LRI Emergency Department

Escalation procedures and triggers for the Childrens Emergency Department and Paediatric Single Front Door

Staff relevant to:	ED medical and nursing staff , CAT medics, Managers and Flow coordinators
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Escalation Policy for Children's ED

There is an escalation policy for the whole Emergency Floor which should be the first point of reference in relation to a whole Emergency Department response. There is also an escalation policy for the Children's Hospital.

It is recognised however there are some specific actions that can be taken in the Childrens Emergency Department.

These are a series of practical suggestions to help maintain patient safety during times of heightened activity within the Children's Emergency Department and Children's Hospital.

The main issues leading to difficulty within the Children's Emergency Department are:

1. Staffing 2. Overcrowding 3. Inflow 4. Outflow 5. Acuity

Obviously, these issues can be closely interlinked and may not occur in isolation, but addressing the primary cause may prevent secondary events.

NOTE: It is important to acknowledge that senior presence alone can effect changes in behaviour and alleviate anxiety.

Consider implementing the following actions to ensure patient safety and efficiency. Remember the busier it gets the more important it is to consider situational awareness and escalate earlier if you feel you further help.

Use the traffic light triggers at the end of this document to aid when to implement these measures.

Issue	Actions
STAFFING	**Standard Actions** 1. Review existing resources and their allocation: a) Ensure an adequately trained (ideally decision-maker) presence for children in all areas (Majors, Minors, CSSU and Resus) b) Does clinician attendance reflect the daily sheet allocations and can the EPIC/NIC/CAT team offer additional resources? (including themselves, if necessary) c) What additional medical staff/resources are available that a non-clinician may not have considered? (e.g. NNU, GGH, Transfer team, management shifts) **Tracker in Children's ED** 1. When available, the Tracker plays a vital role in Children's ED during winter supporting the nurse in charge. a. Maintaining overview of wait times b. Keeping room allocations on Nervecenter up to date c. Liaising with external support structures, management, other departments d. Identifying blockers to flow and escalating e. Chasing specialty reviews and bed availability f. Freeing up Medical and Nursing personnel to perform clinical duties **Specialty Presence in Children's ED** Ensure speciality teams are available in ED to review patients and that if they have staffing issues these have been escalated to the speciality consultant.

OVERCROWDING	**Standard Actions** 1. Avoid leaving anyone in a space unnecessarily - this impairs your ability to see new patients. 2. Reconfiguring space and resource to assess new patients or house existing patients (see below and room map appendix1) **Minor injuries** 1. Create a "Minors Clinic" system a. Allocate a decision maker to minors b. Team decision-maker with Nurse/HCA for treatments c. Allocate 1 space only per clinician/team d. Utilise bays 22 and 25. Consider the CSSU treatment room but do not leave patients unattended. e. **Do not** examine and clerk patients in sub wait chairs- use a cubicle space f. Operate a "1 in, 1 out" rule where possible for walking wounded g. Place patients on chairs to await treatments and increase minors chair area if needed h. Wait times will increase, but flow, safety and efficiency will be preserved. **Majors** 1. Avoid leaving children in cubicles unnecessarily. Unless a child is having an active intervention they should be moved back to the waiting room. 2. CAT and ED seniors must work closely to free space and ensure flow. 3. Utilise vacant primary care consultation rooms (1-3) for assessing ambulatory presentations but DO NOT leave children in the room following the consultation. 4. Utilise the waiting room stationary store as a base for HCAs to repeat observations. 5. Consider using room 5 for see and treat if assessment wait is <30 minutes 6. Attempt to maintain a resus or HDU bay as a crash space. 7. Encourage staff to use computers in rooms to avoid overcrowding at staff base 8. Refer to room map on how to allocate spaces to the teams (appendix 1) **CSSU** 1. Ensure 1 doctor is permanently based on CSSU to maintain discharge flow 2. CSSU is NOT to be used for patients waiting formal admission. All patients must be on a CSSU pathway. 3. Patients on CSSU who deteriorate and need admission should have bed requests made ASAP to facilitate flow and maintain safety. 4. When there are children awaiting beds on both CSSU and in CED the senior clinicians must work with the NIC to identify the patients to move first. This may not always be the patients in the CED.

INFLOW	**The undifferentiated patient poses the greatest risk in ED** **VAC/Reception** 1. Maintain a visual situational awareness of the waiting area and queue 2. Request second receptionist to aid booking in process if more than 3 families in queue (if not already present) 3. Follow the VAC assessment flow diagram strictly 4. Liaise closely with the Nurse Co-ordinator by phone, avoid leaving post where possible 5. Nervecentre and e-obs will ensure those booked in receive regular formal observations **Assessment/Streaming (refer to traffic light system for specific triggers)** 1. Open additional streaming queues with any available resources (PANP, CSSU staff) – drawing from Adult ED if necessary. Consider freeing up nurse co-ordinator by utilising medical staff in this role. 2. CED EPIC to escalate to ED EPIC and NIC when wait for assessment >30 minutes as a whole department risk • Number of pts needing assessment vs number of staff assessing (ie pt to nurse ratio) • % of whole department activity vs whole dept staffing • Consider redeploying staff for limited time- ie can they help for 45 minutes to get on top of queue • Many paeds pts are non verbal- ie obs and assessment are needed to fully ascertain acuity = high risk • If no help available in the dept – escalate to matron of the day and or flow manager. 3. Stop ALL non time critical treatments in the department to increase streaming capability until wait for assessment is <30 minutes 4. Pull Minor Injury patients straight through taking care to address pain, demographics and social/safeguarding issues. 5. If staffing permits, allocate a HCA to streaming to perform observations 6. **See separate ambulance protocol if ambulance inflow exceeds capacity** **Medical** 1. Consider using ST4+ or paediatric ANP staff to see & treat from assessment. 2. Utilise ED medical staff (ST4+) to take direct ambulance handovers along with an HCA.
OUTFLOW	**Standard Actions** 1. When >2 patients have waited 30min+ for a bed begin cohorting “admitted” patients into minors bays 23 and 24 2. Ensure all patients awaiting beds have a drug chart and documented plan in the notes. 3. **HAND THEM OVER** - Allocate a NAMED CAT clinician, nurse and HCA to care for these patients exclusively, like a ward, to ensure: a. Investigation results are chased b. Management plans are executed (i.e 2nd dose antibiotics) c. Patients are reviewed regularly for deterioration d. Relevant specialty reviews occur Ensure that the CH bed coordinator is aware of all patients awaiting a bed and use Nervecentre to give as much info as possible on the type of bed needed (RSV status, needs oxygen etc)

	Children's Hospital – Expected Response Ensure that the Children's Hospital Escalation policy is being implemented and that ALL ward patients have had a senior review with regards to discharge. Redirect junior staff to best enable flow under direction of CAT and ED consultant. **Speciality Team- Expected response** Duty management team to ensure that speciality teams are aware of the bed situation and accept ONLY emergency transfers from out of area (as there are no base ward beds for these patient.) **Childrens Intensive Care Unit – Expected Response** Should activity lead to a lack of available HDU or ICU beds within the Children's Hospital, it is likely that subsequent unwell children will remain in ED for extended periods, pending identification of a suitable bed, in which case the following actions are suggested: 1. A consultant to consultant discussion is required to determine the level of care required and the resources currently available to deliver. 2. Consider other areas a child may be cared for (Adult ITU, Glenfield PICU or Theatre Recovery). 3. Discussions re where a patient should be cared for will need to involve PICU, ED or CAT and Anaesthetic consultants. 4. Acknowledging neither service is infinitely resourced, cooperation is required to ensure patient safety, delivery of intensive care, and provision of a bed. 5. Beyond airway management and emergency resuscitation, release of medical and nursing personnel may be required to help deliver intensive care at the bedside. 6. If transfer to another centre is deemed necessary, the CICU team will explore bed availability within the region and beyond, as well as transfer/retrieval options**. Involve the COMET team early (0300 300 0023).**
HIGH ACUITY	**Standard Actions** 1. Ideally, all very unwell children should be housed in the Emergency Room 2. Utilise the HDU cubicles 13, 14 and 15 for suitable patients (HDU patients, ER step-down) where safe to do so. 3. Ideally, maintain a decision maker in all main paediatric areas (Majors/HDU/Minors/ER) with a separate co-ordinator. **Critical care / Ventilated patients remaining in ED** Referred patients in Children's ED remain the JOINT responsibility of the ED **AND** the Specialists involved. This is of critical importance in the case of high acuity/intensive care patients (e.g. intubated/ventilated patients) awaiting transfer. Clear communication and documentation is essential. Suitably qualified personnel must be identified to remain with the patient at all times, from available staff (ED, Anaesthetics, Children's Hospital) escalating as necessary to support depleted areas. Remember that 1:1 or 1:2 nursing is required for PICU/ HDU patients. If ED staff are being asked to stretch beyond this it MUST be escalated to the duty manager as a department risk. Liaise closely with the PICU consultant and nurse in charge to assist each other as able.

	Multiple high acuity patients in the Emergency Room/ Multiple Red Calls en-route 1. **RESIST** the temptation to manage multiple red calls with 1 doctor and 1 nurse 2. **CONSIDER** who is available to help you: a. Additional CED personnel (requiring backfill) b. Existing Emergency Room personnel c. Additional ED personnel d. Wider Children's Hospital personnel (CICU/HDU medical/nursing staff) and **ASK** them

REMEMBER - The busier it gets, the more you need to:

STEP BACK to

Maintain situational awareness

"Do the most, for the most, with what you have"

ESCALATE (EPIC/ED NIC/Flow manager/Duty Manager) - You are not alone!

Please also remember the power of a senior decision maker going out to the waiting room to explain to families that we are experiencing exceptional activity and that there may be long waits.

Triage Escalation

Trigger point	Departmental status	Nurse in Charge Action(s)	Senior Doctor Action(s)
Wait for triage <15 mins	Normal practice	Designated triage nurse	Normal activity
Wait for triage 15-30 minutes	Getting Busy	Consider opening a further triage stream.	Normal activity
Wait for triage over >30 mins	Increased pressure	Open up additional triage streams If triage mainly injury pull all minor trauma through If triage mainly illness consider PANP or ST4+ see and treat stream Pause non essential treatments to free up nurses for streaming Inform DIC and NIC	Identify patients in department on 180 mins or more. Ensure these patients have a clear plan or discharge/ admission. Assist with coordination if needed to free up triage staff
Wait for triage > 45 mins	Potential to be unsafe	Additional triage streams already in progress and all of above in place Pull HCA/ student nurse from CSSU to speed up triage by doing observations etc Inform flow manager and matron of the day– ask for additional nursing help to open triage streams Ambulance crews to hand over directly to doctor in department. Triage by joint senior doctor and HCA.	Ensure nursing plan is in action. Identify patients in department > 180 mins have clear plan in place ie bed booked, TTA ordered Start taking handover and ST4+ led see and triage of ambulance patients.

Wait for triage >1 hr	UNSAFE	Assume all points above already in action **STOP** – What is waiting? ***Minor injury***– ENP/ Dr to set up see and treat streams as well a current triage stream ***Mainly illness*** PANP and ST4+ with HCA to see and treat Silver command to be informed of status	Ensure nursing plan is in place Ensure all patients that can be move out of the department have been (either to base wards, CSSU or back to waiting room)
Wait for triage > 90 mins	Unsafe department	If all of the above actions have been taken-Discussion with senior doctor and senior management considering closure of department ie redirecting ambulances until safe	

CED escalation (for patients already in department)

Trigger point	Departmental status	Nurse in Charge Action(s)	Senior Doctor Action(s)
<1 hour to be seen	Normal practice	Designated triage nurse	Normal activity
Wait for clinical review >90 minutes	Increased pressure	Ensure triage is safe and sustainable. Identify patients requiring a period of treatment suitable for observation ward (see SOPs) Ensure plans and drug charts available for all patients likely to require admission. Inform flow manager of increased pressure. Ensure bed requests have been made for all patients identified as needing admission	Ensure CAT and CED team working together to see priority patients irrespective of referral method. Ensure clear plans for all patients with length of stay >120 minutes. Ensure specialty teams are present and seeing referrals with appropriate senior review.
Wait for clinical review >120 minutes	Potential to be unsafe	Ensure triage is safe and sustainable. Identify all patients in department for > 180 minutes – have they got a plan? Are they needing ongoing treatment? Inform EPIC/NIC of situation Ask for help in moving all patients with beds ready on wards. DO not delay unless time critical interventions needed.	Prioritise majors and DPS 2 patients. ENP from minors to come and see suitable pts. Ensure all rooms being used effectively Ask EPIC if resource can be pulled from elsewhere in ED DW CAT consultant to ensure team working to get through workstream

Wait for clinical review >180 minutes	Beginning to be Unsafe	Assume all points above already in action. **STOP** – What is waiting? ***Minor injury***– ENP and Dr to set up see and treat streams as well a current triage stream ***Mainly illness*** PENP and ST4+ (PED or CAT) with HCA to see and treat ***A child in resus and high pressure on shop floor*** Can additional nursing support be found? Silver command to be informed of status CSSU ward clerk/ tracker to ensure all patients going to ward have drug charts, plans in notes etc. IF beds are available identify a nurse to do help with transfers- consider asking CH flow or CH matron.	Ensure nursing plan and above steps are in place. Ensure all patients needing admission have been refered to CAT medics. Senior led direct referral to specialty of appropriate patients. Senior review of notes of pts with POPS <1 and direct challenge of 'what are we doing for this patient? How do we get them home?
Wait for clinical review >240 mins	Unsafe department	If ALL of above in process and still unsafe- Discussion with senior doctor and senior management considering closure of department ie redirecting ambulances until safe	

CED Room use during Escalation:

Rationale:

1.CED is a finite space and **all** teams (CAT, CED majors, CED minors, CED primary care) will run out of rooms at times of peak activity

2.Rooms have been allocated between the teams according to predicted volume of activity (eg CED majors 2:1 CAT)

3.HDU cubicles are to be used by any patient requiring enhanced level of care, irrespective of the team they are under.

4.If each room is allocated a function, each team knows what capacity it has to work within (ie "one in, one out") and is responsible as a team for utilising the space as best as possible.

For example room 12 could be for senior reviews, rooms 4, 10 & 11 for juniors to clerk?

(All teams are working within compromised space during excessive demand)

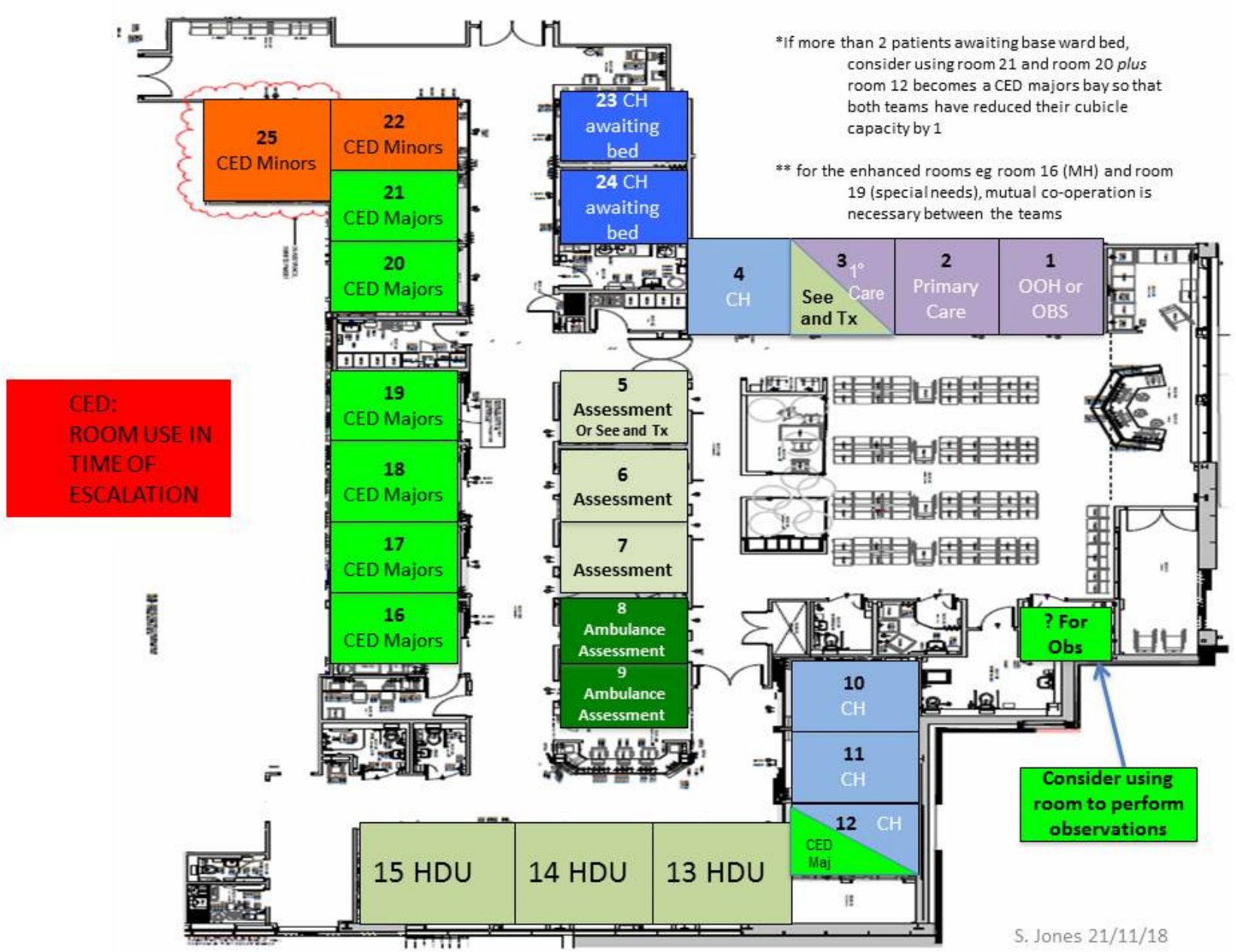
5.Any patient awaiting a hospital bed >30 mins should be moved to cubicles 23/24 and nursing/medical staff allocated specifically to these bays to ensure ongoing care for these patients despite not being on a ward*

6.This will reduce "room requests" on the nurse co-ordinator (currently an unmanageable role) and fits with principle of nursing colleagues being allocated to specific rooms/bays.

7.Each team must keep nerve centre updated for which patient is in which room to maintain safety of the department

*If more than 2 patients awaiting base ward bed, consider using room 21 and room 20 *plus* room 12 becomes a CED majors bay so that both teams have reduced their cubicle capacity by 1

(ie CED majors lost room 21 and 20, but gained 12, CAT team lost room 12).


*If more than 2 patients awaiting base ward bed, consider using room 21 and room 20 *plus* room 12 becomes a CED majors bay so that both teams have reduced their cubicle capacity by 1
** for the enhanced rooms eg room 16 (MH) and room 19 (special needs), mutual co-operation is necessary between the teams
CED: ROOM USE IN TIME OF ESCALATION
25 CED Minors
22 CED Minors
21 CED Majors
20 CED Majors
19 CED Majors
18 CED Majors
17 CED Majors
16 CED Majors
23 CH awaiting bed
24 CH awaiting bed
4 CH
3 See and Tx 1° Care
2 Primary Care
1 OOH or OBS
5 Assessment Or See and Tx
6 Assessment
7 Assessment
8 Ambulance Assessment
9 Ambulance Assessment
10 CH
11 CH
12 CH CED Maj
? For Obs
Consider using room to perform observations
15 HDU
14 HDU
13 HDU
S. Jones 21/11/18