## Document Control

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| **Title**<br>Trust Wide Internal Professional Standards for Acute Patients – the North Devon Way | | | |
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| **Any revision to an NHSLA document requires the agreement of the Senior Governance Manager (Compliance)** | |

## CONTENTS

## 1. Background

**1.1.** This document outlines the guiding principles and Trust-wide Internal Professional Standards (IPS) for emergency patient flow as recommended by NHSI and ECIP.

## 2. Purpose

**2.1.** We all want the NHS to be at its best when we need it most. Access to life-saving emergency services is therefore vital in every sense. The NHS has to determine priorities that will allow it to make best use of specialist skills and limited resources. The four-hour standard reflects public perceptions of quality of care, and has become a key measure of a hospital's standing in its community. NDHT has therefore looked to balance this key performance indicator with Royal College guidance and clinical evidence with regard to the speed with which senior decision-makers can assess and treat individuals who may need emergency admission. This policy sets out the IPS that will serve to fulfil the organisations and professionals' clinical responsibilities to those we serve.

**2.2.** This document has been written to share the Internal Professional Standards to:

- Ensure NDHT provides a high quality emergency care pathway.
- Identify the requirement for individual departments to develop procedures to meet the overarching IPS for an emergency care pathway.
- Support a clear escalation process with specific triggers.

## 3. Scope

**3.1.** This document relates to the following staff groups who may be involved in the assessment and delivery of care of emergency patients attending NDDH. Staff will be both based in the Emergency Department (ED) and in other Trust teams where those teams have responsibility for caring for, providing diagnostics for or receiving emergency patients from the ED.

- Nurses
- Support workers
- ED board co-ordinators
- Medical staff
- Clinical Site Team
- Pathfinder Team
- Management
- Porters
- Ward clerks / discharge co-ordinators
- Allied Health Professionals
- Radiographers
- Healthcare Scientists (path, cardio respiratory etc.).

## 4. Location

**4.1.** This standard operating procedure for internal professional standards relates to the operational management of emergency patients across the whole Trust.

# 5. Guiding Principles & Trust Internal Professional Standards

## 5.1. Guiding Principles

- The Trust **will not** admit a patient who could go home nor discharge a patient who needs urgent assessment or treatment to avoid breaching the four-hour standard.

- The Trust will make best use of its designated assessment areas (for example MAU and SAU) by accepting GP referred patients directly into these areas where clinically appropriate (NEWS <5).
- Patients being assessed in designated assessment areas will be treated by diagnostic departments in the same time frames as applied to patients in the ED.
- A patient will only be managed as an inpatient if their care cannot be managed as an outpatient or in the community.
- A patient's discharge planning will be started on admission
- All admissions should have a completed Acute Admissions Clerking Proforma including a documented Post Take Ward Round.
- Patients admitted to hospital should receive a documented Consultant review within 14 hours.
- At daily board rounds, the expectation is that the patient will go home that day unless they are having active medical, nursing or therapy treatment which cannot be given in the community or as an outpatient.
- The expectation is that the patient will go home (to their usual place of residence) on discharge.

## 5.2. Trust Internal Professional Standards

- Patients will only be directed to ED by medical or general surgical teams if immediate clinical intervention is required. All other patients will normally be seen in designated assessment areas, for example, MAU and SAU.
- An ED decision-making clinician will see new patients on or as close to arrival as possible in the ED (standard within one hour) and determine a provisional disposition subject to any further tests or assessments that may be required to confirm their initial judgement.
- Specialties will have arrangements in place to receive referred patients in designated assessment areas within one hour of referral from the ED clinician. If there is no designated assessment area the specialty team will attend the ED within one hour of referral.
- Designated assessment areas will have their own IPS to manage shortfalls in capacity.
- Where there is a question as to whether the patient needs admission, or which specialty will be the admitting specialty, a senior opinion will be provided by the receiving team within one hour. If the patient is accepted onto SAU or MAU and then needs an opinion from another specialty, then this should be provided within one hour of the request for the opinion.
- Specialties must not insist on ED-based investigations that do not contribute to the immediate management of the patient.
- Medical or General Surgical patients referred to inpatient specialities by GPs should not remain in ED after triage if they have a NEWS <5 or other predetermined criteria that does not require immediate medical attention. Such patients will be directed to the relevant assessment area, where they will be handed over on arrival with responsibility for their care transferring to the relevant receiving clinician.

- If there is insufficient capacity within the designated assessment area and the patient cannot be transferred, the speciality doctor will see the patient in ED within 60 minutes.
- If the specialty doctor sees the patient and then considers that an alternative speciality would provide more appropriate care, there will be a discussion with the alternative speciality to agree who will accept the patient. If there is disagreement amongst junior staff then this should be escalated to a Consultant to Consultant discussion.
- If there is a failure of different specialties to agree on accepting a patient, then the relevant Consultants will agree a means of admission and relevant review; which may be by more than one team. If required the ED Consultant can assist in that agreement and can decide if more junior members are the decision makers.
- If a patient reattends (usually within 24 hours of discharge) with a problem relating to a previous admission, they will be assessed in ED by the triage nurse or nurse in charge. In most cases, they will then be referred directly back to the previous admitting specialty who will be responsible for their care.
- Transfer patients from Critical Care will take priority in in-patient bed allocation over and above any other calls for that available bed.
- An empty bed will be ring-fenced on the Stroke Unit to ensure that patients requiring admission to the stroke unit can be transferred without delay. The Stroke Unit should always have a patient identified who is suitable to move to another ward so that the next bed can be made available.
- Patients with a fracture (excluding pubic rami fractures) that requires only outpatient management but who cannot be discharged home for non-medical reasons and who has been assessed by an ED doctor as having no active acute medical problems will be admitted under the care of Trauma & Orthopaedics. They must be reviewed the following day by the Pathfinder team to facilitate early discharge. If medical problems become apparent after admission that preclude discharge, the care of the patient will be taken over by the physician team covering the ward to which they have been admitted. Patients with fracture-related symptoms who are admitted under the care of the physicians will receive a senior orthopaedic review the next working day.
- ED / the sending ward can handover patients to the receiving wards when the bed request is made. As long as the patient's condition remains stable no further handover is required and the patient can be transferred to the receiving ward when the bed becomes available.
- All wards should update TrakCare in real time when a patient has been discharged. The bed status should include:
- Empty – unavailable due to cleaning
- Empty – available.
- No bed should remain empty for longer than 60 minutes unless a deep clean is required for infection control purposes.
- All patients must have an Expected Discharge Date (EDD) set within 14 hours of admission.
- All in-patient wards must have completed a board round by 9:30am every day in which the individual patients are discussed by the multi-disciplinary team to determine what actions need to be expedited for each patient journey.

## 6. References

- NHSE Operational Pressures Escalation Levels Framework: https://www.england.nhs.uk/wp-content/uploads/2019/02/operational-pressures-escalation-levels-framework-v2.pdf
- NHSI, ECIP Internal Professional Standards: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-making-internal-prof-standards-work.pdf
- Resource Escalation Action Plan (REAP):


Escalation Plan 6 9.pdf

## 7. Associated Documentation

**7.1.** The plan should be read in conjunction with the ED Standard Operating Procedure, ED Escalation Standard Operating Procedure, Major Incident Plan, the Pandemic Flu Plan, Business Continuity Plan and the Bed and Site Management Policy.