and procedures. The nurse in charge is expected to enhance their role through the Scope of Professional Practice and is able to provide direct supervision and leadership to junior staff and take part in on-going teaching programme.

Responsibilities include:

Delegate staff to work in areas within the department

Ensure patients are triaged within the triage standard of 15 minutes of arrival to ED

Manage tracker and flow of patients including minors patients, escalate to matron/ operational manager / manager on-call as appropriate

Move staff within the department according to work demands

Ensure staff utilize their time effectively, i.e. ensure department is clean and stocked, teaching and sharing knowledge

Ensure all staff maintain accurate clinical observations of the patient including continuous cardiac monitoring, neurological observations, ECG interpretation, and act accordingly

Support staff where workload is increased

Support junior staff, ensure they are able to manage their current workload

Complete handover book at the end of shift, i.e. staff sickness, breach information, handover issues to ensure next shifts are made aware

- Ensure GP's are informed of sudden death of patients overnight, to be done on early shift

Attend daily operational bed meeting at 11.00 every morning and 1500 in the afternoon identifying actions to be taken, work with matron/operational manager to ensure breach issues are actioned

Provide staff feedback during/at the end of shift

Ensure the provision of a high standard of quality care to all patients

To work within the framework of the United Kingdom Central Council - Code of Professional Conduct at all times

To act as a role model for all junior staff

Act as a senior resource for expert clinical advice

To maintain own professional practice and have a knowledge of new developments

To be aware of relevant nursing research and promote and participate in nursing research initiatives

Ensure adherence to nursing policies, guidelines and directives to all staff

Ensure complete and accurate documentation of all clinical care provided in the department

To be guided by UKCC directives, e.g. Code of Professional Conduct, Administration of Medicines, Exercising Accountability, Scope of Professional Practice, Record Keeping

To participate and maintain a high level of competent practice within the Scope of Professional Practice

Ensure Patient Charter Standards and other soft Standards are met and participate in audit where appropriate

Ensure that staffing levels are adequate at all times with appropriate skill mix

Deal with complaints in accordance with local and Trust Policy

Maintain effective communication with all patients, relatives and other visitors and ensure that patient confidentiality is maintained

Liaise with outside agencies, i.e. social services, police, ambulance service when appropriate

2.5 Sisters – Band 6 - 7

Manage the nursing team to include annual appraisal, staffing rotas, recruitment and selection and the supervision of students
Ensure that all staff are conversant with and have specific training in the following areas:

i) Fire Safety
ii) Basic Life Support
iii) Paediatric basic life support
iv) Moving and Handling
v) Infection control
vi) Vulnerable adult policy
vii) Mental capacity Act

To ensure that all staff are conversant with and adhere to:-

i) Policies and Procedures
ii) Correct use of equipment
iii) Clinical Guidelines

To act as an educational resource for other members of staff, in other departments where necessary.

To provide supervision and on-going training and development for all staff, in accordance with Individual Performance Reviews.

Have a thorough understanding of departmental budgets

Monitor standards of nursing care and take appropriate action to maintain and improve them

To respond to patients, relatives and carers concerns as they arise and take remedial action as required

To co-ordinate the A&E department response to ensure that patients are managed quickly and effectively whilst meeting the NHS targets.

To assist the Matron in leading the nursing team and deputise in their absence.

Ensure ongoing maintenance of the department and equipment during their shift, delegating responsibility to appropriate individuals

Encourage daily staff training and ensure competencies are maintained, managed and overseen as appropriate throughout each shift

2.6 Emergency Nurse Practitioners

The ENP in the ED will function alongside medical colleagues in a diagnostic (including investigations) and treatment capacity. The role will encompass the sensitivities of nursing experience and the knowledge of the medical practitioner to expand the boundaries of practice.

The Practitioners ever-expanding role will give an opportunity to the Specialist Nurse within the ED to give holistic patient care whilst still acknowledging their own limitations.

The role should aim to be an enhancement to the department rather than an impingement on medical practitioners.

For ENP's, the legal profession will require exact detail far greater than that normally expected within nursing documentation. The UKCC Standards for records and record keeping draw attention to the need for accurate and detailed nursing notes. For the nurse a balance should be found between the practical components of the job and ensuring that they protect themselves in the event of litigation. It is important to remember that where mistakes with documentation of care are found, the nurse will be judged in accordance of the standard of skill expected of a nurse in a position of seniority with a degree of speciality.

2.7 Staff Nurses

Accepts without prior warning any person requiring health care with undifferentiated and undiagnosed problems originating from social, psychological, physical, spiritual or cultural factors.

Leads, initiates and co-ordinates patient care.

To provide the highest standard of assessment, planning, implementation and evaluation of individualised holistic patient care in conjunction with the multi-disciplinary team

Contribute to the provision of the physical and psychological environment which is conducive to providing high standard on nursing care

Responsible in the assessment of care needs under the direction of an experienced registered nurse

To ensure that own nursing practice is research based and that knowledge base is regularly updated in support of professional practice.

Utilise triage principles to identify patients triage priority and patients urgency for need of assessment and treatment

Assist senior staff in setting and auditing standards of care

Contribute to ensuring patient flow is maintained and support the Trust 98% target

Manage specific areas with the emergency department under the guidance of the Senior Nurse on duty in accordance with the staff development plan

Participate in Essence of Care and Nursing & Midwifery benchmarking

Work with fellow emergency department professionals to ensure that skills and knowledge are always current, relevant and used.

To develop and expand clinical skills in a structured and co-ordinated way in line with professional standards in order to improve the care of patients.

Communicates effectively with patients, relatives, carers, all members of organisation and external agencies

Abide by legal requirements and statutory rules relating to NMC codes, scope of practice and local policies

Maintain accurate and confidential clinical and nursing documentation

Participate in the delivery of health education in the prevention of illness

Participate in research as required and the application of research findings into clinical practice under supervision

Take part in the initiating of new ideas and implementation of evidence based practice

Participate in the maintenance and development of all aspects of clinical Governance and Clinical Supervision under supervision

Tackle discrimination and harassment, and promote equality and diversity in the workplace

2.8 HCA's

Support nursing staff by undertaking activities under the direction of the nurse

Only undertake tasks that they have been deemed competent in
Report back to the nurse reporting any abnormalities in patient conditions
Assist patients in activities of daily living under the direction of the nurse
Responsible for cleaning and stocking department resources

Healthcare assistants work within the ED under the guidance of a qualified healthcare professional. The role can be very varied depending upon the area in which the person is employed within the department.

The types of duties include the following:

- washing and dressing
- feeding
- helping people to mobilise
- toileting
- bed making
- generally assisting with patients overall comfort
- monitoring patients conditions by taking temperatures, pulse, respiration's and weight

Nursing healthcare assistants usually work a 37.5-hour week on a shift or rota system, probably including nights and weekends.

2.9 Discharge Co-ordinator

Patient discharge from ED is supported by a discharge co-ordinator. This support is provided during the hours of 08.00 – 16.00

The role is to expedite discharges by chasing Dr Decisions, time and dates for tests and investigations.
Liaising with OT and Physiotherapy to expedite assessments
Referring and liaising with social services/age concern for support if required and prevent otherwise social admissions

Admission avoidance- by liaising with medical, therapist and nursing staff regarding those patients who can be otherwise safely discharged home with rehabilitation/support/or medications from community services
Refer for rehabilitation to community hospitals beds in the locality

2.10 Cardiac Assessment Team

The acute Cardiac Nurse supports ED staff in the assessment and management of patients presenting with cardiac problems. When the Cardiac Nurse is not on duty support is provided by designated coronary care staff. This resource can be accessed via bleep. The Cardiac Nurse also provides teaching to staff and clinical supervision in the management of patients presenting with cardiac conditions.

2.11 DVT Nurse Practitioner

Patients referred to the medical team or who present to ED with a suspected DVT are managed by the DVT nurse practitioner along the agreed DVT pathway. The service operates between 09.00- 17.00 Monday to Friday. Patients who present with a suspected DVT outside of these hours are managed by the ED doctors utilising the agreed pathway.

2.12 Emergency Department Physiotherapist

The emergency department is supported by a part time physiotherapist. The hours of service are:
Monday - am

Wednesday - pm
Thursday - pm
Friday - am
Patients who require physiotherapy can either be seen following their assessment by the ED doctor or ENP or if the physiotherapy service is not available at their time of presentation an appointment can be made for them to be seen in the next ED physiotherapy clinic. ED reception staff will book the clinic appointment.

2.13 Department Assistant

Assist in ensuring the department is kept clean and tidy
Reports broken equipment
Assists in the management of stores and department resources
Assist in the transferring of patients within the department and on external transfers when the portering service is under pressure.

2.14 Secretarial staff

Provide secretarial support to the consultants, completing dictated notes, patient reports, complaint responses etc.
Assist in organising ED doctors training schedules
Controlling diaries.

2.15 Administration Model

Administration staff across the unit will be provided 24 hours per day, 365 days per year

All Administration staff will be skilled to Reception Clerk level and will be the first point of contact for all patients arriving in ED. These staff are the first port of contact for the patients and they will welcome patients to the area.

Ward clerks will be based at reception within the Major's area of the ED and working Monday to Friday 07.00-20.30. Weekends and Bank Holidays do not have a Ward Clerk provision.

Ward clerks will be responsible for updating the Medical Tracker

3. Registration of Patients

All patients must be registered on the ED module at the time of their arrival in the department regardless of route of arrival or medical condition.
Patients who are unable to identify themselves are to be recorded as unknown until further information can be gained.
Patients who die before they arrive at the Trust but who have not been certified, should be recorded as an attendance.
Patients must be recorded on the EDM within 15 minutes of arrival in the department, regardless of route of arrival or medical condition.
Every effort should be made to ensure that the patient has not attended the hospital on a previous occasion before creating a new registration in order to minimise clinical risk.
ED reception staff must ensure that all correct demographic details are captured including checking that the current address, next of kin and GP are accurate. Once

these details are complete the information will be uploaded through the EDM to MEDITEC confirming a record of attendance.

4. Triage of Patients Who Self Present

All patients must be triaged within 15 minutes of arrival to the ED. During 24 hours a day, Monday to Sunday a dedicated triage nurse is deployed to undertake this task. Patients, who present outside of these times, will be triaged as soon as possible, aiming for within 15 minutes after their arrival to ED, by the nurse who is allocated to work in minors.

On the occasions that the demand for triage means that patients are not being triaged within 15 minutes of arrival, redeployment of additional staff from the main staffing pool in the department to triage should be considered. This consideration will be undertaken by the nurse in charge of the department, who should be made aware of the exceeding 15 minute target by the Triage nurse. Patient safety and clinical priority will be the driver for this consideration.

The triage nurse will assess the priority of the patient and update the patients priority location within the department on the EDM. The triage nurse will update the CAS sheet with appropriate triage priority, observations and history details and place in the appropriate queue to be seen upon clinical presentation and urgency by either the doctor or ENP.

Any patients presenting to the reception who are deemed to be in need of immediate medical attention according to either presenting appearance or description of symptoms from the guidance provided to reception staff, should be alerted through the use of the call bell. A response to the bell should be made by either the triage nurse, the nurse in charge of majors or delegated to another senior member of the nursing team deemed clinically competent to triage the patient by the nurse in charge.

The nurse responding to the buzzer may take a brief history from the patient either in the triage room or reception and when clinically appropriate bring the patient to the main department to be assessed in either resus or majors. The history and observations (where necessary) taken of patients must be documented and their priority determined. Majors patients will be handed to the nurse in charge who will allocate the appropriate management plan to an allocated nurse. Minors patients will wait in the waiting room in accordance with their clinical priority.

Triage of all patients may include taking a brief history to identify the presenting problem, base line observations as appropriate (dependant on presenting condition), first aid treatment, initiate investigations where appropriate as long as this does not delay triage of other patients, and identify priority for need of treatment and care.

Triage should not delay patient assessment. If there is no wait to be seen by the Doctor or ENP then the patient will be seen directly by them. To avoid confusion, the doctor or ENP should enter a triage priority on the EDM as soon as possible.

Triage of patients arriving to the ED having already been seen in Primary Care and arriving with a letter are to be accepted directly by the most appropriate speciality and assessed in the most appropriate clinical environment, which may include ED but more likely AAC or AEC.

Patients who have a letter will not be the responsibility of the Emergency Medicine team to assess and treat unless there is an immediate risk to life or limb.

5. See and Treat

The aim of See and Treat is to assess treat and discharge patients in a timely manner.

See and Treat

The rota for See and Treat is displayed in majors and minors.

Process

The time for operation will be 1000-2200 Mon-Fri and 1200-2000 at weekends

The trigger is a **triage time >1h**

This will be flagged by the ED board reviews or by the following:

Triage nurse
ED consultant in charge
Nurse in charge

The designated doctor will then use room B in minors and select appropriate patients from the triage tray to See and Treat.
They will be assisted by a clinical support worker during this time.

When the triage time is then <1h See and Treat may stop or can continue at the discretion of the consultant or nurse in charge.

Both RAT and See and Treat can evolve over time following review and audit by the Emergency Department senior team.

Those patients who can be managed within 10 minutes will be managed via See and Treat stream and those that require longer assessment and investigation will be managed by another ED doctor or ENP. The decision to commence See and Treat will be made in conjunction with the triage nurse, nurse in charge and Dr in charge of the shop floor (consultant or middle grade). It will be the ED consultant or ED middle grade who will become the see and treat lead at this time. A nurse or HCA should be allocated to work with the person undertaking See and Treat in order that the process is managed as efficiently as possible.

Patients who can be seen, treated and discharged will be managed via See and Treat. Patients who require x-ray will be sent to x-ray and followed up by either another ED Dr who is working in minors or by the See and Treat person if workload allows.

If the triage time in minors exceeds 60 minutes the consultant in charge must be contacted to look at the potential for See and Treat.

This may be provided by the consultant or a senior middle grade in emergency medicine.

The rota for see and treat is in minors and majors.

6. Documentation

The time the patient is assessed by the doctor or ENP for treatment must be recorded on the EDM/ CAS sheet or computer notes on EDM in real time.

On completion of treatment the time of discharge or admission must be recorded on the EDM.

6.1 Scanning

All non admitted patient notes will be scanned and available on PCI within 24 hours of the patients attendance at ED. Ideally patients admitted to the ward should have their notes scanned on discharge from the ward, but at present this does not happen.

6.2 Casualty Cards on Patients

Time of referral to a speciality will be recorded on the patients casualty card and EDM by the person making the referral.

Time of decision to admit will be included on the patients casualty card and EDM by the person making the decision to admit.

All nursing documentation must be recorded either in the patients nursing notes on HISS or documented on the patients casualty card.

All treatments must be recorded on the patients casualty card and EDM recorded and annotated with date and time.

The casualty card must be completed; appropriate dates and times must be annotated against all written entries. The casualty card will be sent with the patient to the ward.

If the patient is transferred to another hospital then the notes are photocopied. The copies are sent with the patient and the originals go to be scanned.

On transfer to a ward or other hospital or discharge from ED the patients record is updated and episode concluded with the discharge details completed and patient discharged from the EDM.

When a patient is discharged from ED the discharge information will be captured on EDM and a letter automatically generated. A copy of this letter will be sent out to the GP within the next 48hrs. Copies of this letter are also sent to the community midwife or health visitor if appropriate.

7. Decision to Admit

Patients will arrive in the department as:

999
Self Referrals
GP referrals (direct to AAC, unless clinically inappropriate to go)

If, following medical assessment, the patient is deemed to require inpatient treatment a decision to admit will be made.

A decision to admit will prompt the following action:

1. Once it has been identified by either the nurse or the doctor that the patient requires admission a bed will be requested via the bed management team during Monday – Sunday 07.00 – 21.30 or the NNP 21.30 until 07.00.
2. The decision to admit time must be placed onto the EDM immediately this decision is made by the nurse looking after the patient
3. Bed management must be informed of the type of bed required
4. Any patient who has waited for 3hrs since arrival who requires admission and there is no bed available must be escalated by the nurse in charge to either the ED matron/ Service Manager in hours or to the NNP or on call manager out of hours.
5. Bed management will allocate the patient a bed, if one is not immediately available, they will contact the ED nurse in charge and advise as soon as one becomes available.
6. All bed requests should be finalised within the four hour target, if this does not happen then the breach will be attributed to bed waits if the delay for a bed has been greater than half an hour.
7. Handover to allocated nurse on the accepting ward with expected plan which may include:

   ↙ Level of monitoring required, including frequency of observations

8. Majors Patients

8.1 Triage

All patients arriving by ambulance will be received by the nurse in charge who will either initiate own triage or direct the patient to the most appropriate area to be triaged by an allocated nurse. The nurse in charge will decide upon presentation the destination of the patient by allotting either minors, resus, trolley, AAC for all GP expected patients if clinically stable

The nurse in charge (or appointed deputy) will assess the patient's condition by either receipt of the ambulance handover (if satisfactory observations have been conducted) or by physically assessing the patients condition her/ himself. The nurse in charge may appoint another member of staff to carry out these base line observations. All observations must be recorded (including the patients weight) and handed over to the nurse accepting care for this patient. All ambulance sheets must be signed and the time written on them by the accepting nurse. The sheet must be stabled to the CAS sheet as soon as possible.

The nurse in charge assumes responsibility for all patients while in the department including the waiting area.

All patients being escorted by prison guard should undergo triage and then be seen in Room 13 if possible or be placed in a more acute area if clinically necessary.

8.2 Majors/ Trolleys

8.2.1 Patient process

Seven days a week between the hours of 10.00 until 20.00. a middle grade/consultant, will be allocated to work on majors. If the work load increases, the senor doctor in the department will move doctors from minors to help as necessary.

All patients arriving by ambulance will initially be handed over and assessed by the nurse in charge of ED. The nurse in charge will direct the patient to the most appropriate area where they will be triaged by the nurse managing that area. The paramedic will handover to the assessment nurse or allocated trolley nurse, base line observations will be recorded and documented and commenced on TRP chart. The patient will be undressed if required and wristband applied. The patient will be assessed by the doctor and appropriate investigations instigated. Initial treatments will be undertaken i.e. IV fluids, analgesia, medications. Patients requiring x-ray will go directly to x-ray. Patients requiring manipulation will be moved to an appropriate trolley and the procedure undertaken by an appointed doctor. Patients in the main trolley area will have their episode of care managed by an appointed doctor / speciality doctor / nurse. When it is identified that a patient requires a bed or potentially requires a bed, the nurse will inform the nurse in charge who will inform the bed manager.

9. Paediatric Patients

9.1 Triage

Once a child (considered to be 0 to day of 16th birthday) has registered in ED they will be encouraged to wait in the children's waiting area which is a designated area with age appropriate toys. Following triage they may be asked to return to this area to wait until a doctor or ENP is available to see them. Where ever possible children will be seen in room H, the designated paediatric room. Paediatric patients who require a trolley can be allocated to trolley 4 (if available) and managed by the majors nurse allocated to manage those trolley's and will be nursed in Bay 3 in the resuscitation room if their condition warrants it.

9.2 Safeguarding / Non-accidental Injury

Where there is any doubt that the child has sustained injury that is not consistent with the history or any doubt that the child is at risk, a referral to Social Care must be made immediately and the patient referred to the on-call paediatric team. The nurse must identify if the patient is on the 'at risk register' by accessing HISS, in the 'review by date' screen. This screen will provide information as to whether the patient is on the 'at risk register'.(This only occurs for children in Staffordshire. For children who live outside Staffordshire, then it will be necessary to ring the appropriate Social Care team to gain access to the At Risk Register.) Social Care may need to be contacted and this can by done via the single access telephone number available on the information board in minors or in the Paediatric Information folder.

Where there is suspicion of NAI, the child's parents will be informed that a referral to Social Care is to made.

All non mobile children who present with an injury must be discussed with paediatric registrar/ consultant or ED consultant prior to discharge, even if there is an adequate history for the injury.

Notification to the Liaison Health Visitor is required for all children in whom NAI is suspected.

9.3 Referral

Any child who needs social services input regarding safeguarding/Police input will be referred to paediatrics if the assessment cannot be done within the 4h window in ED.

When a child leaves the ED and is transferred to the paediatric ward the responsibility for consultant care is handed to the on-call paediatric consultant. EM consultants will not be responsible for the care of patients on the paediatric ward.

Admission to the children's ward is for children between the ages of 0 – 16 (birthday day) years.

Children who are referred to another hospital, parents will be informed of all procedures regarding the transfer to specialist unit/other hospital (including directions).

The NSF states that children up to 18 can request to be on a paediatric ward, but this must be agreed with the accepting Doctor.

If the patient is 16 -18 years of age and currently under CAMS, paediatrics will accept these patients. If the patient has been referred to CAMS and likely to be or has been accepted by CAMS, then paediatrics will also accept these patients (as long as the patient doesn't compromise the safety of the other patients on the ward) (Please see the Paediatric Admission Policy for further details).

Children must be escorted by a parent or guardian unless they are deemed Gillick competent. Where children are not escorted and it is determined that supervision is required, the child's parents will be contacted prior to any consultation or intervention of care being carried out. Parents will be encouraged to be involved in their child's care and will be informed of any options of care available, parents will be informed of their child's condition and plan of care.

10. Resuscitation

patients referred in via the BAT phone will be assessed in resus (as appropriate)
The nurse in charge and the senior doctor must be informed about all BAT phone calls.
An alert call will be put out by the nurse in charge. The type of call will be determined by the case to which it relates.
999 patients will be seen immediately by the ED doctor and nurse allocated to resus.
Senior ED doctor and ED consultant will be informed immediately via the bleep
The final decision regarding care delivered in the resuscitation room lies with the senior ED doctor or the speciality senior doctor.
Airway management will be the responsibility of the allocated senior doctor with support from the on call anaesthetic and intensive care teams.
Senior anaesthetic and intensive care support will be available 24 hours per day. A timely response is essential when a request to attend the resuscitation room is made.

If a paediatric alert is received via the BAT phone the senior paediatric doctors will be alerted as will the paediatric nursing staff by the nurse in charge of ED as well as the senior ED doctor/ED consultant

If an alert is received for GP expected patient the nurse in charge will alert the speciality team and the ED senior doctor / consultant will assume responsibility for the patient.

Relatives / next of kin will be kept informed of the patients condition and ongoing management by either or both the doctor or nurse caring for the patient. Patient confidentiality must be maintained at all time.

Referral to the coroner must be made by the doctor caring for the patient in all cases where the patient dies even if it is felt a certificate can be issued.

The appropriate form for referral to the coroner must be completed by the doctor looking after the patient

Where a death occurs at night or a weekend, the nurse in charge will usually call the coroners office at 09:00 am on behalf of any doctor who is then off duty.

The nurse in charge will inform the patients GP of the deceased.

11. Transfer of Patients to another facility

Patients who's condition cannot be managed within the Trust will be transferred to an appropriate receiving hospital for their on-going care needs.

The doctor in charge of the patients management will arrange which hospital the patient will be transferred to.

The nurse looking after the patient will arrange for ambulance transfer of the patient ensuring appropriate staff and resources are available.

Documentation will be sent with the patient and tracked out or copied. X-rays will be copied onto a disc and sent with the patient.

Prior to leaving the exact location within the hospital will be obtained, along with the name of the receiving doctor.

Patients and/or relatives will be informed of the transfer and the reasons why they must be transferred.

Relatives will be provided with directions the receiving hospital.

12. ED Admissions to CDU

This is a 23 hr facility that is used for patients who require a short period of observation, investigation and/or treatment

It will also be used for ED patients who need a further period of time in order for the diagnosis or exclusion of specific conditions, as agreement in the CDU operational policy.

It is not a holding or overflow area.

Discharge should be anticipated within 12-23 hours in the majority of cases.

Overall clinical responsibility will lie with the Emergency Department Consultant on duty.

The senior ED doctor on duty must agree to any CDU admission and the appropriate form must be completed.

All patients from EM who are admitted to CDU must have:

- A CDU admission proforma completed
- NO PROFORMA = NO ADMISSION
- Discussion with a consultant or middle grade before admission (MG overnight)

12.1 Standards

The average LOS will be 12 hours, maximum 23 hours.
Every admission will be discussed with an ED consultant or middle grade in their absence
Patients will be managed in accordance with the appropriate protocol / care pathway
Every patient must have a management plan documented in the notes at admission, this should include an estimated time of discharge
A discharge letter will be sent to the GP within 24 hours of discharge.
All patients admitted under ED are under the care of the on call ED Consultant
No patient will be admitted to CDU under the care of a speciality consultant

- There will be a designated trained nurse allocated to work in CDU 24 hours per day. A HCA may be required as clinical workload dictates. Support for checking medications and TTO's will be sought from the nurse in charge of ED.

13. Trolley Waits (Waiting Time for an Emergency Hospital Admission)

The waiting times for an admission through the ED is measured from the time of the arrival until the time the patient is placed in a bed on the ward. The standard relates to patients who wait more than 4 hours and less than 12 hours for admission. The 4 hour target is from arrival until admission or discharge. All patients who come into this category must be reported on the weekly SITREP reports by bed management.

14. Discharge

All doctors will create a discharge letter for each patient at the time of discharge.

The ED receptionists will book all follow up appointments with outpatient specialities.

Any patient who leaves the ED without being seen by a doctor or ENP will have this reflected in their GP discharge letter. Any child who leaves without being seen will be referred to either the health visitor or school nurse, unless the doctor In charge feels it does not warrant referral.

Patients who present with having taken an overdose or deliberate self harm who leave the department without being seen by a doctor or ENP will be referred to the police and the request will be made to undertake a well person check on the patient. This procedure will be undertaken to ensure the patient is not a danger to themselves or others.

All patients who leave the department who do not wish to wait to be seen by a doctor or ENP will be encouraged to complete a self discharge form. This will be filed with the patients notes. – this must always be completed for potentially suicidal patients.

15. Breaches

All potential breaches between 09:00 and 17:00 will be escalated to the Matron or Service Manager by the nurse in charge by 3 hours.

Out of hours the Clinical Site Practitioner (CSP) should be advised of all potential breaches at 3hrs.

The CSP should advise the on-call manager of the likely breach within the four hours to ensure guidance is given.

Appendix 1 shows the agreement for time frames for referrals

16. Radiology

Patients requiring x-ray will have their x-ray ordered on HISS and the patient either sent to x-ray or a portable x-ray requested.
Between the hours of 09.00 – 21.00 Monday to Friday independent patients will be directed to the x-ray department and asked to report to x-ray reception. When the radiographer is not present in the x-ray department, patients will be asked to wait in ED until advised by the radiographer that patients are able to attend the x-ray department.

X-ray should be rung in the department extension 5160 or bleeped 294 out of hours for all trolley patients. The x-ray department will be responsible for organising porters to take patients to the x-ray department.

Portable x-rays will be requested by the attending doctor, for patients in the resuscitation room or for patients with chest pain where it is deemed unsafe for the patient to leave ED.

Patients who require CT scans will have scans requested by ED middle grade doctor or ED consultant.

17. Pathology

The maximum turnaround time for blood results will be two hours for those tests which can be done in this timeframe. Specimens/bloods will be sent to Pathology on site via the pneumatic tube or hand delivered. When results are ready they will be available on HISS. Pink blood labels will be used to denote bloods and actioned from AAC/ED more urgently.
Opening times and access arrangements of the laboratory are listed below:
Clinical Chemistry and Haematology is open routinely from 0800-1700.

Clinical Chemistry and Haematology On Call

Staff: Two Biomedical Scientists are on duty, one covering each department. On call is not a shift system.

Service: The following system is in place for Haematology and Clinical Chemistry.

Week Day Nights: Monday – Friday On Call staff start work at 1700 hr and are working their routine 7 hour day until 2400 hr. Staff will be in the laboratory during this period and should only be bleeped if the results are required for the immediate clinical management

of the patient, but always for a **Blood Gas specimen or Urgent Cross Match specimen.** It is accepted practice for the on call staff to be bleeped by nursing staff to advise of a **Blood Gas specimen or Urgent Cross Match specimen.** . After midnight the on call period starts and the on call staff must be bleeped or phoned when required. At 0800 hr the laboratory is open for routine work.

Week End/Bank Holiday Batch Times: On Saturdays, Sundays, and Bank holidays bleeping is not required between 0900-1200 hrs, after 1200 hr batches run 1400 hr, 1600 hr, 1800 hr, 2000 hr, 2130 hr and 2330 hr after 2330 hr on call staff should be bleeped.

Bleeping On Call Staff: On Call staff should only be bleeped between batches if the results are required for the immediate clinical management of the patient, but always for **Blood Gas specimen or Urgent Cross Match specimen.** It is accepted practice for the on call staff to be bleeped by nursing staff to advise of a **Blood Gas specimen or Urgent Cross Match specimen.** The CLINICIAN must bleep the on call staff if they consider that waiting for the batch time would adversely affect the clinical management of their patient.

Batch Times Explained

Tests assayed in the batches at weekends

Clinical Chemistry	U/E, GLU, LFT, AMY, SUA, LIP, CRP, Digoxin, Paracetamol, Salicylate, Ethanol, CSF protein & Glucose, Gentamicins, Troponin, Ectopic HCG.
Haematology and Blood Bank	FBC, COAGSC, INR, FIB, DD, ESR, RETICS, MP, Sickle Cell Screen (if patient for theatre), Blood Film (if necessary). Urgent Cross Matches. Rhesus typing and issue of Anti D. Non urgent cross matches.

Tests assayed after 2330 hr batch at weekends & after Midnight weeknights

Clinical Chemistry	U/E, GLU, AMY, Paracetamol, Salicylate, B/Gases, CSF Protein & Glucose and PIH Screen, Ethanol only if the following criteria apply unconscious patient with head injury, alcohol overdose* and/or when Salicylate/Paracetamol is raised. * Does not mean drunk.
Haematology and Blood Bank	FBC, COAGSC, INR, FIB, DD ESR, RETICS, MP Sickle Cell Screen (if patient for theatre), G6PD (if MP positive), Blood film (if necessary). Urgent Cross Matches.

Any requests not covered by this document may be referred to the Consultant Clinical Pathologist or Consultant Haematologist as appropriate

- Ammonias are run as and when required

Routine cross match for the correction of anaemia should not be done after 23.30 hr unless the patient is symptomatic and request is from a consultant.

Blood Gases are run as and when required

Troponin samples are run up until 24.00 hr, and after this time if urgent. At weekends and Bank holidays the first batch of Troponins are run at 10.00 hr.

Gentamicins are run in batches twice a day, at 10.00 hr & 16.00 hr. Paediatric samples are run when required, but with prior notification.

HCGs will not be done after midnight. Request for HCG's should come via a Clinician or midwife.

Microbiology on call exists during the following hours

a) Monday – Friday 1715-0845
b) Saturday 1200-0900
c) Sunday 0900-0900

2) Specimens to process.

a) Monday- Friday

Any request is processed until 2100 hrs. After this time it is CSF specimens only, or specimens requested by Consultant.

b) Saturday As above until 1900 hrs. The on call BMS, is required to come into the department between 1700-1900, to process any blood cultures e.g. new blood culture positives, and. check morning blood culture positives. Also load any new blood culture specimens received. Check the pathology specimen trays/ incubator, for specimens. Store any specimens requiring refrigeration, store in cold room.

On a Saturday, specimens that you are contacted by the hospital, can be batched, and processed when the blood cultures are checked, unless the specimen is regarded as urgent e.g. CSFs

c) Sunday 0900-1200. Blood culture bench, as normal routine morning. Cdifficile specimens. Stool identification, ensuring no positive Salmonella specimens on hospital inpatients. Sunday 1200-0900 Same as Saturday afternoon.

18. Pharmacy

Pharmacy will be responsible for maintaining a given stock level of drugs and fluids within the ED. They will top up the stock on a Tuesday and Thursday morning. Any drugs required in addition to this will be requested from the pharmacy by the nurse in charge between the hours of 09.00 and 17.00hrs.

During the hours of 17.00 – 09.00, any drugs required but not stocked by ED will be obtained from the Pharmacy Out of Hours cupboard.

Advice and guidance can be obtained either direct from Pharmacy or from the Pharmacy intranet site. Between the hours of 17.00 – 09.00 if the intranet does not provide adequate information the on-call pharmacist may be contacted via switchboard.

Prescriptions
Medication required for patients will be prescribed by the ED doctor in the designated space, on the casualty card. TTO's will be prescribed on EP and dispensed from the department stock. If stock is not readily available the prescription can be obtained from the Pharmacy Out of Hours cupboard. Only those medications deemed essential for the patients well being will be prescribed and dispensed. Medication deemed helpful that can be obtained from a pharmacy, will be advised to the patient by an authorised practitioner.

19. Police

Any patient or relative who demonstrates verbal or physical violence to either staff, relatives or other patients will in the first instance be advised that their behaviour is unacceptable. If the behaviour continues, the police will be contacted to attend ED to manage the situation. If necessary the patient / relative will be removed from the ED. In any circumstances when the police are call an adverse clinical incident form must be completed by the nurse involved or the nurse in charge of ED.

Any communications with the police regarding patient information must comply with the data protection act. Information must not be release until appropriate forms have been completed. The only time information is released to the police will be when the person concerned is a risk to themselves, other patients or the local community.

The police must be informed if a patient presents to the ED with gunshot wounds in accordance with Police Guidelines and data collected at presentation regarding any knife wound.

Patients who are brought in by ambulance and their identify is unknown, the police will be informed in order that they can determine the patients identity.

Where patients attend ED and no next of kin contact details are available, the police will be informed and asked to attend the house of the next of kin to inform them their relative is in hospital. Upon request the police will escort the relatives to ED.

20. Legal Aspects Of Practice And Documentation

"Any document which records an aspect of the care of a patient or client can be required as evidence before a court of law, or before the preliminary proceeding committee, or professional conduct committee of the council (UKCC), or other regulatory bodies for the health care professions, including the General Medical Council, the comparable body to the UKCC for the medical profession."

The Legal Status of Records (UKCC 1993).

The writing of a patients documentation is as important as the treatment subsequently received. As a legal document, its' completion is required to be complete and concise; it is also useful as an educational tool and therefore the writing should be deliberate, detailed and precise**.**