

Emergency Medicine Standard Operating Procedures

Surge and Rapid Assessment

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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

'Surge' generally refers to when a large number of patients attend the emergency department (ED) over a relatively short period of time. Defining the exact numeric value of 'surge' is difficult due to the many factors that also need to be considered, in addition to the actual number of patient attendances. A department with 200 attendances per day and experiences 10% of its workload over an hour (20 patients/hr) may well consider this a surge, 5% (10 patients) may not be considered a surge however the following factors also need to be taken into account as well:

- The State of department before 'surge' – was it experiencing 'Exit Block'
- Type of patient – ambulance vs 'walk-in majors' vs 'minors'
- Time of day and staffing levels (eg. night vs day; levels of sickness)
- Patient acuity
- Duration of surge eg. 30 patients over 2hrs is very different to 60 patients over 4hrs

Surge can result in delayed times to assessment and treatment, compromise the 4hr Emergency Access Standard and exacerbate ED crowding. Surge may delay ambulance handover times and may also lead to patients waiting in ambulance vehicles if ED is already crowded.

'Surge' for practical purposes maybe defined as when both the ED Nurse in charge and the Senior ED doctor feel an unusually large number of patient have arrived in the ED over a short period of time with the potential to 'stretch' the ED resource significantly.

Context: at the time of writing this SOP, assessment areas within the hospital are frequently closed on a daily basis and divert their 'expected' patients to the ED on a regular basis. Practically this means the ED does not have the opportunity to stream patients directly to assessment areas from the front door. WRH ED also receiving specialty patients from the Alexandra Hospital ED and wards because assessment areas at WRH closed. Use of one or more corridors in the ED to house patients is endemic /routine. Internal Professional Standards at WAHNT current mandate a specialty review within 60min of referral, nationally this standard is 30 mins.

Strategies

Patient safety in this setting is paramount and risk stratification; triage and NEWS2 is essential. The ED nurse in charge should consider whether more triage resource is appropriate for a short period of time. It is likely that as the queue for triage builds up the 15 minute triage target gets harder and harder to achieve and the opportunities referral, deflection, checking whether the patient is expected are lost due to time pressure.

Professional Standards

Expected patients must be identified at triage or else they contribute unnecessarily to the increased workload of the ED, exacerbating the surge effect.

Patients with letter from GPs should be referred directly to the most appropriate in-patient specialties (with some exceptions eg. head injury)

Patients who have been discharged from hospital within the last 48hr should be immediately referred back to the original specialty for them to see directly, not the ED.

Deflect

Re-direct to other services eg. Primary Care, Ambulatory Care streams.

This strategy can only work at certain times of the day (opening hours of the services) and if specific guidance already exists making it clear which patient groups are included (and by definition excluded).

This strategy may require the input of a senior doctor.

Refer

Referral before ED doctor assessment and after ED triage eg. are ENT available to directly see a patient with epistaxis (without the need for bloods etc.) ? Are Gynaecology able to accept a lady with a PV bleed directly (without the need for bloods etc.)? Can paediatrics take a wheezy 6 month old who has had 3 previous admissions with similar.

This strategy may require input from senior doctor as well as triage nurse.

ED Patient Processes

To cope with surge the ED senior doctor may elect to change the assessment model to maximise the efficiency of staff on duty at that time. This may include a rapid assessment type model eg. 'power round' (see later) or using one of the techniques from the table below.

Table 1 Problem solving approaches used by emergency physicians in charge		
Heuristic	Definition	Example
Deflecting	Triaging a patient to alternative care	Sending a self-presenting patient to an urgent care centre or a general practitioner
Front loading	Organising investigations for patients early on in their ED stay	Ensuring X-rays are organised early for patients with suspected fractures or CTs for patients with head injuries or suspected renal colic
Placing	Moving patients to a different area, either to improve the appropriateness of care or to free up specific resources	Identifying which patients who have arrived by ambulance can sit in the waiting room, or identifying which patients can go to the observation ward
Plucking	Picking out patients that need a specific intervention to speed up their progress	Early referral to liaison mental health services for appropriate patients
Flooding	Putting a large number of staff in an area to empty an area in advance of a surge	Allocating extra staff to the paediatric area to cope with an expected surge of children after school hours
Targeting	Putting specific resource into an area to help flow	Placing a senior doctor into an area of low acuity to efficiently see lots of patients
Chasing	Chasing investigations and consultations and decisions from inpatient teams. Managing dissent	Clarifying which inpatient team will take over further care
Guiding	Advising staff	Advising junior clinical staff which patients can be sent home safely and which need to be admitted
Juggling	Moving resource around to alleviate bottlenecks	Reallocating a single staff to a resuscitation room case and arranging another staff member to take on their other work

Safety remains the priority and it is key that time critical therapy (eg. antibiotics in sepsis) and investigations (eg. CT heads in anticoagulated head injuries) remain the focus rather than efforts merely to potentially minimise the number of '4hr breaches' later on down the line.

'Specialty Plucking' – prioritising those patients who clearly are going to require admission. Brief rapid assessment and commencement of any urgent therapies and investigation with the focus on early treatment and referral rather than exhaustive ED documentation. This form of rapid referral can sometimes raise eyebrows from specialty teams.

ED Nurse In Charge

The ED nurse in charge should minimise the number of nurses leaving the department, for example on patient transfers so that the resource can consistently be kept in the ED to deal with the surge. In-patients wards / assessment areas should either collect their own patients or accept telephone handover and no nurse accompaniment.

ED nurse in charge may look at re-allocating staff from quieter areas of the department to busier areas during surge.

Any surge that lasts more than an hour ought to be escalated to the Clinical Site Lead (bleep 300) especially if the techniques described above have had no impact. Escalate to Clinical Site Lead to seek help from wards collecting their own patients/prevent loss of ED nurses

out of the department and whether the Clinical Site Lead is able to find more staff resource to help deal with the surge.

Rapid Assessment and Treatment

Rapid assessment and treatment (RAT) comes in various guises eg. front door senior doctor, RAT team (eg. nurse, doctor, HCA) working in a specific cubicle, mobile team roving the department. At the time of a surge any 'new' process should not be so alien to the staff involved that they struggle with the new process, it should not rely on additional staffing resource, it should prioritise safety as well as maintaining clear lines of patient ownership / responsibility.

The '**Power Round**' is just one example of RAT, it is likely no better than any other but it is used regularly in the WRH ED and has had positive feedback from the junior doctors involved and the nursing staff.

A Power Round can really only effectively be undertaken when the senior doctor is able to delegate immediate management of patients in the Resus Room to a senior ED MG or another consultant. The ED consultant will have reduced ability to provide 'oversight' to the rest of the department when there is only 1 consultant on the shop-floor if they undertake a power round.

Process

- ED Consultant and SHO form a team.
- SHO assigns themselves to each patient seen and is responsible for their on-going care (investigations, treatments, referral etc.). SHO keeps a list of all patients seen and accumulating jobs.
- ED Consultant uses the 'Consulted Personnel' function on Patient First to show that they have been involved in the patient's care.
- Team sees patient together – Consultant takes history, performs the examination and determines management plan; SHO documents and questions consultant if any omissions or areas of concerns.
- Computer work done, investigations requested (can these be delegated to a nurse ?), any immediate treatments commenced. Responsible nurse informed.
- Team moves onto the next patient, only allowing for approximately 3mins between each patient.
- Team repeats cycle until 4-6 patients (depending on complexity) have been seen, at which point SHO likely to have accumulated work which needs to be done to progress the patients out of the department.
- Team breaks up and the ED consultant finds another SHO to do a power round with for another 4-6 patients.
- Consultant still around to be told about previous patients and make any further decisions based on returning investigations if plan not clear.

Etc.

Benefits

Consultant / Senior doctor management plans.

Clear lines of on-going clinical responsibility.

ED Consultant not tied up with individual patients (less likely to breach).

Junior doctors seem to like this style of working as long as they are told it is not a form of supervision because someone thinks they are under performing.

Uses existing resource and no extra space or equipment is required.

Most efficiency benefit usually seen in the 'non-ambulatory majors' patients.

Referral decisions by consultant.

Some educational benefit.

Disadvantages

Can occasionally lead to delays in implementation of management plans.

Consultant prone to 'decision fatigue'.

Focus on 'non-ambulatory majors'.

A very 'sick' or injured patient will lead to a stalling of the process because by necessity all treatments and investigations need to be done immediately.