Worcestershire Acute Hospitals NHS Trust

# Emergency Medicine Standard Operating Procedures

## Ambulance Triage

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| **Date of Approval** | |
| **Date of next review**<br>This is the most current document and is to be used until a revised version is available | |

### Aim and scope of Standard Operating Procedure

### Target Staff Categories

## 1. INTRODUCTION

The Emergency Department is committed to achieving the nationally mandated 15minute ambulance handover target. This Standard Operating Procedure (SOP) supersedes the Senior Initial Assessment Nurse (SIAN) SOP and prioritises the release of ambulance crews over other Emergency Department (ED) tasks. The ED will work within the resources that it has at its disposal (staff, space) to enable the rapid turnaround of Ambulance Crews.
Ambulance patients who are 'Fit to Sit' should be directed into the main waiting room, to self-register (see separate 'Fit to Sit' SOP.)

## 2. STAFFING

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| 2-3 Registered Nurses | Trained in triage assessment |
| 1 Health Care Assistant | Electrocardiogram (ECG), Phlebotomy role pre-dominantly |
| 1 Health Care Assistant | Care & Comfort role predominantly |

## 3. ROLE

The role of the Ambulance Triage Nurse (ATN) will be to ensure ambulance crews are released on Computers Aided Despatch (CAD) within 15 minutes of arrival and ensure that each patient has an initial assessment within 15 mins of registration on Patient First by an ED receptionist.

- Monitoring Computer Aided Dispatch (CAD) system and where appropriate escalating issues/discrepancies to the Nurse in Charge (NiC) or Hospital Ambulance Liaison Officer (HALO) or hospital desk on 01384 246373.
- Meeting and greeting ambulance crews immediately on arrival
- Taking Handover from the paramedic.
- Requesting and entering Personal Identification Number (PIN) and recording reason if PIN withheld /delayed on form – Appendix 1.
- Escalating high priority cases (e.g. Sepsis, Stroke, NEWS ≥5) at handover if not already alerted by ambulance crew prior to arrival.
- Liaising with Health Care Assistant (HCA) regarding need for urgent ECG (priority) and Bloods.
- Completing Patient First triage process +/- electronic observations either using Laptop on Wheels (LOW's) or at the ambulance Check-in Desk.
- Printing Casualty Card (CAS) and completing appropriate nursing documentation
- Highlight any over 1 hr. delays to NIC.

Whilst there is flexibility within the ATN role to undertake tasks such as cannulation, giving antibiotics, intravenous (IV) fluids, requesting X-rays etc. the focus of this role will be to ensure as rapid as possible handover from the ambulance service.

There is flexibility within the role to allow multiple handovers of ambulance crews prior to completing their Patient First triage process, so long as accurate times are documented for retrospect input if required. The NiC will proactively monitor the ambulance queue and attempt to allocate extra resource if able at times of ambulance surge.

ATN will be visible to West Midlands Ambulance Service (WMAS) crews by wearing an arm band.

Delays in ambulance handover will be escalated to the NIC if there are any issues beyond increased volumes of patient / surge.

In-hours the role of the divisional director of nursing will be to ensure adequate support for the Emergency Department team and ensure additional non-Emergency Department staff are provided to the Emergency Department to complete GRAT60 assessments for any patients waiting over 60 minutes outside on ambulance vehicles. The Hub will be expected to monitor any delays in ambulance handover in their Live Version of Patient First (mode 1) and escalate to the Senior Nurse for the Division (in hours) or the clinical site manager (out of hours).

Out of hours the NIC will be responsible for the further escalation of ambulance handover delays eg. to the Senior Nurse (Matron)/ Senior Manager( if Clinical) on call via the Clinical Site Manager, (the option also to utilise the Night Nurse Practitioner and Clinical Site Manager to support) will be requested. If this escalation is triggered then a non- ED response will be required to complete the GRAT tool to ensure prospective oversight on the safety of patients awaiting access to the Dept in conjunction with the NIC and the paramedic crews.

4. **PROCESS**

**15 minute time to WMAS release**

1. On Arrival, unless deemed 'fit to sit' by WMAS or the ATN, the patient is transferred onto a WRH ED trolley, ideally in one of the designated RAT bays. Any patient requiring resus will be taken directly to resus.
2. Crew member (driver) books patient in if not already pre-registered either at Ambulance Check-in Desk or main reception and receptionist ensures patient is in the 'Awaiting Ambulance Triage' section of the patient first whiteboard.
3. A verbal handover occurs between ATN and remaining WMAS crew member.
4. The Patient Record Form (PRF) or Electronic Patient Record Form (ePRF) is signed by ATN.
5. The ATN requests the crew's PIN and enters PIN into the CAD system. If for whatever reason WMAS crew refuse PIN, inform the HALO in the first instance, if this does not resolve the issue contact the hospital desk and inform them of the situation – record this on a form kept in ambulance reception desk and maintain a professional working relationship.

**5. TTIA (Time to initial assessment/triage)**

1. ATN receives verbal handover from WMAS and signs EPRF – this is TTIA
2. The patient record will appear on Patient First following their registration by receptionist and triage documentation will be inputted on Laptop on wheels by the ATN and printed generating ED Notes at the Ambulance Check-in desk.
3. Once clinical handover has been completed the ATN will move the patient on patient from 'Awaiting Ambulance Triage' section of Patient First to another appropriate location in Patient First e.g. 'Majors' or 'Resus corridor'.
4. Nursing Documentation Bundle commenced, first page completed including sepsis screen and first hour of hourly checklist
5. Full set of observations carried out – documented in both bundle **and** front of CAS Card.

The ATN will allocate tasks to the HCA responsible for bloods and ECG and completion of the appropriate sections of the nursing pack.

The ATN will direct the patient to an appropriate area within the department depending on triage category or care needs in conjunction with the NIC.

ED co-ordinator will inform named nurse of their new patient and the patient's immediate requirements in terms of therapy (e.g. analgesia) and need for further investigations (ECG, bloods, X-rays etc.) or print out of TOXBASE advice.

The Senior Doctor on duty or Emergency Physician in charge (EPIC) will also be informed of any patient with a clinical concern by the NIC. eg. sepsis

In the event of no space within the main department the patient will remain in the Resus Corridor Triage Area and their care will be progressed as able within the limits of the staff resource in the area and the need for the ATN to prioritise ambulance handover. The two 'Rapid Assessment and Treatment (RAT) cubicles will be used primarily for ambulance handover, other clinical assessments (e.g. by doctors) should happen in an appropriate clinical space, should no space be available the patient will be assessed in the 'M Cubicle', which can be found opposite the nurse station within the main Emergency Department and then returned to the non-clinical area.( Eg. Resus Corridor)

## 6. Resources and Equipment

- Trolleys with full working Oxygen cylinders and Suction units.
- Access to wheelchairs.
- Observation Machine (charged) with ability to monitor Blood Pressure, Oxygen Saturations, Pulse and Temperature.
- A Blood Glucose machine, calibrated and stocked to allow measurement of blood sugars.
- Storage area for name bands and nursing documentation bundles.
- ECG machine
- A computer with CAD and Patient First installed and in full working order.

## 7. Assessing Patients unable to 'Offload' from Ambulances

During periods of ED crowding it may become unfeasible, due to pure lack of physical space in the Emergency Department to 'offload' patients from ambulances despite the ED's commitment to prioritise ambulance handovers. The process below details what should happen during these periods of extreme pressure.

**Process:**

The ED co-ordinator and ED Senior doctor should agree that the department's capacity has been reached and that no more patients on trolleys can be safely physically accommodated in the Emergency Department – Appendix 2. Flexible use of the two RAT bays and, as appropriate the 'vacant bereavement room' allow for additional space; however once these have been used to accommodate patients, there is no further space to allow doctors to fully assess patients and compromises the ability to perform urgent initial investigations (e.g. ECGs)

ED Co-ordinator / senior doctor should inform the HALO and the Clinical Site Manager (bleep 300). In the absence of a HALO the Clinical site Manager should escalate to Ambulance control and inform them that no further ambulances will be 'offloaded' unless patients are very unwell.

Ambulances waiting to 'offload' will be booked onto Patient First in the 'At ED on WMAS Vehicle' column until patient moved into the department.

HALO will be responsible for liaising with ambulance crews waiting to 'offload' including monitoring for signs of patient deterioration and changes in patient's condition. Concerns about individual patients kept on the back of ambulances need to be escalated by paramedic crews to the HALO and then to the ATN and then ED Co-ordinator / Senior Doctor if necessary.

If there is no HALO present then one of the members the first ambulance crew in the queue will undertake this role until a designated HALO is assigned / arrives.

The order of which patients will be offloaded from Ambulances will be determined by clinical priority and length of wait as determined by the HALO, who may seek advice from the ED senior doctor / ATN.

At this stage, the ED Senior Doctor or EPIC will escalate directly to the Corporate Nursing Team (within hours) and to the senior Manager on call (out of hours) to instruct delegation to Clinical Senior Manager On-call. The Clinical Site Manager will be responsible for ensuring GRAT 60 assessments on patients held in the back of ambulances or else will delegate this role to non ED Staff eg. Out of Hours Nurse Practitioner. Non- adherence to support required will be escalated to the Executive on call.

ED staff may accept patients into the department despite lack of physical space and unsafe working conditions if ED Co-ordinator and Senior Doctor feel it is a safer and more appropriate option (such as patients with time critical conditions) for that individual patient than remaining in an ambulance and patient potentially experiencing significant compromise in care.

Clinical Site Manager will proactively monitor the situation until all patients are off-loaded from the WMAS vehicles.

**Role of the Hospital Ambulance Liaison Officer (HALO)**

It is beyond the scope of this document to define exactly the role of the HALO, however, the following is indicative as ATN and HALO will need to work closely together.

- The HALO role is designed to assist with the smooth transition of patient care from WMAS to Worcestershire Royal Hospital (WRH).
- The HALO will support chasing of PINs if not given by crews and calling the Hospital Desk to amend times, where applicable.
- Once the patient arrives at WRH the HALO should, where possible, work closely with the ATN to reduce anything that may result in delaying the ambulance handover process.
- The HALO role includes a strategic view to reduce inappropriate conveyance (e.g. alternate destination).
- The HALO will attend regular bed meetings along with close liaison with the capacity team to provide a situational report to the hospital desk providing the Senior Operation Command (SOC) with local intelligence of the operational capacity issues within ED and the wider organisation.
- The HALO will challenge ambulance crews in a positive manner when appropriate to ascertain why an alternative option where not used instead of ED.
- The HALO may decide to undertake the role of co-horting in the event of extremis or as a direct instruction from the Strategic Operational Commander (SOC).

**Audit**

The achievement of the Time to Initial Assessment (TTIA) target is closely monitored internally and any patients waiting over 1 hour to be handed over from the ambulance service is reviewed prospectively through the Global Risk Assessment Tool (GRAT), which enables a prospective review of patient safety and a timely escalation if required.

The quality of care provided will require a consistent audit approach by means of a random selection of the GRAT Tools' completed for patients who have been delayed in Ambulances awaiting placement in the Dept. This will be undertaken at least weekly and a harm review process triggered where any concerns exist regarding the GRAT tool review.

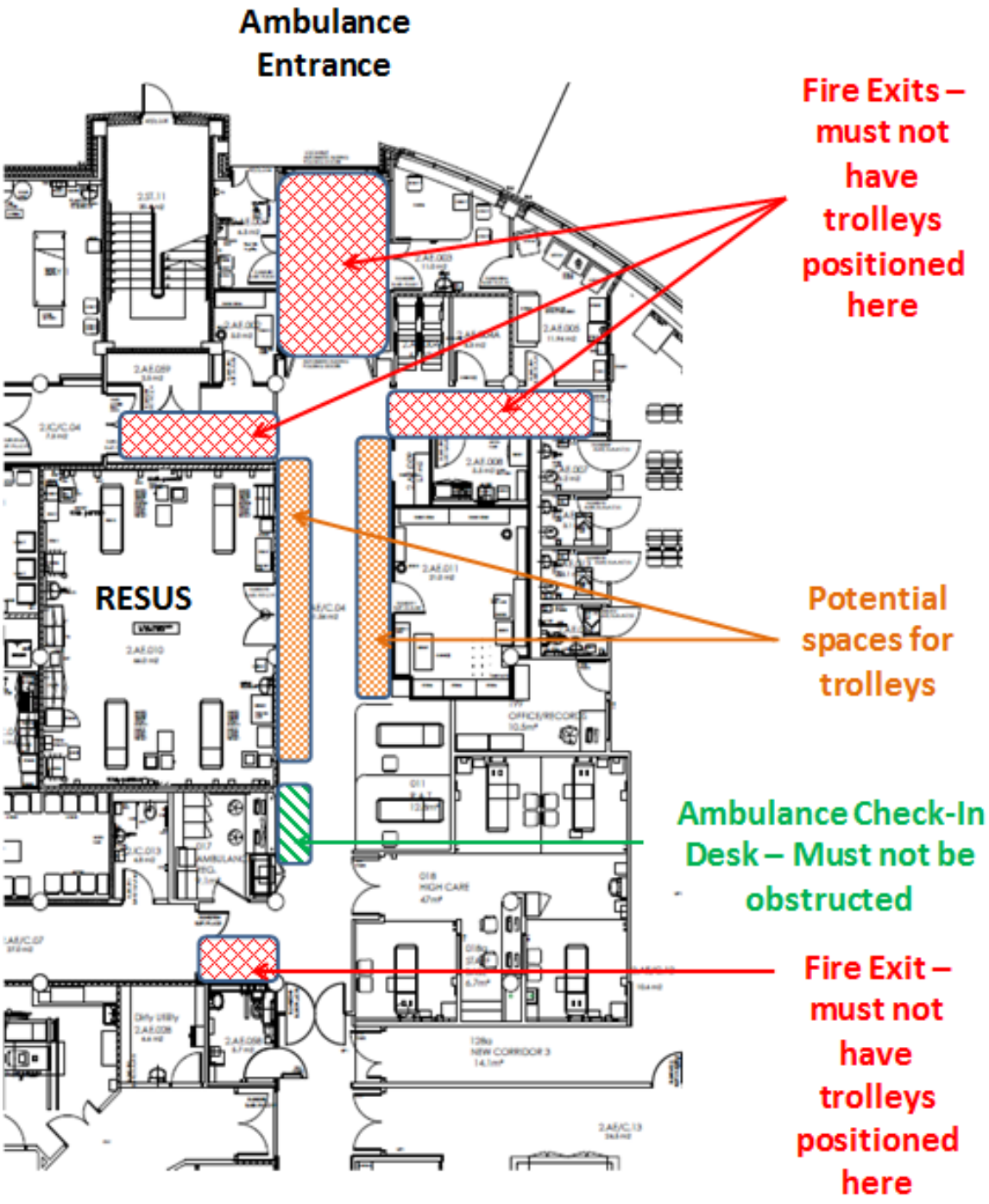
- Daily Senior Operational Commander (SOC) report, available on the WMAS extranet.
- Time individual patients spend in the 'Awaiting Ambulance Triage' section of Patient First.

**Appendix 1**

## WRH Emergency Department Ambulance Handover Record

| DATE | Patient Initials Or Attendance number Eg. (18W23450) | Triage Time (24hr Clock) | Crew Call Sign | Time of PIN handover (24hr clock) | PIN Issues or delays or Concerns | 60min GRAT Completed | Sign |
|---|---|---|---|---|---|---|---|
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |
| | | | | | ▫ No ▫ Yes (state) | | |

**Appendix 2**


Ambulance Entrance
Fire Exits – must not have trolleys positioned here
RESUS
Potential spaces for trolleys
Ambulance Check-In Desk – Must not be obstructed
Fire Exit – must not have trolleys positioned here