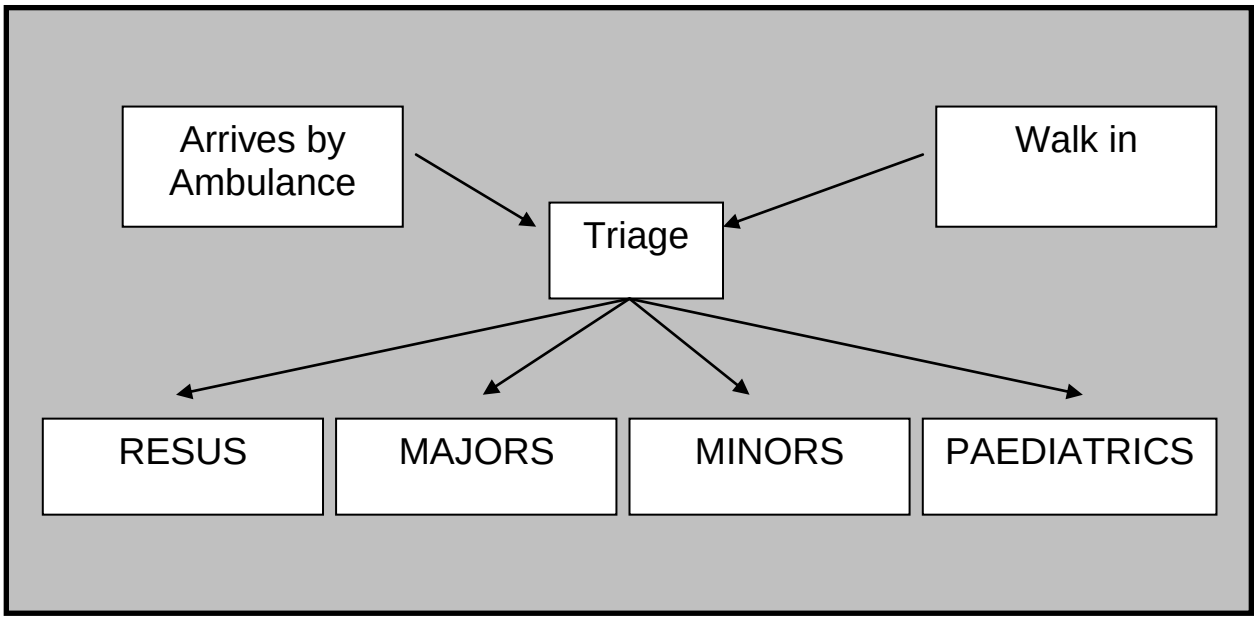
THE PATIENT'S JOURNEY

- *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

Allocation to the streaming system operates as follows:-

- All non-walking patients (i.e., 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 – e.g. "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 e.g., 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 raised 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 e.g. 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 90 minutes 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 AMAA?

- 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 re-attending 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, U&E and pH, PO_2, PCO_2 etc., 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" & any clinically important results on patient's flimsey(e.g. 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 inpatient teams'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 and acted upon the result. 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 scaphoid 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 e.g. 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 REF 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 requirememnts.

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 e.g. 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 (N.B. 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 desp.ite 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/ unresp.onsiveness[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 e.g. 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 occupational 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 inter-current 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 patients 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.

Phone: Office 352552

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.

EMERGENCY DEPARTMENT OBSERVATION WARD

- *There MUST be a single focused goal*
- *The goal should be achievable within 24 hours.*

The Emergency Department Observation Ward is a ten-bedded ward that is an integral part of the Emergency Department. The unit has a dedicated ward manager and nursing staff, while medical staffing is provided by the ED doctors on duty.

The purpose of the Observation Ward is to extend the time available for investigation and treatment of selected ED patients from 4 to 24 hours thereby reducing the emergency admission rate to the inpatient wards. Its ultimate goal is to improve the quality and effectiveness of care for patients.

a) Admission Criteria

There are set criteria and proformas for admission to the Observation ward, these must be accurately completed and Kardex filled before admission to the ward. Any urgent treatment must be completed in the ED prior to admission to the ward. The admission must be vetted by ED ST4 or above.

Only patients aged fifteen or over may be admitted to the Observation Ward. A list of suitable conditions for Obs care is given later, however this is for guidance only and doctors must use their clinical judgement in every case while applying certain general principles:

The following is the current admission list:

1. Diagnostic
    a. DVT
    b. Low risk PE
    c. Low risk chest pain
    d. Ureteric colic
    e. ? hip fracture (x-ray negative)
2. Observation and risk stratification
    a. Head injury
    b. Seizure (not status)
    c. Self harm / suicidal ideation
    d. Post procedural sedation
    e. Alcohol intoxication requiring medical re-assessment once fit
    f. Pneumothorax post aspiration
    g. SVT post treatment
    h. Anaphylaxis

3. Therapeutic
    a. Self harm
    b. Cellulitis
    c. Tonsillitis
    d. Awaiting defined procedural sedation procedure “in hours”
    e. Pharmacy education for enoxaparin administration, warfarinisation or novel oral anticoagulants.

This list is not exhaustive; it is for guidance only. Not all patients with the conditions above will be suitable for Observation Ward care – general admission / exclusion criteria apply.

b) Specific Exclusion Criteria

Patients with the following conditions must not be admitted to the Observation Ward without the ED consultant’s permission:

- Low back pain (unless due to acute extrinsic injury)
- Post-Chemotherapy complications
- Patients with complex or multiple medical needs are generally not suitable for Observation ward

c) Admission Procedure

When the ED doctor has decided to admit a patient to the Observation Ward he/she should:

- Tell the patient and relatives or carers that he or she will be kept in the Observation Ward for a period of observation/treatment and that discharge home is likely within 24 hours
- Enter “ADMIT OBSERVATION WARD” on the Emergency Department notes and on Symphony
- Must complete a properly labelled Observation ward proforma and ensure all tasks have been completed in accordance to each individual condition.
- Must write up the patient’s regular medication (where appropriate) on a properly labelled drug kardex and prescribe iv fluids if required.
- Analgesia must be prescribed regularly.
- Ask the Emergency Department nursing staff to arrange admission to the Observation ward
- There can be NO OBSERVATION WARD OUTLIERS if no bed is available refer on to medical/ surgical team.

d) Medical Re-assessment

It is essential that patients' progress in the Observation Ward is reassessed regularly. There is a named Consultant responsible for this area throughout the day. However if you admit to the ward it is YOUR responsibility to ensure that the patient receives the correct investigation/ management. For some conditions Nurse led discharge may be appropriate if certain criteria are met (see proformas)

e) Emergencies in the Observation Ward

Emergencies in the Obs Ward will be managed in exactly the same way as those arising elsewhere in the Emergency Department. Clinical guidelines and policies are available in the Emergency Department Handbook. If necessary patients who become critically ill can be escorted by a doctor to the Emergency Department resuscitation room immediately for further care (it should not normally be necessary to move the patient from a bed onto a trolley for this purpose). Patients may require onward referral to the appropriate inpatient speciality; contact the SHO for admissions via the on call bleep.

f) Mental Health Presentations

Patients on the combined medical and mental health pathway should be managed according to the pathway. A focused mental health assessment should be performed if there will not be a timely mental health assessment by the CRHTT or patient is at high risk of absconding.

g) Discharging Patients

Patients should be discharged home according to the Trust's Discharge Policy. The discharging doctor is responsible for completing a handwritten discharge coding and medication record and filling out the relevant details (Diagnosis, DADT and relevant details) on the Symphony system. Nurse led discharge should be facilitated where possible.

CONSENT

Written consent must be obtained before any procedure such as reduction, fb removal, incision & drainage. Fingertip surgery using the Hospital's consent forms (if in doubt re the need for written consent, ask an EM consultant)

This section on consent is taken from "12 Key points on Consent: The law in Northern Ireland"; a guideline from the Chief Medical Officer for NI

When do health and social care professionals need consent from patients/clients?

1. Before you examine, treat or care for patients/clients who are competent you must obtain their consent.
2. Adults and young people aged over 16 are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient/client understand and weight up the information needed to make this decision?" Unexpected decisions do not prove the person is incompetent, but may indicate a need for further information or explanation.
3. Patients/clients may be competent to make some health and social care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Individuals can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient/client still consents to your caring for or treating them.
5. Can children give consent?

Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents should ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent from a patient/client?

6. It is always best for the person actually treating or caring for the patient/client to seek consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided when seeking consent?

7. Patients/clients need sufficient information before they can decide whether to give their consent; for example, information about the benefits

and risks of the proposed treatment or course of action and appropriate alternatives. If an individual is not offered as much information as they reasonably need to reach an informed decision, and in a form they can understand, his/her consent may not be valid.

Is the patient's consent voluntary?

8. Consent must be given voluntarily; not under any form or duress or undue influence from health or social care professionals, family or friends.

Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusals of treatment

10. Competent individuals have the right to refuse treatment or care, even where it would clearly benefit them. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health (Northern Ireland) Order 1986. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. No-one can give consent on behalf of an adult who is not deemed competent. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical or social care interest, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these matters. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's/clients needs and preferences.
12. If patient/client who is now deemed not competent has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal') and those circumstances arise, you must abide by that refusal.

This short summary cannot cover all situations, further guidance will, therefore, be issued by the DHSSPS.

The hospital has consent forms that need to be used. It is your responsibility to know common procedures you will be doing and potential risks involved.

HEALTHCARE ASSOCIATED INFECTIONS

HCAI are a PREVENTABLE cause of illness, misery and even death. As a doctor, you have a duty to protect your patients from HCAI. Average rates of HACI vary from 15-30 % but experts say that ALL cases are avoidable.

HCAI include

- Staph Aureus /MRSA
- C Difficle Associated Diarrhoea
- Norovirus Gastroenteritis
- Extended Spectrum Beta Lactamase Producing Organisms (eg coliforms)
- Glycopeptide-resistant enterococci
- Blood Borne Virus Infections

THE THREE PILLARS OF HCAI PREVENTION ARE

1. HAND HYGEIN
2. ENVIRONMENTAL CLEANLINESS
3. EFFECTIVE PRESCRIBING

- Wash or cleanse you hands thoroughly* between patients – and be seen doing it!
- Use the correct gloves, aprons etc for the type of procedure you are undertaking and dispose of these properly
- If you see blood spills, contaminated equipment etc, alert nursing staff but where possible clean up after yourself. Maintaining a clean environment is EVERYONE'S business
- Dispose of sharps and other clinical waste safely
- Adhere to the Trust's Guidelines on Empiric Antibiotic Prescribing for Secondary Care (on PC desktops)
- Do not prescribe unnecessary or "routine" proton pump inhibitors; they predispose to CDAD
- If you have an infectious disease do not expose patients or colleagues to the infection
- Be vigilant about admitting patients with a potential infection risk to general wards
- Only insert venflons if appropriate and using a clean technique

*When washing your hands, your forearms should be completely bare – no watches, sleeves etc- use the standardised "seven step" method to ensure all surfaces of your **hands are** cleaned and, for assurance and reassurance, make sure that whenever possible you are seen doing this by patients and colleagues.

DIFFICULT INTERACTIONS WITH PATIENTS AND RELATIVES

- *"Listen to people - we aren't always right!"*
- *"You are not obliged to treat aggressive or verbally abusive patients"*
- *this Emergency Department has a well below average number of violent incidents*

Remember that when you are angry you are more likely to misjudge situations. Battles with relatives are notorious sources of future complaints or mistakes - be careful. Keep situations calm by using phrases like "it is my job to help you" or "you're obviously very annoyed, would it help to speak to another doctor or the nurse in charge?"

Patients have the right to know your name, the ED consultant and the nurse responsible for their care. If a patient is dissatisfied and this cannot be resolved on the spot they have a right to make a formal complaint that can be written or telephoned to one of the Trust's complaints officers (there are leaflets about this in the waiting area). Formal complaints like this are taken very seriously and are to be avoided if at all possible. If you are locked in conflict with a patient or relatives ask a medical or senior nursing colleague to speak to them - they can usually diffuse the situation.

Some patients are violent or are mentally ill, intoxicated and so on. You must never take risks with them or endanger other staff - always ensure that such patients cannot corner anyone and that all involved in their care are aware of the danger. If you want you can carry one of the department's personal alarms when working out-of-hours. Ask the Emergency Department Sister for details.

You are not obliged to treat aggressive or verbally abusive patients and you can ask hospital security staff or the police to remove them if necessary - you do not have to treat them first. Make sure that there is *medical and nursing* documentation of such events. If a patient becomes violent, *leave as quickly as possible* and raise the alarm. In the extremely unlikely event of your being cornered by a "patient" carrying any form of weapon, wait to be rescued – other staff will raise the alarm on your behalf.

- Experienced staff are better at handling violent/aggressive patients
- You must take reasonable steps to exclude a physical cause for violence/confusion – consider hypoxia, metabolic upset, CNS lesion etc.

NB: There are guidelines for rapid sedation of the violent psychotic patient in the CLINICAL section.

SECURITY CHECKLIST

Your safety is paramount. Be aware for potentially aggressive patients.

Potential trigger conditions:

Known aggressive patient or relative
History of aggressive behaviour from NIAS / PSNI
Alcohol or substance misuse
Psychosis or personality disorder

Danger Signals:

Agitation
Confrontational behaviour
Gesturing

Actions:

- keep patient safe
- keep yourself safe
- keep department safe including other staff and patients

1. Identify these patients early and assess in timely fashion
2. Inform nurse in charge and EPIC/senior doctor
3. Take patient into cubicle near a nursing base
4. Ensure patient safety – keep door open / obstacle free, inform named nurse of cubicle when entering or bring chaperone
5. Use diffusing techniques as appropriate or escalate to more experienced staff
6. Escalate to security +/- PSNI as necessary

<u>If escalation of violence occurs</u>

Ensure own safety and that of staff
Call PSNI
Document incident

LEGAL AND ETHICAL ISSUES

All doctors are expected to have read and to adhere to the GMC's publications "Good Medical Practice" & "Maintaining Good Medical Practice" as well as their publications on transmissible diseases, research and consent. If you have lost your copies, replace them or visit the GMC website(www.gmc-uk.org). The law is also powerful and ED doctors can get into even worse trouble if they choose to ignore it. It is important to understand the law's view of the doctor-patient relationship before setting foot in an Emergency Department. An outline is given below under the heading of "consent". It is also essential to be familiar with the basics of Child Protection. In addition to the information in the clinical section and the Induction Course, you can consult the booklet "Child Protection: Medical Responsibilities" or ask a senior Emergency Department doctor.

a) Chaperones

Doctors should be familiar with the importance of obtaining informed consent and a chaperone prior to performing intimate examinations on patients. While a chaperone is not necessary on every occasion, a proper explanation of the nature and purpose of the examination is. If any patient declines or exhibits any reluctance for the examination a chaperone should be offered. No examination should be carried out on a patient without consent unless it is an emergency and their capacity is impaired. Allegations of sexual misconduct have been made against Emergency Department medical staff after they have simply carried out "routine" medical procedures – you must protect yourself against such allegations.

Patients also have the right to refuse a chaperone, document this in the notes.

The commonest setting for an allegation of sexual misconduct in the Emergency Department is the patient with low back pain or a suspected spinal injury. Patients do not understand why a rectal / peri-anal examination is needed in this situation – make sure consent for this procedure is fully informed.

b) The Coroner: 028 9044 6800 (also Sudden Unexpected Death in Infancy in CLINICAL SECTION)

- *It is NOT necessary to inform the Coroner about all deaths in the Emergency Department.*

The coroner should be informed about any deaths in the following circumstances:

- A doctor did not treat the person during their last illness
- A doctor did not see or treat them within the last 28 days before they died
- The cause was sudden, violent or unnatural such as an accident, or suicide
- The cause of death was murder
- The cause of death was an industrial disease of the lungs
- There is a question of negligence or misadventure about the treatment of the person who died
- The patient died before a provisional diagnosis was made and the GP is not willing to certify the cause
- The patient died as a result of administration of anaesthetic
- The death occurred in other circumstances that may require investigation

In hours:	Contact the coroner directly and give verbal +/- written clinical summary Contact patient's GP by telephone
Out of hours:	Leave message on answering machine to contact EPIC in morning (phone 1286) Write clinical summary and leave in handover diary ensuring senior doctor is aware GP will be contacted by daytime staff

Relatives' consent is not required for a Coroner's Post Mortem, the coroner will advise whether a PM is required or not.

If a patient dies in Emergency Department, record on the flimsy whether or not: (a) a Death Certificate was issued (b) you spoke to the GP (c) you spoke to the Coroner/Coroner's Office. The letter containing these details is sent to the patient's GP within 24 hours so it is essential that this information is available.

Coroners Letter

On the top left when identifying who you are writing to:

HM Coroner
Coroners Service for Northern Ireland
(you can add address "Mays Chambers Belfast" if you wish)

DO NOT WRITE "TO WHOM IT MAY CONCERN"

Address the Coroner as "Sir" i.e. "Dear Sir" or "Dear Sir or Madam" and "yours faithfully" are the correct forms for this letter

Write RE : patient name, address ,date of birth.

Express regret at the death e.g. "it is with regret that I am writing to inform you of the circumstances surrounding the death of "patients name". Explain who you are e.g. "the emergency medicine trainee on duty".
When you write your summary DO NOT use any abbreviations e.g. say ventricular fibrillation not VF, cardiopulmonary resuscitation not CPR

Sign and print your full name at the bottom of your letter. Keep a copy in the clinical notes

Statements for the Coroner (i.e. for an inquest) are made on a statement of witness (PSNI) form - they are statements of fact only and should normally reflect what you have written in your clinical notes. Finish with a statement of condolence "I would like to express my sincere condolences to Mr. X's family circle... ". This is because your statement will normally be read out in court with the family present and if you are subpoenaed you may have to read it out yourself.

c) The Police

Police officers will frequently request statements from you, eg after RTAs and alleged assaults. You can go ahead and provide these if the PSNI officer has the necessary consent and paperwork. You report facts only (not opinion or interpretation) but seek advice from a senior doctor if unsure. If police make general requests for information or patients' details, refer them to the Consultant or SpR on call – this information is confidential and can only be released in certain situations. If police ask for a statement in reference to a Coroners investigation, they should be advised to phone Mrs Michelle Carey on extension 4661. Do not give the police a written statement directly.

Police may ask permission for the police doctor (FMO) to examine a patient or check serum alcohol. This request should only be declined if the patient is genuinely unfit – try to accommodate the police in every way possible.

d) Court / Professional Witness Written Statements

During your time in the Emergency Department you will receive requests from the PSNI for a report regarding your care for a patient that you attended. It is your responsibility to fill in this report. You get paid for it! Junior staff should seek advice from a consultant regarding completion of these forms until they are familiar with the process. They are a legal document admissible in court. If attending court, discuss with a senior doctor. It can be arranged that you need only attend when needed. It is imperative that any summons to the Coroner's Court , are discussed with a consultant.

DEFENSIVE MEDICINE

What is it?

Defensive medicine is commonly defined as the ordering of tests, treatments, etc, to help protect the doctor rather than to further the patient's diagnosis. Although this is not "unnecessary care", defensive medicine offers more economic and psychological benefit to the doctor than to the patient. There are two types of defensive medicine.

- Assurance behaviour (positive defensive medicine) – providing services of no medical value with the aim of reducing adverse outcomes, or persuading the legal system that the standard of care was met, e.g., ordering tests, referring patients, increased follow up, prescribing unnecessary drugs.
- Avoidance behaviour (negative defensive medicine) – reflects doctors' attempts to distance themselves from sources of legal risk, e.g., forgoing invasive procedures, removing high-risk patients from lists.

Would defensive medicine lower the risk of litigation?

No, defensive medicine is different from defensible practice, which is good practice – defensive medicine is not: it could, in fact, make your practice more risky.

Strategies to minimise defensive medical practices

- Communicate effectively with patients, explaining what you are doing and why
- Have robust systems for follow-up
- Be open about risk
- Offer an appropriate standard of care
- Only order tests based on a thorough clinical history and examination
- Discuss difficult cases with colleagues
- Keep clear and detailed documentation
- Know what it is you seek to exclude or confirm with a test to determine if it's necessary
- Identify learning needs (find good mentor)
- Undertake courses or independent study.

DO NOT ATTEMPT CARDIORESPIRATORY RESUSCITATION ORDERS

For most patients treated in the Emergency Department, including those we admit to hospital, discussion regarding resuscitation is not applicable and therefore does not need happen.

Occasionally when patients are in extremis it will be necessary to make a decision regarding resuscitation. Decisions about resuscitation are sensitive and complex and should only be undertaken in the ED by experienced medical (ST4+) and nursing staff. The overall responsibility rests with the consultant in charge of the individual patient's care. Only if cardiac arrest is imminent should theses discussions occur in the ED by ED staff, otherwise it is the responsibility of the admitting team.

The decision not to attempt CPR should be based on

- The likely clinical outcome that can be realistically expected after successful resuscitation
- The burden of resuscitation versus any possible benefit
- Imminent death expected as a natural progression of the disease process
- Valid and applicable advance directive
- Resuscitation would not be in accord with the patient's known or ascertainable wishes or their previously expressed view, feelings, beliefs and values.

If the adult patient is competent and willing to engage in the decision making process, their involvement in this is paramount. Where this is not possible, discussion with relatives can be helpful to ascertain the views of the patient. However, neither patients nor those close to them can demand treatment that is clinically inappropriate.

When paediatric patients are involved, the ED consultant and the paediatric team MUST be informed so that they can lead the process.

The DNACPR must be clearly documented in the medical and nursing notes with any discussions regarding the patient and / or family or documentation as to why the discussions did not take place. The Trust DNACPR form must also be completed and attached to the clinical notes.