Document Control

<table>
<tr><td colspan="4">Title
Emergency Department Operational Standard Operating Procedure</td></tr>
<tr><td colspan="3">Author</td><td>Author’s job title
Consultant Emergency Medicine</td></tr>
<tr><td colspan="3">Directorate
Unscheduled care</td><td>Department Team/Specialty
Emergency Department</td></tr>
<tr><td>Version</td><td>Date Issued</td><td>Status</td><td>Comment / Changes / Approval</td></tr>
<tr><td>0.1</td><td>Feb 2016</td><td>Draft</td><td>Initial Version for Consultation</td></tr>
<tr><td>1.0</td><td>Apr 2016</td><td>Final</td><td>Final for publishing.</td></tr>
<tr><td>2.0</td><td>March 2017</td><td>Final</td><td>Updated version</td></tr>
<tr><td>3.0</td><td>May 2018</td><td>Final</td><td>Updated to reflect SWAST handover procedure</td></tr>
<tr><td>4.0</td><td>June 2019</td><td>Final</td><td>Update to reflect governance process</td></tr>
<tr><td>4.1</td><td>July 2019</td><td>Revision</td><td>Update to reflect access of Labcentre</td></tr>
</table>

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<tr><td colspan="3">Lead Director
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<tr><td>Document Class
Standard Operating Procedure</td><td colspan="2">Target Audience
ED Staff</td></tr>
<tr><td>Distribution List
Senior Management
All ED Staff</td><td colspan="2">Distribution Method
Trust’s internal website</td></tr>
<tr><td colspan="3">Superseded Documents
N/A</td></tr>
<tr><td>Issue Date
June 2019</td><td>Review Date
June 2022</td><td>Review Cycle
Annual</td></tr>
<tr><td>Consulted with the following stakeholders:
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• Emergency Medicines Consultants
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- Site Management Team
- Chief Nurse
- ED Reception Team Lead

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Education/ training will be provided by:
Emergency Department Consultants
Emergency Department Matron
Band 7 Nurses
Emergency Department Group Manager
Reception Team Lead

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Approval and Review Process

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<tr><td colspan="2">

Local Archive Reference
G:\Policies\Emergency Department
Local Path
G:/ ED Resources/ Forms and Templates/ ED SOP Operational Plan
Filename
ED SOP Operational Plan

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<tr><td>

Policy categories for Trust's internal website (Bob)
Emergency Department

</td><td>

Tags for Trust's internal website (Bob)
Referral, Discharge, Admission, Discharge

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1. Purpose

1.1. The Standard Operating Procedure (SOP) has been written to:

- Identify the procedure for the triage and assessment of patients arriving in the Emergency Department is clear and precise and for the overall management of all patients through the department.
- Improve the flow of patients from initial reception through to discharge or admission to a ward.
- To ensure that all patients receive the care and treatment they need in the appropriate time
- To enable the staff to work as a multi-disciplined team enabling care and treatment to all the patient however busy the department gets

2. Scope

2.1. 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
- Admin Staff

2.2. 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. Management of the Emergency Department

Command and Control

3.1. 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 a SAS Emergency Department doctor or consultant present in the Emergency Department 24 hours a day.

3.2. The ED Patient flow co-ordinator assists the NIC with patient flow through the ED when on duty from 1200 – 2000. The board coordinator facilitates flow, liaising with the site management team, the wards and works closely with the ED senior nurse in charge. They are responsible for keeping the Trakcare data up to date and assist with preparation for patient transfer. They arrange hospital transport as necessary.

Escalation

3.3. There is an Emergency Department escalation policy with pre-defined triggers. Communication around escalation should be through the Emergency Department consultant or 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.

3.4. 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.

Reception

3.5. Ambulatory patients or those who self-present to the Emergency Department, including those who have been referred by their GP 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 Trackare). Additional information will be recorded onto Assault Related Injuries Database (ARID) in any case of assault.

3.6. This initial information includes:

- Name
- DOB
- Address
- Contact Numbers
- NOK contact details and relationship
- GP
- Presenting complaint
- Mode of arrival
- Have they lived in the UK for the last 6 months?

3.7. For patients under 18 years of age, the name and relationship of the accompanying adult are requested. The safeguarding information is displayed at reception for their accompanying adult to read.

3.8. All patients under 18 years of age, attending the ED Department, will have their CP-IS status checked on the NHS Portal by the reception team. The CP-IS status will then be recorded on Trakcare for the nursing staff / clinicians to view. If an alert is found on CP-IS the alert will be printed and put into the ED card.

3.9. Additional information on ARID includes

- Special information on whether or not alcohol or a weapon was involved
- Whether the assailant was identified
- Precise location of event
- Time of day and day of week of event
- Whether or not the police have been or will be notified

3.10. Patients with known special circumstances or who have an agreed action plan are held on the secure Emergency Department resources drive. If a patient has an alert on Trakcare to this effect, any permanent member of the ED team can print the Care Plan from the GDrive/EDResources/Patients with Special Circumstances. Short term alerts are also temporarily entered onto Trakcare and information found in the ‘Special Details’ folder in reception.

3.11. 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.

3.12. If the patient presents with any of the following conditions:

- Chest pain
- CVE symptoms – Slurred speech, facial droop
- Chemical / Burns to eyes
- Severe bleeding / Amputation
- Severe SOB
- Compound / Open Fractures
- Severe Pain
- Anaphylaxis / Allergic reactions
- Unresponsive / Floppy infants
- Convulsion / Fitting
- Patients on chemo with potential neutropenia
- 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

3.13. For patients who present by ambulance the ambulance staff will register the patient at reception. The time of the ambulance arrival will be the time of arrival entered on the 'Mobimed'.

3.14. Reception staff will print identification stickers and ED attendance sheet for all patients attend ED; a wrist band for all ambulance attendances, all expected patients and anyone for admission.

3.15. All patients who present to the Emergency Department will be given a unique Trakcare identification number

3.16. In office hours all patients who are taken to resus, majors, or who are expected by a in-patient team; medical records will be requested from the healthcare records team. Out of hours emergency medical records will be requested on a clinician's request, through the site management team Out Of Hours (OOH).

3.17. To preserve confidentiality, any member of staff who books in will have their presenting complaint recorded as 'unwell'.

Ambulance handover

3.18. At no time should a patient waiting to come into the ED be kept in an ambulance outside of the hospital.

3.19. Upon arrival at ED the SWAST crew will ring the bell located outside of the ambulance doors.

3.20. On arrival into the Emergency Department the SWAST crew will be met by the Nurse in charge who will take a brief handover and sign and time the Mobimed.

- If the patient is fit to sit in the waiting room they should then be re-directed to the waiting room accordingly
- Whilst handover is taking place the second SWAST crew member will book the patient in at reception.
- Reception staff will print off the ED labels, wrist bands and the Emergency Attendance sheet.

- Once the patient has been allocated a cubicle and the ambulance trolley is empty any member of the ED team can sign and time the Mobimed this must be completed as soon as the patient has been transferred onto an ED trolley.
- If practicable please ensure any cleaning, hand washing, completion of PCR etc is completed following the handover sign off. This is now SWAST time and should not be counted as hospital time.
- The SWAST crew must not be expected push any patients to x-ray/CT/ following handover
- If patients are conveyed straight to resus the handover must be recorded and signed for as soon as possible. Ordinarily this is when extended handovers occur when the actual handover has been extremely swift but crews then observe complex procedures or complete the PCR.

3.21. All ambulance handovers should be complete within 15 minutes. If waits up to 30 minutes are developing the ED escalation SOP should be implemented and site management notified. Ambulance activity is discussed at the timetabled board roads and at Trust tactical meetings. Ambulance waits in excess of one hour should be recorded on Datix.

Missing children

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

- The safeguarding team phone and ask to speak to the Nurse in Charge and inform them that a child is missing
- The nurse in charge notifies the receptionist who tracks the child on TrackCare.
- The reception staff will add a temporary 'Alert' onto Trakcare 'child reported missing on........ please inform police if they present to ED'
- When the child is found, the receptionist is informed, and the 'Alert' removed.

4. Patient Assessment

Initial Assessment – Ambulatory Patients

4.1. 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 (PGD's). 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.

4.2. A modified Manchester triage system is used focussing 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.

4.3. 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 will deploy a second nurse to triage and/or move to a see and treat approach. Triage times are subject to regular audit.

4.4. Patients will then be streamed into different pathways including:

- Back to GP for primary care presentations
- Directed to dental services
- Direct referral to co-located OOH GP services
- Direct referral to psychiatric liaison as per protocol using the assessment tool
- Direct referral to Early Pregnancy Assessment Clinic using the assessment tool
- Direct to specialty if expected / open access to CT / failed discharge in last 24 hours
- Direct referral to ED GP
- Resus
- Majors
- Minors

4.5. Patients are advised to seek further attention from the triage nurse as necessary whilst they are waiting to be seen

4.6. Patients will either be asked to take a seat in the either the main waiting room or separate children's' waiting room or directed to a resus / majors / minors cubicle according to 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). The triage nurse is responsible for monitoring the paediatric waiting area.

Initial Assessment – Ambulance Patients

4.7. All ambulance patients will be seen on arrival by the nurse in charge who will take a handover from the ambulance team (see section 3.2). The time of handover is noted. The last set of ambulance observations will be recorded in the Emergency Department records. .

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

4.9. 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.

4.10. Once initial assessment is complete the patients will be streamed as outlined above.

4.11. 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 speciality, will be reviewed and signed for the need for immediate action by an ED doctor.

See and Treat

4.12. 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

Pre-alert

4.13. Pre-determined patients will be pre-alerted to the ED by SWAST according to their protocols, including stroke, major trauma and sepsis patients as well as other patients for whom SWAST have a particular concern.

4.14. All calls should go to the 'red' phone in majors. The red phone is answered by the most senior nurse or clinician on the shop floor in majors at that time. The pre-alert form is filled in and the nurse in charge and senior doctor on the shop floor notified.

Expected Patients

4.15. Once an expected patient has had an initial assessment, if their Early Warning Score (EWS) is less than or equal to 4 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 EWS is greater than 4 they will remain in the Emergency Department in a majors cubicle if one is free or otherwise in the waiting room. The nurse who completes their initial assessment or the board co-ordinator will notify the admitting team accordingly.

4.16. 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.

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

Referral/Review Process

4.18. All patients identified by the RCEM as needing senior review should be seen by or discussed with an Emergency Department senior prior to discharge. Including adults with non-traumatic pain, febrile children under 12 months and unplanned readmissions within 72 hours. Any child where there is a safeguarding concern should also be discussed with an ED senior.

4.19. 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.

4.20. The admitting team can be identified through the daily on-call rota supplied by switchboard. A working group within the organisation is revising the referral pathways.

4.21. 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 advice on the need for specialist involvement accordingly.

Admission/Discharge Process

4.22. 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 photocopied – original ED card to remain in the ED – photocopy of any additional paperwork to remain in original ED card
- Handover either verbal or in person to receiving ward
- Nurse escort to the ward with porter

4.23. 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.

4.24. 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.

4.25. Excluding the patient groups listed below all patients who attend ED should have a discharge summary completed by the doctor who directly supervises their care. All ED cards which are found by the reception team not to have a discharge summary will be put into the clinicians Discharge Summary box to be completed.

4.26. ED attendances which do not require a discharge summary are: Patients expected by a speciality other than EM, patients referred to a speciality and admitted or discharged, re-attendances for dressings or wound reviews, patients who are streamed to their own GP, GPOOH, the psychiatric team, the EPAC clinic, patients who die in the department or who are dead on arrival, patients who are referred to another hospital, patients who are treated and discharged from triage. The procedure for patients who do not wait to be seen is discussed elsewhere in this document.

4.27. 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.

Deaths Including Child Deaths

4.28. Patients who have died in the community and have been certified dead by an appropriate medical practitioner can be taken directly to the mortuary. Patients who have been recognised as dead but not yet certified, presenting by ambulance must be booked into the ED. In office hours they may, in uncomplicated cases, be certified dead in the ambulance and taken with a copy of the ED paperwork to the mortuary. However, if family need to be contacted, and / or are accompanying the patient, or a forensic enquiry is underway they can also be admitted to ED to allow family members to stay with the deceased prior to admission to the mortuary.

4.29. Out of hours the patient must be booked in and admitted to the ED. If a patient dies in the ED the deceased patient record notice of death form, including information around tissue donation, is completed. 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.

4.30. 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. See Exeter, Mid Devon and East Devon Guidelines for Unexpected Deaths in Infancy and Childhood on ED guidelines homepage

4.31. If no relatives are in attendance, any valuable property is identified with 2 named nurses, entered into the property book, labelled and sent to the general office in hours or given to the site management team OOH.

Organ and tissue donation

4.32. All patients who die in the ED should be considered for tissue donation. See Tissue and Organ donation guideline on ED guidelines homepage. All patients intubated in ER who are not actively dying should be considered for organ donation (ie check organ donation register and liaise with organ donation team) before withdrawal of life support. Especially in the case of brain injury, accuracy of prognostication is greatly increased by a 24 hour period of ICU support.

Imaging and Pathology

4.33. Most imaging occurs within the Emergency Department or in the closely located CT scanner but also in main X-ray department. 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.

4.34. 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 or admitting wards are then contacted directly to make arrangements for their on-going care. A letter will be sent to the GP for all discharged patients in whom there is a recommendation for a follow up CXR.

4.35. Haematology and biochemistry results are available in real time in the Emergency Department on Labcentre and the results are reviewed by the clinician.

Breaches

4.36. All patients should be seen and treated within 4 hours. Reasons for breaches are recorded on Trakcare. The reasons for breaches are validated daily by the senior ED nurse

Handover

4.37. There are regular handovers throughout the day

- Nurses 0700 and 1900
  - All patients reviewed and handed over to named nurse, communications book notices read out, staffing issues identified, bed status reviewed
- Doctors 0800 and 1600
  - All patients reviewed, handover of outstanding tasks from night team to identified doctor, handover notices read out, significant events reviewed, ad hoc ‘5 minute teaching’ sessions.

There is a 2pm board round attended by all the MDT, this is held in the resource room and disseminated to the daily forum meetings.

5. Safe care and communication

Analgesia and allergy status

5.1. A pain score is recorded for all patients attending the ED or not applicable is noted. The pain scales used are Wong and Baker faces or analogue 1-10 scale in accordance with the patients age, development and cognitive function. The same pain score is used by SWASFT in the pre-hospital setting. Step wise analgesia should be administered according to RCEM guidance and repeat pain scores assessed thereafter. Ketamine should be considered in the context of major trauma when conventional analgesia is insufficient to control their pain. The intranasal route may be used for diamorphine and ketamine in children, or in adults when intravenous access is not achieved.

5.2. Morphine will be the first line analgesia for patients with severe pain and spinal injuries. For patients with a fracture neck of femur of fractured mid-shaft femur, additional analgesia in the form of a femoral nerve block or fascia iliac should be administered by the ED staff or a referral should be made to the on-call ITU team for a femoral nerve block catheter if longer term pain relief is needed. Patients with multiple rib fractures are referred to the pain team for consideration of thoracic epidural or PCA.

5.3. 30/70 and 50/50 nitrous oxide concentrations are available in the ED. Entonox should not be used in isolation for the manipulation of distal radius fractures, but may be sufficient for the immediate reduction of foot and ankle fractures.

5.4. See ED sedation policy for advice on conscious sedation.

5.5. Allergy status must be recorded for all patients.

5.6. Documentation of pain and allergy score is subject to regular audit.

Communication

5.7. Comfort rounds are used to re-asses majors patients' status, pain, personal needs and to communicate updates in treatment plans.

5.8. If a patient is critically ill or injured a named nurse will be assigned to spend time with, support and communicate to, any family, siblings, friends and other relatives in attendance, especially if there are unaccompanied children or vulnerable adults, and to contact any next of kin if no-one is in attendance. With the patient's consent if relevant, the next of kin will be invited to remain with their relatives in the resuscitation room and in direct line of site when possible, especially if the patient is a child or vulnerable adult. The named nurse will update the relatives on what is happening and why with the results of tests and investigations.

5.9. Staff will ensure they communicate in direct line of site of any patient with a suspected spinal cord injury to minimise neck movements.

5.10. The relatives' room is available for the friends and family of any critically ill or injured patients. Refreshments will be provided by the named nurse and there is a telephone available for their use.

Resuscitation room

5.11. The resuscitation room is only to be used for patients who have a clinical need for such a level of care, not as an overflow area when the department is overcrowded.

5.12. The patient details of patients treated in resus should be entered in the resus log book

5.13. Procedural sedation should only ever be performed in resus. The senior doctor on duty should be notified for all episodes of procedural sedation. The sedation checklist must be completed. Two doctors must be present, the sedationist and the doctor doing the procedure. A minimum of verbal consent should be documented in all cases unless the patient lacks capacity and there is an urgency to act. The sedationist must have the correct level of training and experience to perform the sedation. Unless an ED or anaesthetic consultant with the appropriate training is available, paediatric sedation will NOT occur in the ED.

Refreshments

5.14. Food and drink are available in the vending machines in reception. Sodexho provide sandwiches to the department and additional food can be requested when the department is in escalation. Food and drinks are provided to majors and resus patients as appropriate by the named nurse in charge of their care. Comfort rounding allows for identifying which patients require food and drink in a timely manner. Refreshments are also offered to the relatives of critically ill or injured patients and for any vulnerable accompanying children or adults.

Valuables

5.15. Patients who are due to be admitted or transferred are asked about any valuable items they have in their possession and encouraged to entrust to relatives for safe keeping prior to admission. For patients with impaired levels of consciousness with no accompanying relatives, the same process for deceased patients as above applies.

Language line

5.16. All ED staff have access to Language Line to allow for direct real time communication with patients who do not speak English. There are 2 mobile hand devices to allow for communication in any appropriate clinical area.

Patients in police custody

See patients in police custody SOP. Patients should be seen as a priority within their triage category, ideally either in the blue room or cubicle depending on their clinical presentation

Missing patients

5.17. A capacity assessment should be considered for any patient who leaves the ED against medical advice. If the patient is thought to lack capacity *and* is deemed to be at real and significant risk of death, serious illness, harm to themselves, harm to others or likely to cause a serious breach of the police, then the police should be notified that the patient is *missing* from the ED.

Security

5.18. There is a single security guard on site 24/7 who is there as a presence and can assist with de-escalation. However, the current staff are not health trained in restraint and cover the whole site. A business case has been approved to have 1 security guard on site 24/7 health trained in restraint, but unable to intervene in isolation. If there is a breach of the peace in the ED, the police should be called on 999 for assistance. There are Pinpoint alarms kept in reception and available to DPT staff when assessing patients in the blue room. These are routinely tested and records kept.

Medicines

5.19. Medicines cupboards are located in majors, minors, resus and triage. Control drugs are checked daily and recorded in the control drugs book. This forms part the daily department checklist by the nursing staff. Drugs of diversion are checked daily.

6. Emergency Department Clinical Governance & Mortality & Morbidity

6.1. There is a designated governance lead consultant who is job planned time to undertake this work. The role comprises oversight of compliments and complaints, mortality and morbidity and other aspects of clinical governance as defined by the Trust. A second consultant has responsibility for audit and QIP. The ED governance co-ordinator is a member of the management team and it is their responsibility to co-ordinate responses to complaints and incidents, to set and publicise the date of the governance meeting, to see that the minutes are produced and shared, and to hold and update the action log.

The ED governance meeting is held quarterly. The meeting is held on a Wednesday and runs from 08:30-12:30. The Governance lead, Clinical lead, Matron and Group manager or their designated representatives are required to attend for the meeting to be quorate. All ED staff are invited to and are encouraged to attend the meeting. The Divisional senior nurse, Associate Medical Director and ADOP are invited to attend. Clinicians from other areas are invited to attend when specific issues relevant to their practice are on the agenda.

The agenda of the ED governance meeting will comprise:

Minutes of the previous meeting

Review of the action log

- Safety Clinical reviews of all deaths within 24 hours of attendance
- Review of incidents
- Specific concerns or themes identified

Effectiveness

- Audit reports
- Quality improvement
- New guidance/handover notices
- Research
- Experience
- Complaints
- Staff surveys

- Compliments

Stroke

- M&M data

Trauma

- M&M data

Sepsis

- Performance data

The minutes and action log will be held by the ED governance co-ordinator. Minutes of the ED governance meeting are sent to the divisional governance meeting and to the trust M&M committee. Minutes are distributed via ED resource file, ED newsletters, Learning from incidents. Exception reports will be escalated if appropriate prior to planned meetings.

7. Induction for Agency Staff and Locums

7.1. All locum doctors 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. This package includes all the major Trust HR policies, a link to the Trust's induction homepage, a section on safeguarding children and a video including information on coding, information governance, fire, major SOPs such as cardiac arrest phone numbers, and a tour of the hospital. On arrival in the ED locum doctors are given a tour of the department and familiarised with our standard operating procedures.

7.2. Agency and bank nursing staff 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.

8. Paediatric Trained Staff

8.1. Due to national shortages of dual trained nurses we cannot supply a paediatric trained nurse for every shift. However, there will be a senior nurse with either PILS, EPLS or Bristol HDU course training on every shift. A rota 'rule' requiring such a trained nurse on each shift on e-rostering will support this. In addition whenever there is a critically ill or injured child in the resuscitation room, the High Dependency Unit (HDU) nurse on Caroline Thorpe Ward will be contacted to attend the Emergency Department whenever she / he is available.

8.2. All Emergency Department senior doctors have training in advanced paediatric life support.

9. Safeguarding Children and Vulnerable Adults

Child protection

9.1. All patients under 18 years of age, attending the ED Department, will have their CP-IS status checked on the NHS Portal by the reception team. The CP-IS status will then be recorded on Trakcare for the nursing staff / clinicians to view. If an alert is found on CP-IS the alert will be printed and put into the ED card.

9.2. The Trust Safeguarding Children Policy, Safeguarding Children Liaison Forms child protection protocol and safeguarding liaison team and Multi-Agency Safeguarding Hub (MASH) referral forms can be accessed through the ED homepage. There is a named lead nurse and lead consultant for child protection. All nursing staff receive regular safeguarding supervision from trained supervisors.

Did not waits

9.3. Any under 18's who are removed from the department without being seen / young people who leave without being seen by Medical staff or a Nurse Practitioner or who do not arrive at the Emergency Department having been referred on by MIU staff may raise safeguarding concerns with the child or young person not having received the treatment they need or may be an indicator of underlying safeguarding issues.

9.4. There may be medical or safeguarding issues which need to be addressed immediately discuss these with senior staff. If there are safeguarding issues also follow guidance in the NDHT Safeguarding Children Policy.

9.5. All children / young people who leave an Emergency setting (ED, an MIU or a Walk in Centre) or are not seen as planned should have this followed up by communication with their Primary Healthcare Team.

9.6. If there are no safeguarding concerns written communication is sent from the ED service Consultant, MIU or WIC staff including information on the clinical presentation and any on-going medical needs. A copy of this letter should be e-mailed to the safeguarding administrator's ndht.childprotection@nhs.net, the information will be reviewed and forwarded using the same process as the Safeguarding Children Liaison Form (SCLF).'

Learning disabilities

9.7. 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.

Dementia

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. There is a dementia SOP in place. The patient should ideally be nursed in room 4 in majors in the ED and the Admiral Nurse informed of admission to the ED according to availability.

Domestic violence

9.8. All patients attending the department are questioned on arrival at triage about domestic violence. 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. Safeguarding measures must be taken whenever children are involved in or witness domestic violence. NICE guidance is adhered to and there are good links with MARAC and IDVA.

Patient experience

9.9. All patients or their parent / guardian or carer will be given a Friends and Family feedback form at reception. The ED matron or deputy will collect the cards daily and check for feedback that needs immediate action and collate other free text feedback and information which will be fed back to the ED staff through the Governance Framework. The trust Friends and Family team will the collect the feedback forms from the ED matron as per existing Trust policy.

10. Associated Documentation

Northern Devon Healthcare NHS Trust Policies for:

ED guidelines

- http://ndht.ndevon.swest.nhs.uk/?page_id=8516
- Peninsula Trauma network
- http://ndht.ndevon.swest.nhs.uk/?page_id=13193

ED proformas

- http://ndht.ndevon.swest.nhs.uk/?page_id=8907