Worcestershire Acute Hospitals NHS Trust

Emergency Medicine Standard Operating Procedures

WRH Emergency Department 'Reverse Queuing' Operational Policy

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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

This policy has been written to mitigate against the continuing high levels of 'Crowding' in the WRH Emergency Department (ED). One of the major factors currently affecting the WRH ED is 'Exit Block' (crowding due to patients waiting for bed on a ward or admission area). This policy is primarily aimed at those patients waiting for admission to a ward / admission area. WRH ED is already having to routinely care for patients in the corridor and whilst not wanting this to be seen as acceptable practise, pragmatism and safe care dictates that the ED has to use its resource as best it can for the benefit of the ED patients. Patients have traditionally queued *to get into* the department, this policy describes what should happen to enable patients to queue *to get out of* the department – 'reverse queuing'.

RATIONALE

The primary role of the ED is to undertake the initial assessment, treatment and emergency management of undifferentiated patient patients presenting either by ambulance or as self-presenters. The role of the ED is not to provide care that should and could be better provided by a ward / admission area.

Safety of patients in the ED is of paramount importance and those patients who have long waits for initial assessment, due to lack of physical space in which to be assessed; may ultimately have their care compromised as a result of the ED resource being put into patients already in cubicles who have been seen and assessed and waiting for a bed on a ward / admission unit. It is important that the assessment of the ED undifferentiated patient is prioritised over those patients who have already been assessed and a treatment plan commenced.

The ED team need to be able to prioritise the care of the ED patients to ensure safety and compliance with national standards around emergency access (eg. 4 hr target).

NHS England is clear that as part of each organisation's resilience plan that 'boarding' in a ward corridor is acceptable, this policy merely uses the same principle 'if the patient is in the ED corridor why can't they be on a corridor in the ward for which they are awaiting a bed'. Research suggests that patients would rather be in a ward corridor than an ED corridor.

Those patients waiting for placement on a ward / admission area often have different requirements to those awaiting assessment by the ED team eg. drug rounds.

If extra staffing resource is provided from the wards at times of peak demand / surge then it makes sense that this can be directed to a cohort of patients who would otherwise (if it were not for 'Exit Block') be on a ward.

STAFFING

Staff Nurse	1 RN, 1 CSW

WHEN TO IMPLEMENT THIS POLICY

When all Cubicles and High Care are full, excluding the M bays, the paeds area, the resus room.

Maximum of 7 ED patients in the Main Corridor and 5 in the Resus Corridor, to comply with fire regulations.

WHICH PATIENTS ARE NOT SUITABLE FOR REVERSE QUEUING

- 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>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 not to apply the 'Reverse Queuing' policy to individual patients (ie they can be moved to the corridor):

- 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]

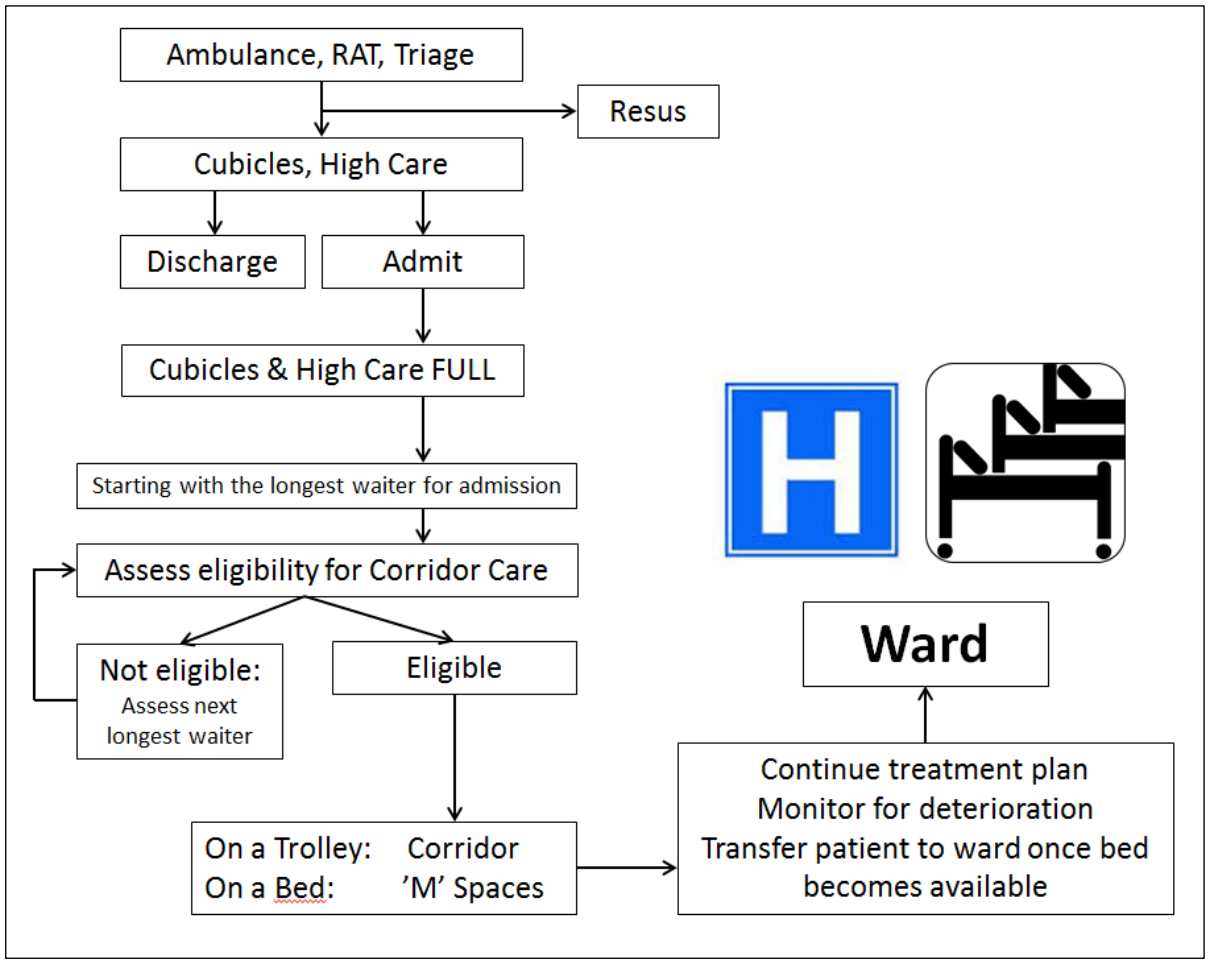
APPLICATION OF 'REVERSE QUEUING' and ROLE OF CORRIDOR NURSE

- Document time of decision to move patient to the corridor in ED notes
- Explain to the patient that they are going to be moved to the corridor
- Give patient a corridor patient information leaflet, if available
- Change the patient's Patient First location status to ensure their name is pre-fixed with 'Corr'
- Vital signs assessment
- Pain assessment
- Ensure clearly documented whether can eat and drink
- Ensure continuity of treatment plan

All patients in the corridor will be on trolleys and will face away from the ambulance entrance and towards the in-patient wards.

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.

Patient Pathways



REVERSE QUEUING AREAS