The Role of Specialist Services in Emergency Pathways

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THE ROLE OF SPECIALIST SERVICES IN EMERGENCY PATHWAYS

AT SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

1.1 INTRODUCTION

Provision of emergency and unscheduled care is one of the most important functions of our organisation and poses some of our biggest challenges. Rising but unpredictable demand, surges in activity and exit block frequently put our systems under pressure but we cannot close the front door. Our performance in this area is subject to intense external scrutiny and to a large degree defines the reputation of the hospital.

Emergency patient pathways involve all the clinical Care Groups in some way and emergency care requires a coordinated approach crossing Specialty boundaries Specialty teams are required to work together with Emergency colleagues to support delivery of timely urgent care and not to work as separate unconnected groups.

The Emergency Departments are too frequently the front door pressure points where most of the organisational risk resides. To ensure safe care for our patients we must work together to ensure patients are assessed as swiftly as possible and brought out of the Emergency Department in to the most appropriate area for delivery of their care. This ensures a safe balance of risk across the organisation and supports flow from the Emergency Department enabling other sick patients to enter the system. This policy describes how the specialty teams should appropriately respond to the needs of patients, to provide swift assessment and decision making. . The challenge of accessing timely access to specialist opinion is not solely restricted to the ED and is encountered daily on our wards. These internal delays impact on the quality and safety of care patients receive, as well as negatively impacting on patient flow.

This document is intended to provide clarity about the responsibilities of specialist teams in supporting our emergency patient pathways. This document complements the Escalation Policy and acknowledges the need for effective flow of patients through SaTH, supported by capacity and site management processes. This policy also describes decision making and actions required in response to those decisions which are required all the time when a specialty review is required but also supports those occasional times when there are disputes over where the patient in the ED would best be assessed by specialty teams even when there is capacity on assessment units and wards. There are also delays in ward patients receiving the specialist opinion necessary for them to progress down their management pathway. Delays in this patient's assessment can be detrimental to their outcome, as well as detrimental to other patients needing to access the Emergency Department. There is a need to set internal professional standards for accessing specialist opinions and it is the main purpose of this policy to describe this.

1.2 PRINCIPLES

Underpinning this policy document are the following principles:

Patients should be treated by the doctor best qualified to deal with their problem.

- The Emergency Consultant in charge makes the decision as to where the patient care should reside and the ED team will contact that team to request the review. The ED consultant decision takes precedent and any further change or transfer should take place outside of the department i.e. the patient is accepted by the first specialty without question.
- Transfers of care between clinicians should be avoided unless there is a clear advantage in terms of expertise of the receiving clinician.
- Senior review should occur as early as possible in the pathway.
- Emergency pathways should operate in the same way regardless of day of the week or time of day.
- Admission to hospital should be avoided where possible provided safe and effective community services are available.
- Specialist advice from other teams for inpatients should be available the same day in most instances.

1.3 PROBLEMS

Current challenges to us upholding these principles, precipitating the need for this policy.

- Multiple transfers of care are common and create delays within the EDs
- Each specialty provides their service according to its own rules. There is no consistency between specialties
- It is accepted that specialty decisions may change but later transfers should happen outside of the ED from one specialty to another – any dispute should be resolved and the patient transferred to the most appropriate patient outside of the ED department
- Specialist opinions may be delivered by very junior members of the team – the specialist opinion should be provided by the most appropriate grade of doctor who is able to make a decision. We cannot be in the position of the most junior doctor arriving in the ED and upward progression from junior to core trainee to middle grade etc. as this delays the decision making process and adds to ED delay
- Long waits for opinions from some specialties – delays should be minimised by the ED escalating delay issue to the next most senior doctor – to the Consultant on call if required and then to the appropriate Care Group Medical Director .
- Lack of clarity about who should look after patients with specialist problems. Some specialists will take over care whilst other "leave it to the ward team" – this policy will drive uniformity and reduce inappropriate delays and therefore risk within the ED
- Arguments in ED about which specialty should take the patient – as stated, this ceases and any further change is managed outside of the ED
- Patients sometimes wait for definitive specialist treatment until they can be transferred to the specialty ward – the ED is the place to deliver immediately required intervention, anything further should be carried out in the appropriate ward for those patients who require admission. Patients not requiring admission should be transferred as appropriate to CDU (at RSH) or AEC (either site – in hours)
- Cover at night/weekends varies between specialties.
- Patchy availability of specialist admission avoidance/rapid access clinics.
- Changing management plans as on call specialist consultants change over.
- Inequity of distribution of resources such beds and junior doctors.

2 SPECIALITY UNDER WHICH ADULT PATIENTS SHOULD BE ADMITTED FROM ED

2.1 MAIN PRINCIPLE

The patients presenting complaint will determine which speciality the patient is referred to and which speciality will admit the patient. . Prior to referral to any speciality the patient's clinical details and condition will be discussed with the ED middle grade or consultant prior to referral.

On occasions there are disputes as to which team the patient should be admitted under causing delays in patients being seen and managed. Patients increasingly present with multiple acute and chronic conditions and so at times it can be difficult to determine under which speciality the patient should be admitted. This can be time critical. On occasion joint care will be required but the most prevalent specialty should take the patient out of the ED to a base ward and later changes managed outside of the ED. The following list is intended help prevent these conflicts through making it clearer as to which specialty patients should be referred and accepted, by presenting complaint. This is not an exhaustive list and will be updated if necessary with other conditions where delay has been experienced. The diagnosis listed is the primary diagnosis with which the patient presents to hospital. Other speciality teams provide an expert assessment and opinion on the patient, but the primary reason for admission will determine which team they will be admitted under.

2.2 SURGICAL SPECIALTY UNDER WHICH PATIENT SHOULD BE ADMITTED BY PRESENTING COMPLAINT

The list below does not include medical conditions. The list is devised to address scenarios which have recently been encountered.

2.2.1 GENERAL SURGERY

Cellulitis of trunk

Head injuries (including skull fracture)

Chest injuries

2.2.2 ORTHOPAEDICS

Suspected #NOF

Fracture pubic ramus to Medicine if unequivocally no other bony injury

(facial fractures to maxillo-facial team)

Limb trauma

#pubic rami should be admitted under **Orthopaedics**

Back pain

Back pain with suspected cord compression

Upper limb cellulitis

Hand infection

Suspected septic arthritis, or soft tissue infections close to a joint

EXPLANATORY DETAILS

Patients with a painful hip unable to mobilise after a fall, should be regarded as suspected #NOF, despite no radiological evidence of #NOF on plain radiology and should be admitted under **Orthopaedics**. This includes patients admitted because of "social reasons". Patients may subsequently be referred to care of elderly team next day after PTWR if required.

2.3 PATIENTS PRESENTING TO ED FOLLOWING RECENT DISCHARGE HOSPITAL FROM SPECIALIST CARE

Complications following surgery should always be considered in patients re-presenting to hospital soon after discharge. Referral of such patients should be directed to the specialty team from whom they had been recently discharged unless it is absolutely clear that the new presenting complaint is unrelated. Even if the patient is referred to a different specialty team the original team should still be informed of the readmission by the accepting team within 24 hours of admission.

2.4 DIVERSION TO ANOTHER SPECIALITY

If a team is referred an appropriate patient, that team should clerk in the patient and write in the notes. If after senior review that team then feels the patient would be more appropriately admitted under another specialty, the case should be referred by that specialty team that originally accepted the referral (not the ED team). The patient will however be admitted under the original team until that time there is agreement by the other team that they will take over care. There will be no delay in admitting the patient to a ward pending this second opinion (see below).

2.5 SUBSEQUENT TRANSFER OF CARE

Patients may initially be admitted with a presenting complaint under a certain speciality, but subsequently it becomes evident that care should be transferred to another speciality. The onus however is on the initial admitting team to admit the patient, investigate and establish the diagnosis. This responsibility will only change once the transfer of care has been accepted.

Examples

1. Patient presenting with chest pain - admit under medical team. Subsequently found to have sub phrenic gas and suspected perforated DU. Refer to general surgeons
2. Patient presenting with abdominal pain – admit under general surgeons. Subsequently found to have DKA and no signs of other abdominal pathology. Refer to medical team.

2.6 DECISION MAKING AND FLOW OF PATIENTS FROM ED TO ASSESSMENT UNITS

- The ED consultant, assisted by current policy, has the final say on where and under which specialty patients are admitted.

- Referrals for opinion when it is unclear to the referrer whether the patient should be admitted or not should be discussed by the ED middle grade or above prior to referral.

    - Specialty doctors should attend ED to review the patient within 30 minutes of referral
    - If the review and/or decision has not been made by 45 minutes the ED nurse /.coordinator or Clinical Site Manager will investigate and escalate to the next grade of doctor within that team
    - If no action has occurred or contact made within a further 10 minutes then the CSM will inform the specialty consultant with an expectation of resolution.

- To help prevent avoidable contact of the on call consultant after 10pm however if there are delays in getting a patient reviewed AND the patient has been reviewed by the middle grade in the ED who is confident that surgical admission is necessary, then arrangements are made to admit the patient to a surgical bed pending that review.
- If at any hour on the rare occasion there is no speciality medical staff available to consult, then the ED consultant or designated middle grade will be informed and will have final say on where and under which specialty the patient is to be admitted.

- When it is clear to the ED middle grade doctor that admission is required, but that he/she is unsure as to which specialty they should be admitted, the referral must be made by the ED middle grade or above. This doctor should decide and refer to the speciality that he/she feels is most appropriate based on presenting complaint.

- The referral will be communicated as being a referral for admission, not for assessment. Any disputes over the appropriateness of the referral that arise after the fact should be raised to the relevant clinical directors so that opportunities to learn and improve referral practices for the betterment of patient care can be taken.

- Disputes must be kept to a minimum and the decision of the ED middle grade supported. If this is felt not possible then it should be escalated to the ED and specialty consultant. Policy points 2.4 and 2.5 will then be followed if necessary by the accepting team.

- If the decision has been made to admit the patient, the referral has occurred to a specialty team, and when the patient's condition is stable, there should be no delay in transferring the patient to a suitable ward.

- All surgical and medical patients in ED, as defined by the policy, will go to respective assessment units unless following an agreed clinical pathway, for example NOF. If there is an agreed pathway for direct transfer to the ward then all steps of the pathway must be completed before the patient leaves ED. If possible all patients' should transfer to an assessment area and a suitable patient from SAU/AMU should be transferred to a ward to facilitate this. On occasions this may include a T/O patient being moved to SAU if a bed on T/O ward isn't readily available.

- Once an empty ward bed is identified, the ward will be given a 30 minute window maximum during which the bed must be ready for the patient. There are only 2 exceptions to the rule: a death on the ward and a cardiac arrest on the ward. Mealtimes, handover, drug rounds etc. are not reasons for refusing ED patients.

- If for reasons of capacity or clinical pathway the patient would benefit from being transferred from the ED of one site to a specialist bed on the other site then the middle grade of the appropriate specialty, or a nominated junior of the same specialty, will assess the patient in ED and liaise directly with the accepting specialist team on the other site. If however the patient in ED is too unstable to transfer or if transfer would in fact delay their access to specialist therapy, then to make capacity within the hospital the CSM can consider transferring a stable patient from that site of any specialty to the other site. Identification of such a patient will be supported by the middle grades of the relevant specialties.

- Please note that there is an existing policy for the assessment, referral, and transfer of surgical patients presenting to the PRH ED to the RSH site. There is also a Hospital Transfer policy which should be considered before all transfers from all areas.

- We will not admit a patient likely to be able to go home to avoid a breach. We must assess them in good time. Patient safety will continue to be at the heart of our decision-making, with urgent assessment/treatment always being provided when needed, without regard to breaches.

- The ED coordinator will escalate and chase a decision and plan such that every attending patient has a plan within 2.5 hours maximum

3 IN PATIENT REFERRALS FOR SPECIALTY ASSESSMENT

3.1 MEDICAL PATIENTS REFERRED FOR SURGICAL OPINION: REFERRAL POLICY

Acute surgical emergencies are to be referred to the on call surgical middle grade in and out of hours (bleep 603 rsh) and (bleep 208 PRH). At the discretion of the on call surgical SpR the on call consultant surgeon may be asked to see the patient.

For clearly speciality specific non-emergency surgical problems in hours (Monday – Friday 0900-1700) the medical team should refer directly to appropriate speciality team (bleep speciality team registrar or contact consultant via switchboard).

Referrals to a surgical team with a request for them to not only provide a surgical opinion but also to take over the care of the patient should be directed to the most appropriate specialist team as outlined above. If the on call consultant surgeon saw the patient, he/she will decide whether it is in the patient's best interests that a surgeon takes over the care of the patient. If the on call consultant or team deems that the patient should be under a surgeon for specialist in he/she will advise the surgical team who to refer the patient to. If it is an acute general surgical problem and it is right for the patient to be under the care of a surgeon the surgical team will co-ordinate care. Pending transfer to a surgical ward, the surgical team will supervise care but the medical ward foundation doctor will continue with routine tasks as directed by the surgical team.

There should be an assumption that all patients accepted for surgical care should be transferred to a surgical ward within 4 hours of first attendance in the ED department – ideally within 3.5 hours.

Occasionally there may be patients which need joint care, in which case they should remain under the overall care of the physicians.

3.2 SURGICAL PATIENTS REFERRED FOR MEDICAL OPINION: REFERRAL POLICY

Acute medical emergencies are to be referred to the on call medical middle grade in and out of hours. At the discretion of the on call medical middle grade the on call consultant physician may be asked to see the patient.

For clearly speciality specific non-emergency medical problems in hours (Monday – Friday 0900-1700) the surgical team should refer directly to the appropriate speciality team utilising existing

referral pathways or bleeping the speciality team registrar or consultant via switchboard when in a time critical situation. (bleep 607 rsh) and (bleep 102 prh).

Referrals to a medical team with a request for them to not only provide a medical opinion but also to take over the care of the patient should be directed to the most appropriate specialist team as outlined above. If the on call consultant physician saw the patient, he/she will decide whether it is in the patient's best interests that a physician takes over the care of the patient. If the on call consultant deems that the patient should be under a physician, and that a specialist in put is required, he/she will advise the surgical team who to refer the patient to. If it is an acute general medical problem and it is right for the patient to be under the care of a physician the medical team will co-ordinate care. Pending transfer to a medical ward, the medical team will supervise care but the ward foundation doctor will continue with routine tasks as directed by the medical team. There should be an assumption that all patients accepted for medical care should be transferred to a medical ward within 4 hours of acceptance.

If the on call consultant physician saw the patient, he/she will decide whether it is in the patient's best interests that a physician takes over the care of the patient. If the on call consultant deems that the patient should be under a physician, and that a specialist in put is required, he/she will advise the surgical team who to refer the patient to. If it is an acute general medical problem and it is right for the patient to be under the care of a physician the medical team will co-ordinate care. Pending transfer to a medical ward, the medical team will supervise care but the ward foundation doctor will continue with routine tasks as directed by the medical team. There should be an assumption that all patients accepted for medical care should be transferred to a medical ward within 4 hours of acceptance.

3.3 PROCESS FOR REFERRAL FOR A GYNAECOLOGY OPINION:

Acute gynae emergencies are to be referred to the on call middle grade (bleep: 328) If there is failure of response then contact the gynaecology consultant of the day (resident 8am to 4pm and after this time the first on call consultant).

Acute obstetric emergencies outside the maternity unit (unusual) contact the on call middle grade (bleep 328) or if there is failure of response contact the consultant obstetrician of the day resident 8.30 am to 8.30 pm and then non-resident)

Pending transfer to a gynaecology ward, the gynaecology team will supervise care but the ward foundation doctor will continue with routine tasks as directed by the gynaecology team. There should be an assumption that all patients accepted for gynaecology care should be transferred to the gynaecology ward within 4 hours of acceptance.

3.4 PROCESS OF REFERRAL OF PATIENTS FOR SPECIALTY OPINION

- All directorates and subspecialties must make arrangements to provide specialist opinions on inpatients within 24 hours of the request being made in the non-urgent setting during the working week.

- Standards of delivering a specialist opinion must be agreed, communicated, and audited against.

- Means of referral need to be clear, consistent, and communicated.
- Each speciality should implement and advertise a consistent telephone advice service for internal and external clinicians to access.
- Those providing OOH including weekend specialist services to ensure means and criteria for referral are communicated and accessible.
- Maximally utilise clinic capacity, underpinned by clinical referral pathways, in support of appropriate use of rapid access/ambulatory care activity.

The role of specialist services in Emergency Pathways

at The Shrewsbury and Telford Hospital NHS Trust

I confirm that I have read this document and agree that my directorate will deliver care according to the recommendations included within it. Any special conditions and exceptions for my directorate that have been agreed with the site team are listed below.

Signature.....Clinical Director

Directorate.....

Date.....

Special exclusions