Worcestershire Acute Hospitals NHS Trust

Emergency Medicine Standard Operating Procedures

Corridor and M Space Care

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Approved by	
Date of Approval	
Date of next review 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

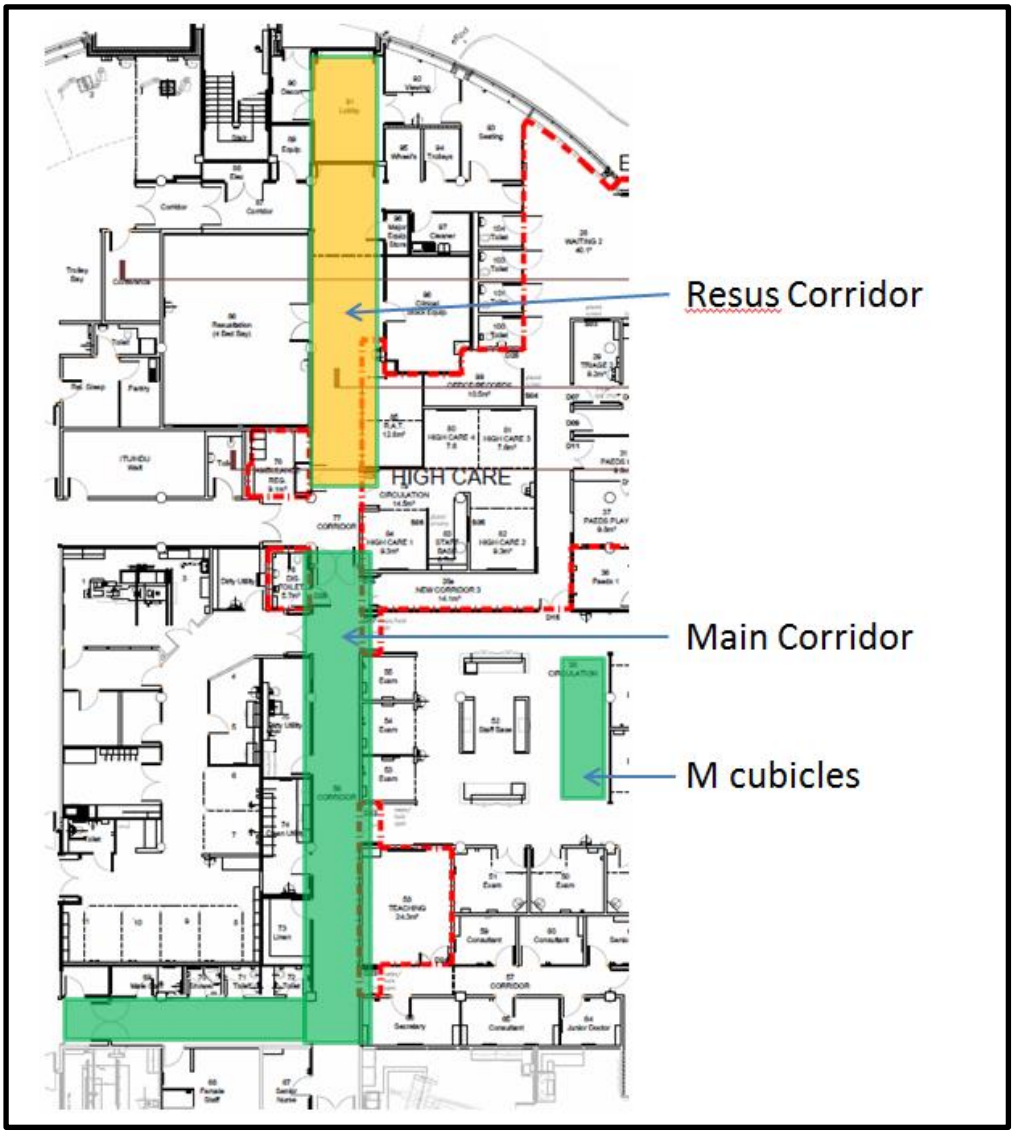
INTRODUCTION

Managing patients in the corridors of the Emergency department (ED) is undesirable but often a necessity. It is recognised that patient care can be compromised as a result of corridor care eg. privacy and dignity, inability sleep. This SOP sets out some general principles to help to try mitigate some of the adverse effects of corridor care. This SOP does not relate to ambulance handovers.

This SOP should be read in conjunction with the following documents:

- Reverse Queuing in the corridor
- GRAT Tool
- Hourly Checklist

CORRIDOR AREAS



PATIENT SELECTION

Ideally no patients would be managed in the corridor. If capacity demands are such within the ED that using the corridor to house patients is essential then all ED patients should be considered suitable for corridor, especially those awaiting admission (see reverse queuing policy) unless they fulfil any of the criteria below:

Patients not suitable for Corridor Care:

- Those requiring the facilities of the Resus Room
- Those who are on a bed rather than a trolley (if on a bed they can be placed in M2, M3, M4 as part of this policy).
- Those on a variable drug infusion
- Those requiring cardiac monitoring
- Those at risk of rapid airway decline
- Those on NIV
- Those at risk of imminent death
- GCS<8
- NEWS / NEWS2 >5 or single vital sign scoring 3 unless both senior nurse and doctor agree
- Mental health patients who are awaiting psychiatric admission (rather than assessment)
- Those patients who require isolation in side room due to likely infectious complaints eg. diarhorea & vomiting

The following are **NOT** reasons to consider corridor care:

- Requiring Oxygen
- Requiring Nebulisers
- Requiring intravenous Fluids
- Age
- Still awaiting to be seen by a specialty team following referral from the ED [M1 to be used as a specialty assessment space – patients must be put back in the corridor afterwards]

CARE OF PATIENTS WHILST IN THE CORRIDOR

- Patient must know who their named nurse is.
- Patient shown how to attract nurse's attention if there is a problem eg. alarm bell.
- Patient given Care in corridor leaflet.
- Patient given General ED advice sheet.
- Use of the hourly checklist to ensure regular observations, food and drink etc.
- Relatives to be accommodated within reason, bearing in mind the number and need for them not to block the corridor for other patients on trolleys / staff.
- Toileting of patients should take place in the 'M spaces'.
- Care and comfort check and GRAT assessment must been performed 2-4hrly on all corridor patients.
- Patients must have wrist band / patient identity bracelet.
- Examination of patients in the corridor should take place in the 'M spaces', however if this is not possible then privacy screens must be used. Intimate examination (eg. vaginal) must be performed in room with a door; liaise with co-ordinator.

PATIENTS CARED FOR IN THE CORRIDOR WHILST RECEIVING OXYGEN THERAPY

In-order to minimise the risk of the trolley oxygen cylinder running out of oxygen unnoticed due to its lack of visibility on the bottom of the trolley:

Patients receiving oxygen therapy in the corridor should also have their Oxygen Saturations continuously monitored, if this is not possible due to lack of suitable machines (or space) then the patient **MUST** receive oxygen from an upright Oxygen Cylinder (Type G) with a visible gauge displaying how full the oxygen cylinder is. Continuous Oxygen Saturation measurements and oxygen therapy from an upright type G Oxygen Cylinder with a visible gauge is the ideal situation.

Corridor nurses should document that they are regularly checking the oxygen gauge.

PATIENT DETERIORATION WHILST IN CORRIDOR

If a patient **deteriorates** whilst in the corridor then the ED nurse responsible for that patient will inform either the ED team (if patient not yet seen by specialty team following referral) or the specialty team responsible for that patient's care, with the option of informing the critical care outreach team if the specialty team are unable to provide an appropriate response. Plans should be made to move the patient to a more appropriate clinical area, if possible, within constraints of resource and taking into account acuity within the ED as a whole.

THE 'M SPACES'

The 'M spaces' in the main department represent the former 'minors area' of the department which contained only 4 chairs. As the department has grown and developed new ways of working the 'M spaces' became unsuitable for use as a minors area. The area currently has lighting, electrical plug sockets but no medical gases and 2 spaces separated by curtains. The curtains provide visual privacy. At times of surge it may be necessary to place 4 trolleys in this area with use of additional privacy screens.

Taking into account the limitations noted above, the 'M spaces' may be used flexibly:

-to allow up to 4 trolleys spaces for surge capacity (particularly to allow rapid decants to free up resus room space),

-assessment of waiting room patients,

-when a degree of privacy is required for corridor patients eg. toileting,

-to allow transfers from trolley to bed if appropriate

-to be in view of the majors staff base eg. confused patients, patients at risk of absconding, rapid resus room decants and all other areas full.

It should be noted that the M spaces are not part of the nursing establishment.

STAFFING

Main Corridor 1 RN, 1 CSW

Resus Corridor 2 RN, 2 CSW

CORRIDOR CAPACITY

Main Corridor 7 trolleys

Resus Corridor Fire regulations permit a maximum of only 5 trolleys (see Ambulance Offload SOP)