Internal Professional Standards for Clinicians Working in SaTH Urgent Care Pathways – Updated Version During Covid-19 Pandemic

The Shrewsbury and Telford Hospital NHS Trust

1. **Expected Timelines**: ED operate a senior rapid assessment system to check all plans made for ED patients have had senior input. The ideal timelines for urgent pathway patients are:

Ambulance offloading and Initial Assessment (ED):	within 15 minutes
Time to first clinician (ED):	within 60 minutes
Time to senior plan made and documented (ED):	within 90 minutes
Time to speciality referral (if indicated) - ED:	within 90 minutes
Time to speciality assessment (in assessment area if possible):	within 30 minutes of referral or within total 2 hours
Time for speciality decision to admit:	within 30 minutes from assessment
Time to leave ED (ED & specialities):	within 3 ½ hours

A referral to speciality needs to be made by an ED clinician ST1 level equivalent or above.

2. **Referrals & Disputes**: A referral is a request for help from a colleague – the default answer is "yes". A referral cannot be conditional on test results. Refusals and disputes about patient ownership are dangerous and will not be tolerated at SATH. Any disputes about patient ownership will be escalated to the ED consultant in charge / on-call. This will trigger a resolution of the problem or a conversation between ED consultant and speciality consultant to ensure definitive handover and ownership. Thereafter the escalation is:

   a) Divisional Director Medicine & Emergency Care

   b) Deputy MD

   c) Executive MD

   ED referrals are made for assessment, a short stay admission or a definitive admission – this is part of the clinical discussion between clinicians. A junior doctor cannot refuse to assess or admit an ED referral without discussion with their consultant. Their consultant should have a consultant to consultant discussion with another specialty consultant to agree which team is admitting. However, referrals cannot be "handed back" to ED. The ED consultant on-call or in-charge has the final say to which speciality the patient is referred and admitted to if specialists cannot agree.

3. **Direct referrals**: Patients arriving in ED in possession of a current GP referral letter, or referred to a speciality by phone by their GP, or referred by the CCC or a community referrer will be directly referred to a speciality from the outset – this referral can be made by the ED clinical navigator, by an ED middle grade or consultant or by the ED nurse in charge. Cohorting and location decision as in 3.
   Example: ? DVT with a GP letter – can go directly to SDEC.
   Exception: Conditions that can **ONLY** be treated in ED – e.g. ? shoulder dislocation;

   Patients who are arriving by ambulance from a GP who need resuscitation area – these will be seen by the speciality teams with help and input from ED in Resus.

4. **Returners**: Patients discharged within 24 hours from speciality care and presenting with the same clinical problem will be automatically referred back to the clinical speciality they were discharged from. Principles 2 & 3 apply.

5. **Sick / COVID patients**: Speciality referrals who are very sick, in the Resus area, or high risk for COVID, will need to be reviewed by a suitably senior speciality doctor in the appropriate area (e.g. COVID HIGH RISK zone) prior to transfer. The timelines in 1 apply.

6. **Ward transfers**: Nursing handover can only take place between **two qualified nurses** on the phone, face to face or during transfer of the patient to the ward. Patients who have been referred from ED to speciality will be moved to a ward or AMU bed within 30 minutes of that bed being declared. Wards which have empty beds should be ready to accept an admission within 30 minutes at any time. At a minimum, patients will have the combined ED / AMU clerking completed and their current known medication prescribed on a drug chart and a VTE assessment completed. A concise clinician to clinician handover will take place on referral and when a patient has had an ED senior review but not a speciality senior review, the on call speciality middle grade will be contacted with the details of the patient and their ward destination (see SOP). Handovers can still take place during meal times, but this should be kept to a minimum. The site office operates a medical tracking system to ensure no medical admission is 'lost'.

7. **Side Rooms**: Generally, SATH's IPCC guidance for side rooms applies (other pathogens). During the pandemic, a high or medium risk patient will be placed in an appropriate cohorting area – this cannot always and does not have to be a side room, provided they are placed on an appropriate cohort ward under the right speciality with the right PPE policy in place on that ward. The final arbiter of side room disputes are the site offices / CSMs: (RSH Tel.1203 / Bleep 886 – PRH Tel.:4027 Bleep 109)

8. **Speciality Pathways**: During COVID, many specialities (Gynaecology, Stroke, Paediatrics, Trauma & Orthopaedics) are operating 'transfer to assess' pathways to segregate admission areas. Please familiarize yourself with these and adhere to these pathways in order to keep ED transfer time to a minimum. These pathways were designed to minimize the number of contacts with clinicians and other staff. They also help getting the patients quicker to the right speciality.

9. **Sepsis**: Clinicians at SATH commit to timely completion of sepsis assessment and treatment. We regard completion of the sepsis assessment pathway within 15 minutes and completion of the sepsis bundle and review by an ST3 (or equivalent) or above within 60 minutes (https://www.rcem.ac.uk/docs/Sepsis/Sepsis%20Toolkit.pdf) as our prime responsibility. To not do so would mean putting lives at risk.

10. **Critical Care Patients**: Every patient admitted to Critical Care needs to be owned by the admitting speciality consultant (e.g. respiratory). This includes a daily check-in with the critical care team by the speciality ward round, and a seamless handover back to the ward / speciality team when the patient has recovered. In case of a change of diagnosis, the critical care consultant looking after the patient decides which speciality the patient is handed back to. In case of disputes, **2.** applies.

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