Worcestershire Acute Hospitals NHS Trust

Emergency Medicine Standard Operating Procedures

Alexandra Hospital

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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

This Standard Operating Procedure (SOP) has been written to:

- Define with clarity and precision the procedures for the triage and early assessment of all the patients arriving in the Emergency Department; and the process of further management through the department.
- Facilitate the flow of patients from initial reception through to discharge or admission to a ward. To ensure that all patients receive the best care and treatment within an appropriate time.

To enable and empower the staff to work as a multi-disciplinary team in collaboration with other departments to deliver appropriate care and treatment to all the patients even when the department gets busy.

Target Staff Categories

1. Introduction

This Standard Operating Procedure (SOP) has been written to:

- Define with clarity and precision the procedures for the triage and early assessment of all the patients arriving in the Emergency Department; and the process of further management through the department
- Facilitate the flow of patients from initial reception through to discharge or admission to a ward. To ensure that all patients receive the best care and treatment within four hours of Emergency Access target.an appropriate time
- To enable and empower the staff to work as a multi-disciplinary team in collaboration with other departments to deliver appropriate care and treatment to all the patients even when the department gets busy

2. Scope of this document

This Standard Operating Procedure (SOP) relates to the following staff groups who may be involved in the assessment and delivery of emergency care in the department:

- Registered nurses
- Support workers
- Medical staff

This Standard Operating Procedure outlines the day to day running of the Emergency department for all activities not otherwise covered in condition specific or treatment specific SOPs.

3. Definitions

Explained within the document.

4. Responsibility and Duties

Explained within the document.

5. Policy Detail

5.1 Management of the Emergency Department

5.1.1 Command and Control

The Nurse in Charge and the duty Emergency Department consultant are in charge of the day to day running of the shop floor, supported when required; by the Modern matron for the Emergency Department and the Clinical lead Consultant. There is one consultant present on shop from 09:00 to 17:00 hours and another consultant from 09:00 to 19:00, who is on call until 09:00 the next day. From 19:00 to 12:00 there are two ST3 or above Registrars are present and there is one ST3 or above until 08:00 the next morning.

The Nurse in Charge has the responsibility for patients flow through the ED and he/she facilitates the patients' flow by liaising with the site management team, the wards and works closely with the ST3 and Consultant in charge to ensure that ED four hours Emergency Access Target to deliver effective Clinical Care to our patients. The Nurse in Charge is responsible for keeping the data up to date and assist with preparation for patient transfer. They arrange hospital transport as necessary.

5.1.2 Escalation

There is an Emergency Department escalation policy with pre-defined triggers.

Communication around escalation should be through the Nurse in Charge to the site management team, who will then forward information to the duty management team who will escalate to the duty Executive.

Once in a formal state of escalation, appropriate patients will be referred directly to admitting teams prior to assessment by the Emergency Department clinicians. The Emergency Department consultant / Nurse in Charge will identify which patients may be suitable for direct referral.

5.1.3 Reception

Ambulatory patients or those who self-present to the Emergency Department, including those who have been referred by their GPs to an in-patient team are directed to report to the reception where their demographics will be taken by the reception staff and entered onto Patient First.

This initial information includes

- Name
- DOB and age
- Address including temporary address for non-residents
- Telephone numbers including temporary numbers for non-residents
- Marital status and next of kin including their contact details
- GP
- Presenting complaint
- Mode of arrival
- Time since incident

For children, the name of accompanying adult or lack of accompanying adult, and name of school or nursery as appropriate are also recorded. The accompanying adults are asked to read the safeguarding information displayed at reception.

Patients with known special circumstances or who have an agreed action plan are flagged on patient first system. If a patient has a flag on the Patient First to this effect, the information is printed off and placed in the Emergency Department records. An additional short term flag can be placed on patient first who have a short term alert identified by community teams.

Once the patient has been registered they will be asked to sit in either the main waiting area or the children's waiting rooms pending triage. Wheelchairs are available if necessary. The reception staff will explain to the procedure of waiting for triage to the patient.

If the patient presents with any of the following conditions:

- CP
- Acute SOB
- Severe pain

- Confusion or drowsiness
- Significant bleeding
- Chemical splashes to the eye
- New neurological deficit
- Any other cause for concern

The receptionist will notify the triage nurse or Nurse in Charge immediately and the patient will be taken straight to a clinical area for initial assessment.

For patients who present by ambulance accompanied by a family member, the family member will be asked to register the patient's arrival. Otherwise the ambulance staff will register the patient at reception. The time of the ambulance arrival will then be time entered at registration as the time of the patient's arrival.

Reception staff will print identification stickers for major's patients and a wrist band for all ambulance attendances; all expected patients and anyone for admission.

All patients who are taken to resus or majors, or who are expected by an in-patient team or who are admitted will have their hospital notes requested either by the healthcare records team in hours or through the site management team Out Of Hours (OOH).

There is a notice in the waiting area requesting pregnant and diabetic patients to make themselves known to the receptionist.

5.1.4 Missing children

The process for notifying the department of missing children is as follows:

1. The safeguarding team phone and ask to speak to the Nurse in Charge and inform them that a child is missing

2. The Nurse in Charge notifies the receptionist who tracks the child on Patient First. The reception staff add a note on the special details to state that "child reported missing on..... Please inform police if they present to ED"

3. When the child is found, the receptionist is informed, and the note removed

5.2 Patient Assessment

5.2.1 Initial Assessment – Ambulatory Patients

For ambulatory patients the initial assessment will be undertaken by the triage nurse. Observations will be recorded as clinically indicated, including a pain score for all patients. Initial first aid will be administered including analgesia and first line medications according to Patient Group Directions (PGDs). Slings or dressing will be applied as necessary and imaging requested according to nurse requested imaging protocols. Where indicated baseline blood tests may be taken and an ECG performed.

A modified Manchester triage system is used focusing on rapid initial assessment and first line treatment. A 'see and treat' approach, supported by the Emergency Nurse

Practitioners (ENPs) and senior medical staff to allow those patients with very minor injuries to be treated and discharged at the time of first assessment. Other patients will be assigned a triage category of 1-4.

All patients should have their initial assessment within 15 minutes of arrival. If the wait for initial assessment is greater than 15 minutes the triage nurse will escalate to the Nurse in Charge who, where possible will deploy a second nurse to triage and/or move to a 'see and treat' approach. Triage times are subject to regular audit.

Patients will then be streamed into different pathways including:

- Back to GP for primary care presentations
- Referred to dental services
- Direct referral to OOH GP services (Care UK co-located in ED) according to protocol
- Direct referral to psychiatric liaison (Mental Health Matrix) as per protocol using the assessment tool
- Direct to specialty if expected / open access to CT / failed discharge in last 24 hours
- Resus
- Majors
- Minors
- Patients are advised to seek further attention from the triage nurse as necessary whilst they are waiting to be seen
- Patients will either be asked to take a seat in the waiting rooms or directed to a resus / majors / minors cubicle according to their clinical need and availability of cubicles. The Nurse in Charge will be notified of any patient for whom a cubicle is indicated but not available which constitutes a trigger for escalation (see below)

5.2.2 Initial Assessment – Ambulance Patients

All ambulance patients will be seen on arrival by the Nurse in Charge who will take a handover from the ambulance team. The time of handover is noted, which we aim to complete within ten minutes. The last set of ambulance observations will be recorded in the Emergency Department records. All ambulance patients should be offloaded onto an ED trolley or seated in the waiting room within a maximum of 30 minutes of arrival. This time is formally recorded by the ED Nurse in Charge on the ambulance electronic record to validate the time of handover. Any potential breaches due to overcrowding will be notified to the site management team.

Any drugs administered by the ambulance team should be handed over to minimise the risk of duplicate administration of medication in the Emergency Department.

There are a set of pre-determined 'ED triggers' to identify which patients are in need of immediate time-limited treatment who will be escalated by the Nurse in Charge to the senior Emergency Department doctor on duty.

Once handover is complete the patients will be streamed as outlined above. Once a patient is in a treatment cubicle the named nurse will repeat their Observations, assist changing as necessary into a gown, and begin initial treatments including intravenous access,

phlebotomy according to presenting complaint and ECG and urinalysis as clinically indicated. All ECGs recorded for any patient regardless of specialty, will be reviewed and signed for the need for immediate action by an ED doctor.

5.2.3 See and Treat

When demand and staffing permit a see and treat approach is adopted by senior doctors and / or the ENPs in which patient will be seen immediately by a practitioner instead of the initial assessment. This will usually be done in CNU area or in Minors depending upon the capacity available.

5.2.4 Expected Patients

Once an expected patient has had an initial assessment, if their National Early Warning Score (NEWS) is 5 or less and a ward bed is available they will be admitted directly to that ward for assessment by the admitting team. If no bed is available or their NEWS is greater than 5 they will remain in the Emergency Department in a major's cubicle if one is free or otherwise in the waiting room. The nurse who completes their initial assessment or the board coordinator will notify the admitting team accordingly. A MEWS score of less than 5 does not completely rule out the possibility of a serious illness, therefore overall clinical assessment should be taken into account before making a clinical decision in a patient with a MEWS score of less than 5.

Expected patients who are critically unwell will be taken to the resuscitation room and have their initial management attended to by the Emergency Department team pending arrival of the specialty doctors.

All patients with neutropenic sepsis, regardless of whether or not they are expected will have their initial treatment including antibiotic therapy administered by the Emergency Department team.

5.2.5 Referral / Review Process

All patients identified by the RCEM as needing Senior Clinician sign off should be seen by or discussed with an Emergency Department senior (ST3 and above from 09:00 to 19:00 and also ST3 and above during OOH) prior to discharge. This includes adults with non-traumatic chest pain, febrile children under 12 months, unplanned readmissions within 72 hours with the same condition and abdominal pain in patients aged 70 years and over.

As soon as the need for admission has been identified the patient should be referred to the admitting team. It is not usually necessary to wait for all investigations to be complete prior to making this referral, unless the results of those investigations will genuinely change the decision to admit. The time of referral should be documented.

The admitting team can be identified through the daily on-call Rota supplied by switchboard. If specialist advice is required this should be given by the ED SAS doctor or consultant in the first instance NOT the junior on-call for specialties. The ED will then advise on the need for specialist involvement accordingly.

5.2.6 Admission/Discharge Process

Once a patient is ready for admission to a ward, the following occurs

- All essential medications administered / treatments completed prior to transfer
- All ED notes scanned and the originals are sent with the patient
- Handover either verbal or in person to receiving ward
- Nurse escort to the ward with porter
- There should be a BLS equipment bag and oxygen on transport trolley

Any patient who is discharged back to a residential home or nursing home or into police custody must have a handwritten discharge summary to take to those in charge of their on-going care. These may be used in other circumstances to relay information to other healthcare providers.
Discharge advice leaflets are available as hard copies in the Emergency Department or to print from the Trust to give to patients or their carers for a variety of conditions.

All patients who attend the Emergency Department have a computer generated letter sent to their GP outlining the details of their attendance. A copy of this letter is also sent to Child Health for all children who attend the Emergency Department.

The notes of all patients who self-discharge prior to being seen by a doctor are scrutinised the next working day by a consultant. The GP receives additional notification of any child who does not wait to be seen. Any other vulnerable patients, based on the presenting complaint, may be contacted directly as indicated to ensure they have appropriate on-going care.

5.2.7 Deaths Including Child Deaths

If a patient dies in the ED the deceased patient's record notice of death form, including information around tissue donation is completed by Paediatric team. In hours the GP and the coroners officer is notified. Next of kin will be contacted whenever possible by the ED staff if not present at the time of death. Otherwise the police will be asked to identify and contact the next of kin. Out of hours the police are the acting officers for the coroner, and the communication book is used to ensure the GP is notified the next working day.

All children's deaths in the ED should be recorded on DATIX. There is a flow chart and management guidelines on the management of unexpected deaths in infancy and childhood. This applies to all patients under the age of 18.

5.2.8 Imaging and Pathology

The department of radiology is co-located and the facilities of CT-Scanner and MRI scanner are available. All patients are escorted to imaging either by a nurse, doctor or radiographer. Ambulatory patients will walk, or will be taken by a nurse or radiographer either on a wheel chair or on an Emergency Department trolley. Portable imaging is available in the resuscitation room for those patients who are too ill to leave the department.

The reports from the radiologists for all imaging performed in the Emergency Department are reviewed by a consultant the next working day to ensure no significant pathology has

been missed. Patients, GPs or admitting wards are then contacted directly to make arrangements for their on-going care.

Haematology and biochemistry results are printed off in real time in the Emergency Department and the results have to be reviewed before being filed in the Emergency Department records. The haematology and Biochemistry staff reviews the blood results next day and contact ED if there is any concern about the results.

5.2.9 Breaches

We aim to deliver four hours Emergency Access Target and therefore the reasons for breaches are recorded on the ED card and in a breach book. The reasons for breaches are validated daily by the senior ED nurse.

5.2.10 Breaches – Bed wait

If a patient is seen in the department by an ED clinician, investigated, and referred to another specialty, and, the time of referral, and decision to admit time, is confirmed as within three hours of the patient's arrival, but the patient has continued to wait, for availability of a bed, subsequently, the breach will be attributed to ***"bed wait"*** according to specialty.

Specialties include:

- Surgical
- Medicine
- Orthopaedic
- Other (anything other than the above)

5.2.11 Specialty Breaches

If a patient waits for review by a previously requested specialty and the wait for specialty review exceeds the wait for A&E Doctor, and/or investigation preceding specialty review request, then the breach will be attributed to ***"specialist review"*** again, according to specialty as listed above.

5.2.12 Resuscitation and Deterioration

Patients that stay more than four hours in the departments, that require resuscitation or resuscitation room care, will be attributed to **"*resuscitation*"**, likewise patients who suffer deterioration in condition and stay in the department over 4 hours will be attributed to ***"Deterioration"*.**

Other Classifications Include:

5.2.13 Overdose

Patients that present with overdose and require continued care, stabilization and blood review following a period of Monitoring are classed as *"**Overdose"***

***"Always check patient notes and scanned records for evidence of CDU admission as a diagnosis of Overdose is a criteria for CDU admission"*

5.2.14 Treatment/Manipulation

Patients that are delayed due to limb manipulation which requires sedation and subsequent monitoring are classed as a delay due to ***"Treatment/Manipulation"***

5.2.15 Alcohol

Often patients suffering the effect of acute alcohol intoxication need to be monitored and often treated until they are safe to be discharged and if they remain in the ED during this period a delay reason of **"*Overdose"*** is confirmed.

5.2.10 Handover

There are regular handovers throughout the day

- *Nurses carry handover* at 07:30 and 19:30, when all patients are reviewed and handed over to named nurse, communications book notices read out, staffing issues identified, bed status reviewed
- *Doctors carry handover* on a prescribed form at 08:00 and at 22:00. All outstanding tasks from the previous team are handed over to an identified doctor, and significant events reviewed
- *There is a board round* at 13:00 when all patients are discussed in the presence of the shop floor consultants and the management plans are signed off. The staffing status is assessed and a mutually agreed plan for the next shift is finalised

5.3 Induction for Agency Staff and Locums

All locum doctors and nurses receive an induction package prior to starting in post and are required to sign off on having received and read the relevant information before starting work in the ED. On arrival in the ED, locum doctors are given a tour of the department and familiarised with our standard operating procedures.

Agency and bank nursing staffs who has not worked in the department are given a tour of the department and induction briefing on arrival, a record of which is logged in the induction folder. They will only be tasked to work in areas within their area of expertise which will usually be in the majors' bays. They will not be required to be a resuscitation room nurse or perform triage unless they are specifically trained to do so.

5.4 Paediatric Trained Staff

There is a national shortage of dual trained nurses therefore we cannot supply a paediatric trained nurse for every shift. However, there will be a senior nurse with PILS/EPLS course training on every shift. In addition whenever there is a critically ill or severely injured child in the resuscitation room between the hours of 09:00 to 17:00, the Registrar on call for PAU/Consultant on site will be contacted. There is also ITU Registrar on call 24/7. During Out of Hours the Registrar on call for PAU in Worcester / Consultant on call will be available for advice and if required will attend Alexandra ED. There is a separate Rota of nine consultants to provide this cover at Alexandra Hospital Redditch.
All Emergency Department Consultants and Registrars are APLS/EPLS providers with one APLS instructor and an EPLs instructor.

5.5 Safeguarding Children and Vulnerable Adults

All patients with a child protection plan or who have learning disabilities should have an alert pre-registered either on 'Patient first' or they are on a risk register which is kept in

triage. A child protection checklist sticker is being introduced to be completed in the Emergency Department for all paediatric presentations. The Trust child protection protocol and safeguarding liaison team referral forms are kept in a folder in the department.

We have two paediatricians, Douglas Castling and Mary Hanlon, with special interest in safeguarding children who both share the lead role. We also have a senior Paediatric nurse Anne Crowhill who is nurse lead on safeguarding children.

The learning disabilities team should be contacted for all patients in the Emergency Department with learning disabilities and additional nurses to provide 1:1 care should be requested through the site management team when required. The patient should be asked if they have their 'passport' with them for information on their needs and background.

Patients with dementia should have a 'this is me' document with them which should be used to better understand their individual needs; if not this can be commenced in the Emergency Department.

The Independent Domestic Violence Advisor (IVDA) can be contacted for any patients who are known or suspected to be at risk of intimate partner violence.

Douglas Castling – Consultant
Mary Hanlon – Consultant
Anne Crowhill – Safe Guarding Lead Nurse

5.6 Friends and Family

All patients or their parent / guardian or carer will be given a Friends and Family feedback form at reception or there is one in their care plan when in Majors. The patients can put them into designated boxes in the department or hand the form over to nursing staff. Our reception manager collates the information daily and reports it weekly to the governance group.