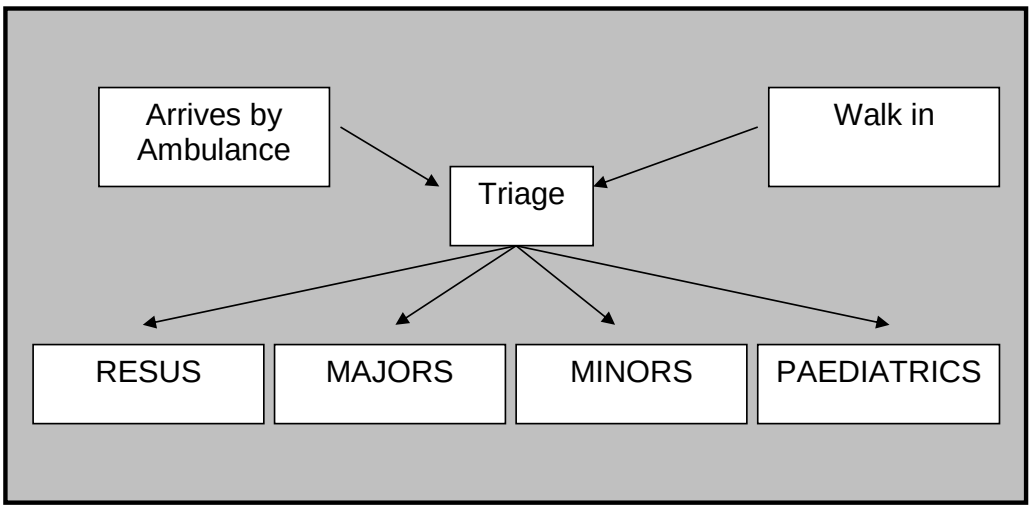
7. Evidence Base Medicine

We practice EBM in this department where possible. This is to ensure safe, effective and efficient management of patients. Highlighted within the manual are most of the ED treatment pathways. These are evidence based and / or best practice. Other sources of EBM or Best Practice include the Trust Policy library on the intranet and recognised clinical guidelines eg. GAIN and NICE. We will endeavour to keep you informed of clinical updates but it is your professional obligation to ensure your clinical knowledge is up-to-date.

THE PATIENT'S JOURNEY

- *Triage means rapidly assessing patients so that the critically ill receive prompt treatment*
- *Triage and streaming are a dynamic process and they are the responsibility of doctors as well as nurses.*



1. Patient Streaming

Each patient's visit to the ED is a journey through a series of assessment/treatment locations (rather like the series of windows you stop at when you go to the Drive-Thru at McDonalds!). Each stream has a dedicated treatment area. The purpose of streaming is to enable patients to receive treatment and to "flow through" the system as smoothly as possible. The doctor/nurse teams in each location must keep up with patient arrival loads in their area or the whole department will seize up.

THE STREAMS ARE:
1. RESUSCITATION (Incorporating Adult and Children's Resuscitation)
2. ADULT MAJORS
3. PAEDIATRICS
4. MINORS
5. ASSESSMENT UNIT

Allocation to the streaming system operates as follows:-

- All non-walking patients (ie mainly ambulance stretcher patients) enter via the ambulance door to be received by the ambulance triage nurse

who takes handover from the ambulance crew and carried out a rapid triage.

- Assessment in Resuscitation is for patients who have been phoned in by NIAS as a "Standby" or have been triaged as a Red or Orange category. This is a rapid assessment of the patient so that tests can be started, pain can be relieved and the seriously ill stabilised. A working plan should be made for the patient. This may include the use of point of care testing, sending specimens to the lab, ECG recording. The relevant specialties should be involved early for the seriously ill/injured/ MI or Stroke. If the patient is obviously requiring admission then fill out the whole ED record quickly and arrange admission. Even though care is rapid in resuscitation you must carefully document treatment and complete your computer work as you go along.
- All walk-in patients report to Reception to register via the public emergency department entrance. The registration details entered by receptionists include the type of complaint that the patient is presenting with – eg "abdominal pain", "ankle injury". These patients are all triaged by the triage nurse and streamed accordingly.

2. Triage

In practice, the main purpose of *triage* is to prioritise patients according to acuity.

i. After a brief assessment, the triage nurse direct appropriate patients back to the waiting room to join the queue for minor treatment.
ii. If a patient of any age is *acutely unwell* the triage nurse escorts him/her into majors or resuscitation area and notifies staff there.
iii. *Stable paediatric patients* (16 and under) excluding those with minor injury, are directed through to the Paediatric area.
iv. *Stable adult patients* with non-minor conditions undergo basic observations eg, vital sign measurement, urinalysis and the "WEAD+" before being directed to the Waiting Room to await an assessment cubicle in majors.

Along with streaming, the triage/streaming nurse use the Manchester Triage scale. This is shown below. This allows the nurse to direct you to the most seriously unwell patient first as opposed to first come first seen.

- Red and orange category patients should be seen immediately.
- Yellow within one hour.
- Green within 2 hours.
- Blue within 4 hours.

Ideally, all patients should be seen in a timely fashion.

UK national triage scale		
1	Immediate resuscitation	Patient in need of immediate treatment for preservation of life
2	Very urgent	Seriously ill or injured patients whose lives are not in immediate danger
3	Urgent	Patients with serious problems, but apparently stable condition
4	Standard	Standard cases without immediate danger or distress
5	Non-urgent	Patients whose conditions are not true accidents or emergencies

3. Ongoing care of Major Cases.

- *Patients should be assessed in order of acuity then arrival time*

Adult Majors: Following their initial assessment in Majors, the vast majority of patients will require to be reassessed with results of investigations ordered. These patients may have been moved to the EDDA (annex off Observation Ward) or x-ray sub wait (all should be tracked appropriately on Symphony) and should be reassessment there. If following the initial assessment there is a clear indication for admission then the patient should be admitted under the appropriate inpatient team at this time. (see admissions policy section)

Ambulant patients should be asked to walk to x-ray or waiting area. For non-ambulant patients, wheelchairs should be used if possible.

At time of reassessment a decision should be made regarding admission, community treatment or discharge. Doctors in training grades should regularly consult their senior colleagues about admission / discharge decisions until they become familiar with this department and document that this is done.

Children up to 16 years: Unless seriously ill or less than 90 days old, children will be directed to the paediatric area accompanied by their parents. The patients will undergo basic observation and assessment by the nurse stationed in the area and then they will be assessed by a member of the medical team as allocated on the daily allocation sheet. (see admissions policy section).

4. Senior Sign off

Groups such as Under 1 with a temp, >18yr olds with non-traumatic chest pain and Unplanned re-attenders and all admissions should be discussed with the most senior doctor (ST4+) prior to discharge. The ST4+ should enter their details under "signoff" on the Symphony system. A note should be made that makes reference to the consultation.

5. Patients requiring admission.

- *All admissions must be vetted by a senior ED doctor (ST4+) and the sign off box completed on Symphony*
- *Hand over the patient using the SBAR tool already described.*

Medicine & Surgery: The hospital has a *direct admissions* policy for adult medical, surgical and cardiology patients who have been assessed in the Emergency Department. Decision rules about admission are given in the CLINICAL section of this book. If the ED doctor decides to admit, the patient flow co-ordinator is notified via the Symphony screen and the doctor notifies the appropriate SHO in the relevant speciality should be contacted via the bleep system and a handover given.

The Observation Ward: The Observation Ward has a set number of conditions with a single focussed goal on admission, this is not "to make them better".
The Protocols must be adhered to and are available in folders in Majors and Observation Ward.
Any deviation from these eg Consultant protocol over-ride must be discussed with a named consultant and documented on the proforma.

Other Specialty Wards: Admissions to paediatrics, gynaecology, ENT are via the take-in SHO or Middle Grade doctor in the relevant specialty. Where possible he/she will choose to accept the admission on the basis of telephone information. If a doctor in any of the above specialties wishes to "vet" the admission by examining the patient, DHSS rules stipulate that this must be completed within two hours of the patient's registration. The visiting doctor MUST inform the ED doctor about the outcome of his/her assessment so that the admission/discharge process including computer screens can be completed (Non-ED doctors must never discharge patients!)

Patients with Mental Health Problems. Patients should be assessed using the Mental Health Triage Tool which will facilitate a joint ED / mental health journey for the patient. Medical needs should be addressed where necessary by ED medical staff. Mental health assessment should be carried out once

patient is fit for assessment (medical needs may still be outstanding in stable patients)

6. Care of Minors

- *Patients should be seen in order of acuity and then time of arrival*

The minors area incorporates 6 cubicles, ENT and eye examination facilities and general examination facilities. There is a seated sub-waiting area near reception. The ENP/doctor team in minors will see patients according to time of arrival (although patients who cannot be treated by nurse practitioners may occasionally be overtaken by those who can). Patients will be called to the minors area and put in a cubicle when it becomes available. Patients returning from x-ray will be directed to return to the small seating area to await reassessment. Fracture reduction without sedation should be carried out in the Plaster Room. Procedural sedation should be carried out only in Resus.

"THE FOUR HOUR TARGET"

Patients should have their DADT screen completed within 3h 00m *of registration*

Each doctor and ENP's individual performance will be audited continuously via the Symphony computer system. Doctors must learn to treat patients SAFELY, EFFECTIVELY and PROMPTLY.

Delays in the Emergency Department are usually related to inefficient use of resources - especially the doctor's time and the treatment cubicles- rather than being simply due to the number of patients attending.

Do's and Don'ts that prevent long waiting times

- DON'T get too engrossed with one patient - make rapid decisions or if you don't know what to do ask for help. You don't have to make a complete diagnosis to plan an Emergency Department patient's management – learn to make the relevant decision as quickly as possible and treat/refer accordingly.

- DO ensure that patients waiting for admission, x-rays etc. are moved out of assessment / treatment cubicles to allow new patients to be brought in - keep things moving! If there is a major problem with space, the nurse-in-charge can implement our escalation plan.

- DO stay with the patient stream that you have been given on the daily allocation sheet unless specifically asked to change by the EPIC.

- DON'T spend ages on the phone trying to contact other doctors/ arrange transfers. Ask the patient tracker or ward clerk to continue to try to contact the person you are looking for. At times there will be one of the reception staff manning the phones.

- DON'T request unnecessary x-rays, blood tests etc.; they cause long delays. (See Defensive Medicine)

- DON'T hang around in *Resuscitation when you are no longer actively involved in treatment* there (this is a common cause of extra long waiting times.).

- DO be NICE!! People who have been waiting for longer than 90minutes can't help getting frustrated and irritable. They appreciate an apology or at least some empathy. They may be anxious, in pain or have young families to contend with. Some acknowledgement of this makes it much easier for you to deal with them - disgruntled patients become a nuisance to everyone and its amazing how easy it can be to pacify them.

- DON'T go off duty if there are a large number of patients waiting to be seen or if the waiting time is long (this is a professional obligation for all doctors and junior doctors' pay-banding calculation allows for this).

- *DON'T forget that staff are important too*. Make sure you take a break now and again no matter how busy you are!" Breaks are rostered into your shift; ensure that you take them in full and on time.

THE EMERGENCY DEPARTMENT CONSULTATION

Sir William Osler the famous Canadian physician once said "there is more to treating the patient than treating his disease". This is certainly true in Emergency Department! In most cases, an *accurate* and *focused* history is the key to diagnosis and management of Emergency Department patients. A "directed physical examination" and the minimum of investigations follow. The clinical section will help you to devise effective assessment routines for common problems. This section gives guidance about how to carry out a time-efficient consultation.

The Emergency Department Consultation
- Why was this patient referred?
- Risk Factors- 'WEAD+'
- Focused history
- Directed Physical Examination
- Directed Investigations
- Final placement

1. Why was this patient referred?

a) Information from the "Source of referral"

Always start by working out the main purpose for the patient's attendance. If you can do this (not always as easy as it sounds), you will find it much easier to make decisions about management.

The Source of Referral prints out on the top right hand corner of the flimsy

- GP or GL – GP referral
- EM – 999 or Doctor's Urgent Ambulance Call
- SR or PG – self or parent referred

Having established the source of referral you can use this information to find out more:

- *GP or GL :* Scrutinise the GP referral letter. If the patient's GP sent him what did he/she want us to do? Was the letter definitely addressed to Emergency Department (written alongside "Department" on the referral sheet) or has the GP asked for direct access to physiotherapy, x-ray or outpatients? Is the patient suitable for the Assessment unit?
- Was the letter written today? Is admission requested or does the GP simply want an ECG or an x-ray. *In general we do whatever the GP requests - they know their patients better than we do.*

- *EM :* Find out who sent for the ambulance and why. There are two types of ambulance call – '999' or 'Doctor's Urgent' (the latter follows a GP call to the Emergency Admissions Co-ordination Centre). Try to speak to the ambulance crew, they know lots of information about the patient's home, who was there etc. If the crew have left, ask the nurse who accepted the patient from them. *People usually dial 999 in some sort of crisis, but it isn't always a medical crisis.*

- *SR :* You need to find out (tactfully!) why the patient has decided to come to Emergency Department at this moment. Have they been to their GP? If it is a chronic problem, what has changed to persuade them that they should get help now? If they are reattending Emergency Department, are they not happy with treatment received earlier? If the complaint seems trivial, what are they worried about? What is the situation they can't cope with? These are questions that cannot be approached bluntly. Contrary to popular belief *very few people come to Emergency Department for nothing*, so never dismiss seemingly trivial complaints and never make them regret coming to our department.

b) Information from Next of Kin

Remember that relatives may have had an important role in initiating the attendance, for example, have the relatives concerns which the patient hasn't passed on to you? Try to involve them as much as possible in a patient's management and take their advice. It is essential to start your history with the relative or other carer if a patient is elderly and/or confused. If the patient comes from a private nursing home you can phone them and speak to the nurse in charge. *When relatives, especially parents of young children, are very concerned or believe that you are making a mistake they often become aggressive - don't let this influence your judgement, they may be right!* It is important you listen to parents in particular if the child is very young, disabled or has learning difficulties. Be willing to change your mind or offer them a second opinion (there is more about this later in the section).

c) Information from Previous Attendances or Admissions

The Emergency Department system will print out the words *"*Prev. episodes*: …"* at the right hand side of the flimsy's triage section if the patient has ever been to Emergency Department before. *Make sure you are check all old records for children under 16/vulnerable adults*. Information about previous episodes is essential - it might alert you to an otherwise unsuspected problem e.g. non-accidental injury, domestic violence, addiction, Munchausen's syndrome etc. Ask the patient if they have ever attended any other department in the hospital before then ask the receptionists to get their old hospital notes if this is relevant. It is also possible through the labs system and radiology systems to obtain previous reports that can sometimes help.

NIECR is a valuable resource.

2. Record Risk Factors – "WEAD+"

WEAD+ stands for Warfarin / Epilepsy / Asthma / Diabetes plus Pregnancy and Peptic ulcer disease. You rarely have time to take a lengthy previous medical history but you must record the 'WEAD' history on every patient, especially in minors, because these are high risk factors in practice especially when prescribing. E.g. warfarin is a risk factor for bleeding after head injury; diabetes: soft tissue infection, silent infarct; epilepsy: drug interactions; asthma: NSAIDs. This will have been filled out on the front of the ED Notes.

3. Focused History

Your time is short. You are highly dependent on an accurate history if you are to make the correct diagnosis. Don't forget to listen to what your patient is saying – failing to do so is a very common source of error and complaints in the Emergency Department. When dealing with trauma, the mechanism of injury is crucial. Don't jump to conclusions – if you miss something important in the history, you will fail to carry out the correct examination and. Take careful note of the vital signs and any other comments recorded by nursing staff in their Triage note – a discrepancy between your opinion and the nurse's opinion should ring alarm bells.

The CLINICAL section gives guidance for history-taking in specific conditions, but don't forget what Dr Richard Asher, the prominent English Physician once said,
"*Listen to your patient, she is telling you what is wrong with her..*"

4. Directed Physical Examination

- *"if you haven't carried out and documented the necessary examination you will have no defence against medical negligence claims*"

A concise and accurate directed physical examination separates the experienced from the inexperienced ED Doctor. When your history is complete you must carry out a careful but directed physical examination, concentrating on the *relevant* physical signs. You must ensure that your patient is adequately undressed for this examination – patients write official complaints if a doctor examines them through their clothes (yes…some doctors are tempted to do this. You will see why when you start working in Minors!). You must document your examination findings carefully.

The CLINICAL section will provide you with important information about directed examination. It will help you to become a more effective and efficient ED doctor.

5. Directed Investigations (see defensive medicine)

- *"Over-investigating patients is the largest waste of time and resources in the Emergency Department"*
- *Concentrate on your clinical skills of history-taking and examination.*

Good ED doctors keep investigations to a minimum - this is a difficult transition for doctors who are used to working in specialities like general medicine where good doctors often seem to order every test imaginable. You must weigh the benefits of ordering an investigation against its cost and the time it takes. Concentrate on your clinical skills of history-taking, examination and examination. Learn the role of investigations in common emergency conditions – more about this in the CLINICAL Section. Doing a battery of investigations if you don't know why will create a nightmare later when you have to interpret them – all results, normal or abnormal must be interpreted in a clinical context.

a) Blood tests

The department has two point-of-care testing (POC) machines: a biochemistry analyser that can be used to measure Hb, pH, PO_2, PCO_2 etc, and an FBP machine. These are precious pieces of equipment – please leave them the way you found them. It is your responsibility to give the necessary details and sign for the blood tests you have performed.

You will be instructed in the use of the POC machines and given bar code access when you start to work in EMERGENCY DEPARTMENT but here are the five golden rules (currently under continuous audit!):

1. Record full Patient ID (name, DOB, EMERGENCY DEPARTMENT or unit number) on machine log sheet
2. Record User (your) ID or use your barcode to access the test
3. Write "POC" and any clinically important results on the patient's flimsey (eg K+, glucose)
4. Any tests whose results exceed credibility range immediately MUST BE REPEATED (see guidelines on each machine). THIS IS VERY IMPORTANT!
5. DO NOT leave results lying around.

Failure to do this will result in disciplinary action. *You are responsible for looking at the blood results YOU have requested.*

Never do unnecessary non-emergency bloods, they are the F1s responsibility. The printed results will come to Emergency Department instead of the wards irrespective of what you write on the request form.
If you request bloods it is your responsibility to ensure that you have checked

the results signed the paper copy that prints out real time and file in the notes. This is known in law as the "Duty of Diligence".
NO-ONE BUT YOU CHECKS THE RESULTS OF DISCHARGED PATIENTS – THINK BEFORE YOU REQUEST A TEST THAT TAKES DAYS TO RETURN –

"HOW WILL I FOLLOW UP THE RESULT??"

NON-SPECIFIC "TOXICOLOGY SCREENS "must not be requested. Request specific toxicology tests only – research has established that alert patients almost never lie about what they have taken. Serum Paracetamol and aspirin should be tested in patients with unexplained coma.

b) Radiological Imaging

Imaging studies are requested through the e-referral system and the images are then accessed through NIPACS. Imaging should be order on clinical grounds and in accordance with IMER guidelines. CT, MRI and USS requests should be vetted by ED ST4+.

The use of portable x-rays should be restricted to the critically ill only – they are less diagnostic than films taken in the x-ray department and this may result in delayed or missed diagnoses.

c) **The following condition specific tests should have these tests done.**

ABDOMINAL PAIN FBP U&E LFT Amylase CRP Urinalysis HCG +/- Erect CXR +/- AXR	**CHEST PAIN Cardiac sounding** U&E CXR FBP Troponin ECG 1 ECG 2
COLLAPSE ?SEIZURE U&E Glucose LFTs Mg Ca FBP Drug levels of antiepileptics ECG Urine & HCG CXR	**GI BLEED** FBP U&E Coag LFT INR G&H BM ECG CXR
HEADACHE a. Thunder Clap headache OR New abnormal findings = CT b.With none of the above BUT>55 years of age = ESR	**NON-SPECIFIC CHEST PAIN** ECG Chest x-ray
PALPITATIONS ECG	**PV BLEEDING** Urine HCG (12-55) Serum HCG if unable to obtain urine sample
RULE OUT PE FBP ECG CRP Wells score U&E +/- D-dimer CXR	**SOB** FBP U&E CRP Sats ABG if sats <92 urine ECG Peak Flow CXR
STROKE/TIA FBP U&E BM ECG Coag +/- INR	**SYNCOPE** U&E/Glucose FBP/CRP Elderly – Troponin ECG CXR Urine Lying/Standing BP
UNWELL ELDERLY FBP U&E Troponin CRP LFT ECG CXR Urine Lying / standing BP	**WARFARIN** INR

6. Final Placement (Part 1): Discharging and Arranging Follow-up

'Final Placement' or 'disposal' are the rather unfortunate terms used by Emergency Departments for what you decide to do with your patient after you have completed their management. Your decision *must* be recorded in writing by completing the final placement box of back of flimsy AND on SYMPHONY.

a) Discharge / referral Plan

This is at least as important as your history and examination – equal care should be taken with devising and recording it.

When you are discharging a patient your written management plan should include:

- clinical management
- verbal +/- written advice (and who receives it)
- follow-up arrangements
- suggestions for action by GP* (Please consider…)
- drugs (generic) dispensed or prescribed *
- who is to care for the patient outside hospital*

* where appropriate.

Specific advice about the follow-up arrangements & advice necessary for patients with common conditions can be found in the CLINICAL section.

When you have made an initial diagnosis and management plan it is essential to explain the diagnosis and prognosis to the patient. For many of the common conditions we have a written advice sheet and the patient should receive one of these as well as a verbal explanation. You must learn the prognosis for common Emergency Department conditions especially soft tissue disorders so that you can advise patients correctly. We have tried to include all the relevant information in the CLINICAL SECTION.

Patients/carers should be advised to return to the department if there is any unexpected deterioration or if things do not improve as quickly as they should- but not for a "Check Up" irrespective of how they are. This advice is usually recorded by clicking the 'return promptly…." Option on the Symphony discharge menu. Specific advice given should be recorded.

b) Discharging Safely

Don't forget to check that your patient will receive adequate help after discharge. Patients who are to be discharged from the Emergency Department should not be allowed to go home unless a responsible adult is available to care for them where necessary. Try to mobilise support from the family or friends for the person living alone. If the patient insists on going home alone follow hospital procedure for "contrary to advice" discharges. For the elderly or those with limb problems the gait assessment should be recorded on the flimsy.

c) Reviewing Patients at the Emergency Department

"The vast majority of patients can be trusted to know when they need to re-attend Emergency Department – you do not need to review patients routinely"

DO NOT bring patients back for review at the Emergency Department except in the circumstances described below. If you aren't sure about a patient's diagnosis or management discuss with the senior doctor on the shop floor, if the management is still not clear leave the notes for discussion at the morning handover. Ensure that YOU have recorded the patient's current (preferably mobile) telephone number and tell them that you are going to ask for a consultant's opinion on their condition, x-ray etc.

You can refer patients directly to the following clinics based in the ED:

1. Emergency Review clinic Wednesday am:
- All significant finger tip injuries
- All significant hand ligament or tendon injuries NOT requiring urgent orthopaedic or plastics input
- Traumatic joint effusions WITHOUT ANY FRACTURE, significant ligament tears
- Limping children including ? Toddler's fracture
- ? fracture in children (x-ray negative)
- *Complicated* wounds, burns etc (excluding treatment room cases)
- Clinical scaphiod injuries

2. Injury Review Clinic (when review is needed earlier than Wednesday clinic)
3. DVT Ambulatory Care Clinic (includes weekends)
4. Observation Ward Attender
- Imaging. CTKUB, CTPA
- Treatment eg. enoxaparin education, IV antibiotics (consider hospital diversion team), warfarinisation

d) Outpatient Review of ED Patients

The following are available direct access outpatient clinics:

Early Pregnancy Assessment Clinic – phone EPAC directly in hours, out of hours contact Gynae ward for appointment. If medical assessment needed contact gynae SHO bleep 5666.
ENT for nasal fractures only – review in 5-7 days, make appointment at ED reception
Fracture clinic (Whiteabbey hospital) for all definite fractures not requiring urgent (within 1 week) orthopaedic intervention / review (discuss these patients with ortho SHO in RVH)
Rapid Access Chest Pain Clinic – complete referral form and fax top number on form
Rapid Access Medical Clinic – complete referral form / clear indication on ED flimsy and book next day appointment though PAS by ED reception staff

e) Red Flag Referrals

All patients with indicators for a RED FLAG referral not requiring admission should be referred by the ED doctor to the appropriate team. Liaise with the ED secretaries to type up a formal referral letter that can be tracked. This should not be delegated to the GP to ensure timely follow-up and reduce chance of loss to follow-up. Other non-urgent outpatient referrals should be delegated to the GP with clear instructions on the GP letter (DADT).

f) Discharge to GP Care

" please consider.."

When a patient is discharged from the Emergency Department/hospital, their GP is once again legally responsible for their care –they have been handed over. For this reason, Emergency Department doctors rarely refer patients directly to another consultant or clinic - their GP's will want to decide about this. You can make a recommendation selecting one of the "GP asked to consider" options on the drop-down menu . Advise patients that their GP will refer only if they think it is appropriate and that they should contact their surgery and arrange an appointment with him/her.

You should also ask patients to return to their GP for repeat BP checks, for review of soft tissue infections after you have prescribed antibiotics, and for reassessment of rashes, sore ears, paediatric or medical conditions etc. In general, patients who require dressings or removal of sutures should be referred to their Treatment Room. Write a concise and accurate discharge

letter (DADT box) detailing pertinent results and specific follow-up requirements. If you wish for the patient to be reviewed by GP within a 2 week period please print off the discharge letter and give to the patient to bring to the surgery as there can be lag time in the postal arrival of the document

g) Prescribing in the Emergency Department

"*Generic prescribing please!"*

You have two options when a patient requires medication:

1. You can prescribe an ANTIBIOTIC or PAIN relief pack or make up seven days supply of other drugs (advice about the antibiotic and pain packs is included in the CLINICAL section).

2. In limited circumstances a hospital prescription may be required eg. controlled drugs. This should be discussed first with senior ED doctor (with the exception of commencement of warfarin as per DVT pathway).

3. *Children's doses* are always different – they must be checked in the BNF every time.

DO NOT OVERDOSE PATIENTS (esp ELDERLY) ON STRONG ANALGESICS –CONSULT BNF

6. Final Placement (Part 2): Assessing and Treating Patients Who May Require Admission

a) Pre-admission assessment (NB The Modified AEP below)

Patients who have attended for pre-admission assessment generally fall into one of three categories:

- *They require investigation by Emergency Department to rule out serious pathology*
  (Examples include ?DVT, headache, abdominal pain, chest pain).
- *They require emergency inpatient care*
- *They require improved social support, home therapy or nursing home care urgently*
  (Examples include the elderly patient with a fracture, poor home circumstances, poor mobility).

b) The Modified Appropriateness Evaluation Protocol

This management tool assists in the decision making regarding appropriate admissions. There are occasions when a patient should be admitted despite a lack of indications on AEP – this is a Consultant case.

At least one of the following:

1. Unstable angina OR ECG or cardiac marker evidence of acute ischaemia[1]
2. Will require monitoring of cardiac rhythm, blood pressure, pulse, temperature *or* respiration either continuously *or* two-hourly for more than 4 hours
3. Will require intravenous fluid or intravenous medication that cannot be administered in the community[2]
4. Will require any form of new artificial ventilation or supplemental oxygen[3]
5. Severe electrolyte/acid base abnormality[4]
6. Likely to require a procedure in theatre within 18 hours[5]
7. Acute loss of ability to move a limb or other body part within 48 hours of admission
8. Acute impairment or reduction of sight or hearing within 48 hours prior to admission
9. Recent acute internal bleeding(except haematuria unless requiring catheterisation)
10. Pulse rate <50 or > 140 per minute
11. Systolic BP <90 or>200, diastolic <60 or > 120 mmHg
12. Acute confusional state/ coma/ unresponsiveness[6]
13. Acute rupture of recent surgical wound
14. Consultant Protocol-override authorised by Dr_____

Notes:

1. Unstable Angina is defined as either crescendo angina, new onset angina within 5 days *or* angina at rest within 5 days where "angina" is taken to mean *typical* cardiac pain)
2. Contraindication to community iv therapy may be medical or due to unavailability of community services
3. Unless patient already on supplemental oxygen and no adjustment of dose needed
4. Check with experienced A&E doctor if unsure
5. This includes interventions such a fracture reduction in A&E procedure room, urgent endoscopies etc
6. This excludes simple inebriation unless CNS obs or monitoring required(see criterion two above)

Admission arrangements for psychiatric patients, ENT patients and those requiring intensive care are different. You need to ask the relevant doctors to assess the patient for you, you cannot admit directly yourself.

Remember, alternatives to admission include:

1. Direct access outpatient clinics eg. RACPC, TIA clinic, RAMC
2. Hospital diversion team
3. GP referral to non-urgent outpatient clinic

Patients requiring admission should been handed over to the appropriate team using the SBAR tool (see below), DADT and bed request completed on Symphony and the final placement box on the ED flimsy completed. The named nurse for the patient should also be informed so they can complete the necessary paperwork and handover to the ward staff. It is also good practice to inform relatives.

c) Transferring to Another Hospital

Some patients require transfer to other hospitals because they need specialist care not available on this site (e.g. head trauma, fractures).

- Clearly document receiving doctor with name and grade
- Clearly document any transfer instructions
- Stabilise and optimise patient condition as possible
- Legible transfer letter / copy of completed ED flimsy to accompany patient
- NICATS transfer for IUC patients
- Critical care neo-natal transfers telephone **07825147266 (co-ordinator) and 02890632499 / 02890633466 (PICU)**
- Critical care paediatric transfer for critically ill children up to their 14th birthday **telephone 02890632499 / 02890633466 (PICU)**

d) Emergency Care in the Community

THERE ARE SOME EXCELLENT SERVICES IN THE COMMUNITY– PLEASE USE THEM AS MUCH AS POSSIBLE.

There is a rapid access community team that includes nursing, physiotherapist and occupation therapists. This is only available in hours and can be accessed by **phoning 25635339**

The hospital social worker should be contacted if an emergency care package is required due to intercurrent illness or injury or a change on social circumstances. Remember that the patient may be means-tested and may have to pay for part of their care (the Social Worker will explain this to the patient but you should also be aware of it)

In addition there are a variety of Specialist Nurses who look after patients with long-term illness and help them avoid unnecessary hospital admission eg Diabetic Specialist Nurses, Respiratory Nurse specialists, Cardiac Function Nurses, Dementia Nurses etc. Your patient or their carer will often be able to give you the name and number of their Nurse Specialist – try to involve them as early as possible as their help is invaluable.

e) Hospital Diversion Team

Hospital Diversion Team can be asked to give iv antibiotics at home for selected patients requiring iv therapy who are not ill enough to require hospitalisation. The HDT nurse should be contacted by phone before the patient leaves Emergency Department so that a firm arrangement can be made in advance of their discharge. The patient needs a drug kardex properly filled out, prescription written with drug and dilutent (i.e. water or saline), HDT referral form (on symphony) and a copy of the patient's notes. These patients remain under the care of Emergency Department and in practice almost all are on antibiotics for severe or non-responding cellulitis or UTI in stable patiens not requiring hospitalisation. A time should be arranged for re-assessment at the Emergency Department if you have particular concerns but often you can give the patient a supply of oral antibiotics to use after their iv's are completed (usually on Day Four or Five) and ask the HDT nurse to monitor progress. In certain circumstances other IV medication can be administrated (this is on a case by case basis) either in the home or in Whiteabbey/ Midulster Clinics.

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f) "Running out of beds"

- *"this Emergency Department does not close* !"

At times hospitals temporarily run out of beds but the Emergency Department can never close! The ambulance service will be asked not to bring patients requiring admission to us but this is only a request, ambulances are still entitled to come if necessary –never argue with ambulance personnel. Never discharge a patient needing admission because of bed shortages and never transfer patients who are unfit. The Emergency Department consultants can help you in the event of difficulties.