ADMISSIONS POLICY
PROCEDURES AND GUIDELINES

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Ratified by: Management Board
Date: June 2005
Review: June 2007
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## GLOSSARY OF TERMS

<table>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ASPH</td>
<td>Ashford &amp; St. Peter’s Hospitals</td>
</tr>
<tr>
<td>CCU</td>
<td>Coronary Care Unit</td>
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<tr>
<td>CF</td>
<td>Cystic Fibrosis</td>
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<td>COE</td>
<td>Care of the Elderly</td>
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<td>DTA</td>
<td>Decision to Admit</td>
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<td>EBS</td>
<td>Emergency Bed Service</td>
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<tr>
<td>ECMS</td>
<td>Emergency Capacity Management System</td>
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<td>ED</td>
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<td>EPS</td>
<td>Electro Physiological Studies</td>
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<td>Early Pregnancy Unit</td>
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<td>ICD</td>
<td>Internal Cardiac Defib</td>
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<tr>
<td>IgA</td>
<td>Immuno-globulin A</td>
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<td>ITU</td>
<td>Intensive Care Unit</td>
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<td>MAU</td>
<td>Medical Assessment Unit</td>
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<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus</td>
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<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>ODP'S</td>
<td>Operation Departmental Practitioners</td>
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<td>OPD</td>
<td>Out Patients Department</td>
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<td>PAS</td>
<td>Patient Access Service</td>
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<td>SITREP</td>
<td>Situation Report</td>
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<td>SWCCN</td>
<td>Surrey Wide Critical Care Network</td>
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<tr>
<td>TCI</td>
<td>To Come In</td>
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ASHFORD & ST. PETER'S HOSPITAL NHS TRUST

ADMISSIONS POLICY PROCEDURES AND GUIDELINES

ADMISSIONS

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1. CAPACITY MANAGEMENT

1.1 AIMS
To ensure that:

- Patients are admitted to Ashford & St Peter’s Hospitals for appropriate clinical reasons. Patients should not be admitted due to lack of social support.
- There is minimum disruption to planned elective admissions whilst responding positively to emergency admission requirements.
- Patients are provided with the bed placement that is most appropriate to their medical need and which takes into account any additional special needs throughout their inpatient stay.
- If a patient’s medical needs change, the decision to alter the patient’s bed location will take account of:
  - the time that the patient would spend in an alternative speciality
  - the ability of an alternative speciality to respond to the patients care needs, (if it is only a temporary placement)
  - the overall on-costs to patients and carers of any move.
If a move occurs, continuity of care needs to be maintained and effective communication of treatment/care protocols are a priority.
- When patient’s specific conditions have been assessed/stabilised/treated and there remains no medical need for the patient to remain in hospital the patient should be moved to a more appropriate environment without delay.
- All staff utilise the Capacity Management system.
- A “Real Time” Capacity Management system is operating.

1.2 PRINCIPLES OF CAPACITY MANAGEMENT
The Capacity Manager’s and in their absence, Site Co-ordinator’s are responsible for:

i Co-ordinating the movement of patients through admission and transfer processes
ii Ensuring appropriate communication between the medical staff, the wards and the Accident and Emergency (A&E) / Emergency Department (ED).
iii Liaison with the relevant managers/clinicians in respect of prioritising admissions and to initiate contingency plans, if necessary.
iv Patients and/or families will be provided with comprehensive information and reassurance about their treatment and care following admission.
v Children, pregnant women and post-natal mothers and babies will always be admitted to the appropriate clinical unit for their age and condition.
vi Patients will be referred to specialist nursing/therapy departments as soon as a need is identified.
vii Discharge planning will commence prior to admission for planned admissions and on admission, or as soon after admission as possible, for emergency admissions.
A patient (presenting at Ashford hospital) warranting admission for specific speciality intervention (Gynaecological, Surgical and Orthopaedic) should be “Treated and Transferred” (See Appendix 1 & 1a for Guidelines on Emergency Assessment and Transfer of Patients) to St Peter’s. Depending on the condition of the patient, (i.e., if the patient has IV drugs insitu) the patient will be transferred in an ambulance and accompanied by

viii a paramedic,
ix a nurse and paramedic or
x a doctor, nurse and paramedic.

xi On admission it is essential that patients with mental health needs/learning difficulties have their community psychiatric nurse/key worker notified of their admission.

xii If a patient does not warrant admission on clinical grounds, but it may be unsafe to discharge them because of their social situation from the A&E, ED or Medical Admissions Unit (MAU), then an Occupational Therapist Care Manager or the Intermediate Care Team should be informed in an attempt to facilitate immediate discharge.

xiii Where a patient is living alone with no immediate support, during office hours the Intermediate Care Sister or Duty Case Manager (dependent on whether the concern is nursing or social) should be contacted in the usual way. Contact telephone numbers and bleep numbers are kept in A&E / ED.

xiv Out of office hours, when a need for services is identified, the Emergency Duty Intermediate Care Sister or Duty Care Manager, should be informed at the earliest opportunity (on-call contact numbers can be obtained via switchboard).

1.2.1 Single sex accommodation

- Except in emergencies, patients have the right to be told before they come into hospital, whether it is planned to care for them in a bay of mixed gender. In all cases, they can expect single-sex washing and toilet facilities. If any patient would prefer to be cared for in a single-gender bay their wishes will be respected wherever possible.

- For emergency or elective patients, if single-gender accommodation is not available at the time proposed for admission, the patient will have the choice of accepting immediate admission or waiting for single-gender accommodation to become available. Where single-gender accommodation is not provided (ITU, HDU, MAU, CCU DSU and Angio Bay) the patient will be informed. At no time should Gynaecology or Urology patients be in mixed gender accommodation.

1.3 BED MANAGEMENT PROCESSES

a) Assessment of bed state

i. There will be a minimum of four bed states (AH & SPH) obtained daily. Bed states will be assessed routinely at:

   06.30 by the Site Co-ordinator
   08.30 by the Admissions Office
   10.30 & 15.00hrs (at CAT meeting)
   19.30 by the Site/Co-ordinator

**NB.** At all other times the Capacity Manager/Site Co-ordinator should ensure they are appraised of the current site-specific bed-state.

ii. All wards must ensure the Capacity Managers/Site Co-ordinators are kept up to date regarding the current bed status.

iii. All ward rounds should be planned **AM** in order to expedite progression of patients through the hospital system.

iv. It is the responsibility of the nurse in charge to ensure that trained nurses are aware of the current bed-state and the forecast for the next 12 hours, including all outliers on the ward.

v. When confirming a bed state, empty beds must be declared even when they are identified for expected patients. The nurse confirming the bed-state should inform the Capacity Manager or Site Co-ordinator that they are expecting a patient for a particular bed (this includes patients expected from other hospitals).

b) Establishment of the number of emergency admissions

i. It is the responsibility of the admitting Consultant, or their deputy (SHO/REG), warrants admission.
ii. The responsibility of locating vacant beds for emergency patients lies with the Capacity Manager/Site Co-ordinator. The Capacity Manager/Site Co-ordinator will liaise with the Nurse in charge when a suitable bed has been identified.

iii. The trolley wait definition is in accordance with National guidelines and has been agreed by DOH – Sitrep/ROCR (2003). The waiting time in relation to trolley waits begins when there is a decision to admit, not from the arrival time in A&E. **Total time in A&E must not exceed 4 hrs.** It is the responsibility of the A&E shift leader to measure waits. Patients are moved out according to how long they are in the department following a decision to admit and according to clinical priority.

iv. Please see Appendix 2 for Admission of Medical Patients to the MAU. (Appendix 2a; 2b; 2c' for Capacity Management Flow SPH & AH Medical Patients and A&E/Ward Communication Guidelines)

v. For all specialities there is a need to maintain speciality Consultant based wards. However if there is a need to outlie patients, please refer to guidelines displayed in each ward and the Site Co-ordinators file for transferring patients as outliers – ‘Buddy Link System’. (See Appendix 2)

vi. When the St Peter’s and Ashford’s ED A&E Department has reached maximum capacity, the Observation Bay (SPH) & Theatre Area (AH) may be used to accommodate patients either awaiting transfer to a ward area, or patients who require 24 hour observation (and/or pending results of tests etc. may be discharged). See Appendix 8.

vii. Any patient awaiting Emergency Theatre or Endoscopy may be transferred to the Day Unit or Endoscopy Unit as priority prior to transfer to ward bed.

c) Review of numbers of patients waiting planned admission

i. The day before admission, the CAT meetings will assess projected discharges across the hospitals and the number of pre-cancelled elective patients for admission, to assess whether planned admissions can still be accommodated. (See Appendix 4; 4a & 4b)

ii. The admissions list should indicate whether the planned admission is urgent/routine or a ‘long waiter’, and whether a patient has been cancelled on a previous occasion, in order to avoid second cancellation.

d) Prioritisation of emergency and elective admissions, leading to cancellations/deferments

i. On the day of admission if there are sufficient beds, admissions office will confirm bed availability with the patient. Fielding at Ashford Hospital confirm directly.

ii. If there are insufficient beds to accommodate all planned admissions the admission office staff will, inform the patient, the Consultant’s secretary. The Capacity Managers will inform theatres.

iii. Priority rating of Elective patients:

   - PRIORITY ONE    Clinically urgent (must come in)
   - PRIORITY TWO    “Long Waiters”
   - PRIORITY THREE Routines can be rescheduled within 4 weeks

iii. Priority should usually be given to those patients awaiting a bed in the A&E / ED. Examples of when planned admissions supersede emergency admissions include patients with clinically urgent conditions i.e. cancer or a long waiter (11 months +).

iv. In the event of dispute the Capacity Manager will refer to the Head of Admissions and/or the Director of Operations, whose decision is final

iii. The Admissions Office and the Capacity Manager/Site Co-ordinator must record all cancelled/deferred admissions. All patients who are cancelled on the day of admission should be offered a re-admission date within 28 days. **No patient under the 28 day rule will be cancelled.**

v. All cancellations should be made in advance of the ‘to come in’ (TCI) date, rather than ‘on the day’, wherever possible. (See Appendix 4 & 4a for Pre-cancellation Protocol and Explanation of Pre-cancellation & Cancellation (on the day).

vi. Patients not fitting the Day Surgery criteria are admitted to an inpatient ward but may be discharged the same day, if fully recovered.

1.3.1 Bed Crisis
As and when serious bed shortages are anticipated, actions should be taken according to the Capacity Management Policy (See Appendix 3)

Pre-cancellation Guidelines (See Appendix 4)

Admission Criteria for Day Surgery please see Appendix 5

For guidelines on the use of Private Capacity, please see (Appendix 6, Guidelines for NHS Admissions to Private Hospitals. & 6a, Guidelines for Transfer of NHS Patients to Private Hospitals (Runnymede & Shakespeare Suite).

1.3.2 Doctor’s Responsibilities Regarding Capacity Management

i. Ensure that the Capacity Manager/Site Co-ordinator is informed of ALL patients requiring admission or transfer from any area within or external to the hospital

ii. Plan the case mix of elective admissions in accordance with anticipated availability of beds and theatre time

iii. Identify the priority of patients for admission (using clinical and social criteria as appropriate) during the out-patient consultation. Ensure patients are informed of anticipated length of stay.

iv. Visit ‘outlying’ patients daily

v. Ensure that the medical contribution to each patient’s discharge is directed at achieving a problem free discharge and that discharges are planned a minimum of 24hrs in advance.

vi. Ensure that all patients for discharge are reviewed as a priority every morning, except when urgent clinical need dictates otherwise

vii. Ensure all post-take ward rounds take place am and that a discharge date, including plan of action is clearly documented.

viii. Identify patients suitable for transfer to MAU or AH/SPH according to clinical priority in response to capacity speciality deficits.

1.4 TRANSFER OF PATIENTS

Patients may be transferred for treatment to or from other hospitals. Reasons for transferring patients include:

- Bed shortages
- Patient to receive private treatment
- Tertiary referrals

1.4.1 Treat and Transfer

Treat and transfer of emergency patients from the A&E, ED, MAU or Ward to a cover site is part of the Capacity Management Plan and used in the event of bed shortage. (See Appendix 1a)

1. The current bed -state should be ascertained. This is to include the following information:
   i. Update regarding patients awaiting a bed in A&E, ED or MAU
   ii. Availability of additional bed cover at either Ashford or St Peter’s
   iii. If bed cover is required and is available, the extent of the cover is to be agreed and communicated to all appropriate doctors on both sites, by the Capacity Manager / Site Co-ordinator/Discharge Co-ordinator following the post-take ward round.

2. Doctors must ensure that a full hand over is given to the receiving site providing the cover. Registrar to Registrar hand-over, (including plan of care, urgent tests pending, special needs e.g. disability, hearing problems etc).

3. Patients transferred should be transported direct to the cover hospital ward and not A&E/ED

4. Notes and x-rays must accompany patients on transfer
5. Transport can be arranged via the Ambulance Service. Ensure they are informed of the treat and transfer arrangement and transfer the patients to the appropriate receiving area/ward. No patients should be transferred after 10pm.

**NOTE:** All patients for transfer must be considered clinically stable

6. It is essential that a record is kept (including accepting Doctors name) of all patients transferred to outlying areas, including the private hospitals

7. The Capacity Manager or Site Co-ordinator out of hours will ensure that doctors know the location of their patients

8. If patients are transferred at weekends, a record should be forwarded to the Capacity Manager

9. All patients transferred must have a property checklist completed prior to transfer and checked on the receiving ward.

10. If NHS patients are transferred to a private hospital who are for discharge the next day, all medications including TTO’s should accompany the patient. The family should be informed and where possible, discharge transport arranged in advance of the transfer.

11. The Shakespeare Suite and Runnymede Hospital occasionally experience difficulty when trying to contact doctors to review patients. If patients need to be reviewed between 17.00 hours and 09.00 hours, the appropriate on call team must be notified of the transfer.

12. The Capacity Manager and Discharge Co-ordinators will monitor all patients transferred

### 1.4.2 Escorts for patient transfers to other hospitals

ODP’s are expected to act as escort in support of anaesthetist if the patient has a compromised airway. ODP’s should not be asked to substitute for nurses in escort situations.

### 1.5 PATIENT REPATRIATION (ASPH)

Patients admitted for treatment to another hospital should be repatriated to a hospital of their own residence, avoiding unnecessary delays.

All inter-hospital sites are programmed to occur during the working day so that patients transferred from a ward in another hospital to a ward within the Ashford & St Peter’s Hospitals should arrive at a time that allows for the ward based team to make a formal assessment of the patient and programme a planned course of action required to cover specific needs.

All teams receiving patients from inter-hospital transfer should insist on a full documentation of patient’s clinical state prior to transfer and should be aware if patients are being transferred in a clinically critical condition.

If patients are deemed to be potentially unstable or require immediate assessment for the possibility of subsequent speciality involvement or if the patients arrive outside working hours that the initial point of delivery of the patient should be to Accident & Emergency or the Emergency Department.

This would provide a safe supervised site for the initial processing of the patient. The on-call speciality team should then be informed if a patient is likely to arrive after 5pm.

#### 1.5.1 High Priority Patients

i. Patients transferred from secondary care to tertiary centres for specialist treatment

ii. Patients transferred to another hospital for intensive care for immediate capacity reasons

#### 1.5.2 Medium Priority Patients

i. Patients admitted to another hospital under a ‘treat and transfer’ arrangement, who have continuing clinical needs

ii. Local residents admitted to another hospital, who are actively under the host hospital for a related condition and who have continuing clinical needs

The receiving hospital has a clear responsibility for these patients and is obliged to respond promptly. The patients should be repatriated within 48 hours of the request.
1.5.3 Standard Priority Patients

i. Local residents, admitted to another hospital, who are not known to the host hospital, but who have continuing clinical needs

ii. Local residents admitted to another hospital that have continuing or complex care (as distinct from clinical)needs that are best organised by the receiving hospital prior to discharge.

The receiving hospital has responsibility for these patients. They should be repatriated within 7 days of the request.

1.5.4 Special group - Local residents being repatriated from abroad

i. If the host hospital has the facilities needed, the patients should be accepted for repatriation within 48 hours

ii. If admission to a specialist unit is needed, the host hospital should accept within 48 hours and make the tertiary referral, although the patient may go directly to the specialist centre

iii. The requirement is for the host hospital to be involved in the referral so that subsequent repatriation is more easily achieved. At the appropriate time, repatriation to the host hospital should proceed in line with the timetable for such moves i.e. within 24 hours to the request.

1.5.5 The Process

Consideration must be given to pressures within the A&E, ED, MAU and to elective activity. Patients should be placed according to previous consultant episode. **In all cases, the relevant clinician must first authorise the repatriation**

i. Patients who live within the Ashford & St Peter’s Hospitals catchment area, who are admitted as an emergency into “out of area” hospitals, require Registrar to Registrar referral.

ii. Liaison thereafter should be between the respective Capacity Managers or out of hours the Site Co-ordinator

iii. With repatriation following an ICU transfer, the aim should be to transfer directly from the ICU of the host hospital to the receiving hospital’s general ward, HDU or ICU.

iv. Orthopaedic wards require the patient to have one MRSA screening clearance or 3 if contact has been involved.

v. In all cases, it is the responsibility of the hospital seeking the repatriation to make contact with the appropriate Capacity Manager at the receiving hospital and to provide all relevant clinical and social information

vi. Hospital MRSA screening policies should not prevent them from meeting their obligations under this protocol

vii. The time limits should be observed at the weekends as well as during the week. Although it is recognised that local Capacity Management arrangements and the availability of the accepting clinical team at the weekends may have an influence

1.6 EMERGENCY CAPACITY MANAGEMENT SCHEME (ECMS)

The ECMS is responsible for controlling all GP and 999 generated emergency admissions. Patients who live in areas that are equidistant from more than one hospital are transported to the one under the least pressure at the time of the call. The scheme is to help ensure that patient workload is shared more equally whilst protecting the interests of patients and their relatives. **(Please see Appendix 11 for details of ECMS)**

1.7 ADMISSIONS OFFICE CASENOTE RETRIEVAL GUIDELINES

(See Appendix 7 for Admissions Office Case note Retrieval Guidelines)

**Section 2**

**ADMISSION POLICIES BY LOCATION**

**2.1 EMERGENCY ADMISSIONS**
i. All Emergency admissions will be admitted via the A&E/ED, (ASPH). Gynaecology patients may be admitted via the Early Pregnancy Unit (EPU). The Capacity Manager/Site Co-ordinator must be informed of all admissions.

ii. Emergency Surgical admissions will be seen and assessed initially by a House Officer (at St. Peters) followed by a Registrar. For Orthopaedics a Senior House Officer will be required to assess patients prior to a decision to admit.

iii. Patients admitted as Emergencies will be admitted under the care of the admitting team and should be transferred to the care of the Consultant specialising in the patient’s particular condition via a formal referral process.

iv. Where possible all Surgical/Orthopaedic patients will be admitted to their speciality ward area. (Please see Appendix 8 for Guidelines on the use of the Observation Bay AH & SPH)

2.2 MEDICAL ADMISSIONS

i. Sources of medical admissions are:
   * Acute referral to A&E/ED/MAU
   * Arranged review in the A&E/ED
   * Admission via Out-Patient Department,

ii. All medical admissions will be seen by a medical Senior House Officer (SHO) or Registrar to assess their medical condition.

iii. All acutely ill patients will be initially assessed by the on-take team. Following a DTA, patients must be transferred to a bed according to their speciality needs.

iv. Patients may be admitted from A&E/ED for further observation and assessment. These patients should be transferred MAU. Plans for investigation and early referral for relevant investigation should be initiated within the first 24 hours of admission.

v. All attempts should be made to avoid admission of patients who are medically stable but do not have sufficient support to return to the home environment. Such patients should be referred to the Intermediate Care Team to see if direct discharge can be facilitated. If these patients are admitted, early involvement of social services and/or the elderly care teams is essential. For further information, please refer to the Discharge Policy.

2.2 TRANSFER FROM A&E OR EMERGENCY DEPARTMENT

i. Following a “decision to admit”, all patients will be transferred as soon as possible from the A&E/ED dept to a ward appropriate for their ongoing, specialist needs. Hand-over will take place on the ward. (See Appendix 2c A&E/Ward Communication Guidelines).

2.4 ACUTE ADMISSIONS FROM THE OUTPATIENT DEPARTMENT (OPD)

i. Acute admissions from the Outpatient Department must be sanctioned by a Registrar or a Consultant

ii. These acute admissions will remain under the care of the admitting team, unless a formal referral to another team/speciality is made.

iii. All admissions from the OPD must be admitted direct to an appropriate ward area via the Capacity Manager. In the event there is no immediate ward bed, patients should wait in the DSU (up to 7.30pm) or clinic area (up to 5pm). Patients can remain in OPD providing the following criteria are met:
   • Patients do not require acute care e.g. nebulisers, IV drugs, IV fluids.
   • The appropriate level of nursing support is available
   • The patients Waterlow scale is appropriate.

NB: If a patients condition is such that intensive immediate treatment is required the patient should be transferred to A&E/ED.

Capacity Managers must ensure clinics are informed of transfer time to ward before 5pm.
2.5 PLANNED MEDICAL ADMISSIONS

In-patient admission for investigations or observation is sometimes required. For Day-case investigations/transfusion, where possible the DSU should be used. Where possible, tests should be pre-booked to limit in-patient stay. All routine admissions must be sanctioned at consultant level. The Admissions Office and Capacity Managers must be notified in advance of the expected admission date. Planned admissions should not come in over a weekend unless the on-call team has been informed in advance and initial investigations required instigated.

2.6 MEDICAL ASSESSMENT UNIT (MAU)

i. Acute Medical Assessment Units enable a prompt and safe assessment of all GP medical referrals. Following assessment, and if there is a DTA, patients should be transferred to a ward bed appropriate to their speciality need. All other patients should be discharged within 48 hours.  See Appendices 2; 2a; 2b & 2c

ii The ECMS (Emergency Capacity Management Scheme) will inform MAU of all expected direct admissions and allocate a ECMS number. The SHO will inform the MAU Co-ordinator of all in-coming patients to allow adequate preparation and trolley allocation.

iii The patient should come with a GP letter.

iv The Ward Clerk will obtain the patients notes and x-rays; out of hours, these can be obtained via A&E.

2.7 CORONARY CARE UNIT (CRITICAL CARE UNIT AH, CORONARY CARE UNIT SPH)

A copy of flow-charts’ 1 – 4, relating to: Coronary Care Unit admissions can be found in Appendix 12.

a) Eligibility Criteria

There is no age limit for admission of patients to the Coronary Care Unit.

Any patient with Angina, Myocardial Infarction (Fast Track MI – STREP/TPA), Heart Failure, Arrhythmia’s i.e., Ventricular Tachycardias, new Supraventricular Tachycardias for Cardioversion/Angioplasties/Electro-physiological Studies or patients with chest pain, can be admitted to the Coronary Care Unit.

Because of the nature of the Unit, patients of both sexes can be accommodated in the same area.

b) Admission

i. Only the SHO and above may admit patients to the Coronary Care Unit.

ii. Only Senior Nurses (Sister), in the Coronary Care Unit may accept patients for admission. (The CCU must ensure the Capacity Manager is informed as soon as a request for a bed has been made).

iii. If possible an empty bed should be made readily available to receive emergency admissions from A&E/ED/MAU or other departments within the Hospital.

iv. If CCU is full and there are no patients suitable for transfer out of the Unit, emergency patients can be admitted to ITU, after consultation with the Consultant/Registrar Anaesthetist. It is the responsibility of the SHO/Registrar, to make the necessary arrangements and to keep the Capacity Manager informed. As soon as possible, a bed needs to be created in Coronary Care Unit and the patient from ITU repatriated.

NB: The day bed will be reserved for patients requiring EPS studies. This bed will also be used as over-spill for emergency admissions (Angio Suite to be informed).

2.8 CHAUCER WARD – STROKE UNIT (ASHFORD)

Flow charts relating to the Chaucer Ward admissions can be found in Appendix. 13

Chaucer ward is a 16-bedded unit for the use of patients with a diagnosis of stroke or head injury, who require rehabilitation.

a) Criteria for admission
i. The following criteria should be met for a patient to be admitted to the Stroke Unit:
   Adults aged 17 years and above.
   Clinical diagnosis of stroke or head injury.
   Potential impact of intensive rehabilitation must be deemed as positive.

NB: Patients are not to be unconscious (unless there is no alternative placement).

ii. If there is a bed shortage, a medical patient with elderly care needs may be admitted

iii. No unstable cardiac or high dependant patients should be admitted unless there is appropriate specialised nursing supervision

iv. Where possible stroke/head injury patients “outlying” in other areas should be repatriated.

b) Access to beds

i. Referral to the stroke unit must be made by either the admitting medical team or via SPH Care of the Elderly Consultants/ or the on-call Medical Registrar.

ii. Each referral will be discussed by the Doctor with the appropriate Consultant and Sister or nominated deputy at the earliest opportunity.

iii. The final decision will be based upon admission criteria and overall availability of beds.

iv. Responsibility for the care of the patient will remain under the lead Consultant for the unit.

v. The Registrar or SHO, will clerk the patient using the standard Stroke Unit proforma.

vi. Under normal circumstances, further investigations, treatment and general management will follow the Stroke Unit Integrated Care Pathway (ICP). Significant variances from the ICP (e.g. development of complications, requirements for medical intervention i.e. invasive procedures) may warrant transfer of patient to alternative speciality area.

NB: Stroke Lead Consultant will identify patients for transfer in/out of unit.

2.9 ANGIOGRAPHY

Angiography procedures are carried out in the Angiography Suite at St Peter’s Hospital. Information regarding the need for Inpatient Coronary Angiography can be found in Appendix 14... A flow chart outlining the procedure to follow for patient transfer for Day Case Angiography (from Ashford Hospital – St Peter’s Hospital) is found in Appendix 15.

2.10. PHYSIOTHERAPY EMERGENCY ON-CALL (See Appendix 16)

Section 3

ADMISSIONS POLICY FOR THE SURGICAL, ORTHOPAEDIC & TRAUMA DIRECTORATES (See Appendix 17)

3.1 ADMISSION CATEGORIES

Patients are admitted to the Surgical Directorate as:
Acute admissions, via the Accident and Emergency Department
Acute admissions, via the Out Patient Department
Elective admissions from the waiting list.
Booked Admissions Project (BAP) – See Booked Admissions Policy
Pathway for Adult Trauma Patient – (See Appendix 17a)
3.2 PATIENTS WHO DO NOT ARRIVE

Consultants will be notified via their secretary, of patients who “do not arrive”. The consultant/secretary will:

i. Refer the patient to the Waiting List Co-ordinators for validation/rescheduling.
ii. Specify a new date for admission.

3.3 LATE CANCELLATIONS

If an elective patient has been brought in for surgery on their “to come in” date yet subsequently cancelled i.e. lack of theatre time, no ITU bed, etc the admissions office will ensure outcomes are correct and updated on PAS.

See Appendix 4c for Overview of Cancellation Procedures on Admission offers before and after admission of patient.

3.4 MANAGEMENT OF WEEKEND BOOKED ADMISSIONS

There are commonly Sunday electives booked admissions to come in for operations on the Monday. However, there are only occasional Saturday booked admissions.

See Appendix 4b for the process to follow for weekend electives booked admissions & threatened cancellations.

3.5 GUIDELINES TO FOLLOW IN THE EVENT OF A THREATENED CANCELLATION:

(See Appendix 4b)

3.6 PRIVATE PATIENTS REFERRED TO THE NHS:

If a patient has had a private consultation and subsequently wishes to move into the NHS system within ASPH then the consultant should write to the GP to inform the GP of the transfer and the reasons for it. No transfer should take place if the patient would not ordinarily have been referred to the NHS in the first instance i.e. the referral should follow the usual criteria for referral to the NHS specialist services.

In the event of such a transfer, the consultant must provide sufficient information to the Trust to allow notes to be made up. The initial private consultation will constitute the equivalent of the first Out Patient attendance to the Trust under this referral and communications and documentation should follow the NHS requirements, e.g. results of investigations, consultation record etc. For PAS purposes, the referral source of the patient will be private/consultant transfer not GP referral.

The patient will enter the appropriate next stage of the NHS system to allow care to proceed. Categorisation of the patient as urgent, soon or routine must be made in accordance with normal NHS practise. It is possible therefore that the patient’s first appearance at the hospital will be for any of the following as normal practice determines: follow up OP appointment; pre-operative assessment; diagnostic pathway to care. The patient will not be accepted as an NHS patient if the referral is solely for a single episode of access to the Trust prior to a return to private care for the duration of the pathway e.g. diagnostics only. These still constitute private access to services within the Trust, and must be clearly identified as such.

(Please see Appendix 6; Guidelines for NHS Admissions to Private Hospitals & 6a for Guidelines for the Transfer of NHS Patients to Private Hospitals (Runnymede & Shakespeare Suite).

3.7 PRE-ADMISSION CLINIC

Pre-admission clinics are held to avoid cancellations of unfit patients by addressing the problem prior to admission and to identify any clinical/social concerns before admission. Also to ensure patients receive a full pre-operative assessment and to advise patients, relatives and carers, so that on admission they are informed of what is to happen and their expected length of stay.
The aim is to have all Elective Surgical, Orthopaedic, Inpatients and Day cases attend Pre-admission clinics 3 – 6 weeks prior to their planned date of admission.

For Orthopaedics, once the patient has been deemed as fit for surgery their admission date is confirmed at pre-assessment this will soon be the case in other specialities.

All patients who require inpatient planned surgery are pre-assessed to:

- Assess if surgery is necessary, and whether the patient is fit to undergo the planned surgery.
- Provide information about the planned surgery and length of hospital stay, and minimize any anxiety regarding their admission and recovery.
- Involve other health professionals as appropriate as to the patient’s needs, at the earliest opportunity to ensure smooth provision of care and prevent delayed discharge.
- Involve the patient and carer where appropriate and with the patients consent, in the assessment process to help their understanding, and involve them in the care and support of the patient.

NB Where possible there should be a “pool” of patients who have been pre-assessed and are ready to come into hospital in an attempt to reduce the “did not arrive” rates of cancelled surgery. (NICE Pre-assessment Guidelines 2003)

3.8 DAY OF ADMISSION

- Patients for major surgery should be brought in to hospital the afternoon before a morning. Procedure and in the morning of the operation, for an afternoon procedure (unless specific preparation is required).
- Patients are asked to telephone the Admissions Office prior to admission to confirm that a bed is available.

3.9 GUIDANCE FOR ADMISSION OF MEDICAL PATIENTS TO ORTHOPAEDIC WARDS

To minimise risks of wound infection to patients who have had orthopaedic surgery, the Infection Control Team advise, that patients with the following conditions are not admitted to Elm/Dickens Ward and only go to Juniper Ward when there is no other alternative.

- Surgical patients with abscesses
- Surgical patients going for major bowel surgery
- Medical patients in the initial acute stage of Methicillin Resistant Staphylococcus Aureus
- Medical patients in the initial acute stage of a chest infection with a productive cough
- Medical or surgical patients who are colonised/infected with Methicillin-Resistant Staphylococcus Aureus
- Patients with exfoliating skin conditions

N.B. Patients with chronic wounds such as pressure sores and leg ulcers should only be transferred following advice from a member of the Infection Control Team.

3.10 GYNAECOLOGICAL PATIENTS

Gynaecological patients (Ashford Hospital) should be transferred to St Peter’s Hospital A&E Department out of hours for review by the Gynaecological team prior to a decision to admit being made. (See Appendix 17).

3.10.1 Referral and Admission of Patients Attending the Early Pregnancy Unit (EPU)

i. The early pregnancy unit will:

- See patients with problems in early pregnancy, i.e. bleeding/pain from conception, until booked with the Midwife at around 14 weeks.
- Review patients whose miscarriage is treated conservatively.
- Review patients who have Laparoscopic Salpingostomy, for Ectopic Pregnancy.
ii. Referrals are received from GP’s, A&E/ED, the Ultrasound Scan Department, Midwives and self-referrals.

iii. It is not always necessary to see patients on the day of referral and may be more appropriate to see them the following day when there is access to an Ultrasound scan.

**NB:** Out of hour referrals are seen in A&E, dependent upon the source of referral.

If there are requirements for bed for a patient the Capacity Manager/Site Co-ordinator should be contacted immediately. Patients with Hyper-emesis should be transferred, where possible, to Joan Booker ward. Patients who may require urgent surgery should either be started off in the Day Surgery Unit or where possible sent to a bed on Kingfisher Ward.

For gynaecological patients requiring admission whom are seen at Ashford Hospital, (See Appendix 17) the on-call Registrar should be contacted to accept the patient. The Registrar must contact the Capacity Manager/Site Co-ordinator at St Peter’s to ascertain bed availability and agree appropriate time for transfer. All documentation must accompany the patient.(where possible such patients should be admitted to a ward area)

### 3.11. Admission to the Day Surgery Unit (DSU)

i. The decision to admit patients’, as inpatients or day cases shall in the first instance be made by the Consultant during the OPD consultation.

ii. All patients deemed appropriate to be treated as day cases, must be pre-assessed at the earliest possible point. If patients do not meet the criteria for Day Surgery, they should be referred immediately back to the Consultant’s secretary, who will ensure the patient is given a TCI (To come in) date as an inpatient.

iii. There may be occasions when it is not safe to discharge a patient home following day surgery, due to an unforeseen outcome following their procedure. In these circumstances an overnight bed will be secured

iv. Guidelines for Anaesthetic Suitability for Day Surgery (See Appendix 19)

v. Pre-operative Fasting Policy (See Appendix 18)

vi. British Association of Day Surgery proposed a “trolley” of procedures, which are suitable for day surgery in some cases. Annex A & Annex B (Appendix 20)

**NB:** There may be occasional circumstances, where it may be necessary to start an inpatient procedure in the DSU, to avoid a cancellation. The DSU should be notified of this as early as possible, in order that they may assess the bed availability within the unit.

## Section 4

### INTENSIVE CARE UNIT (ICU) ADMISSIONS POLICY

**INTRODUCTION**

i. The ICU should be available to all patients who are deemed recoverable and might reasonably benefit from the facility. The Unit at St Peter’s Hospital admits patients from the age of 16 and upwards; there is no upper age limit.

ii. It is recognised that the indication for admission is to provide specialist medical or nursing care.

iii. At Ashford Hospital there is the capacity to accommodate a maximum of three patients (1 x ventilated and 2 x HDU). At St Peter’s Hospital a maximum of eight ventilated patients can be cared for at any one time.

iv. Admission/Transfer Procedures. (See Appendix 21 for Criteria for & Admission to Critical Care and 21a. for Guidelines for the Transfer of Patients to Critical Care)

i. Before any patient can be admitted to the ICU, the Anaesthetic Registrar on call must be contacted. The Registrar of the admitting team should contact the Anaesthetic Registrar for ICU, who will liaise with ICU staff. If there is sufficient capacity and the patient meets the ICU admission criteria, then the referral will be accepted. The consultants in charge of the Unit have the absolute right to decide on all admissions and discharges to and from the Unit. Proposed major elective procedures, which will require postoperative intensive care, should be notified to the unit as soon as the surgery date is booked. Bed availability must be checked 24 hrs prior to the date of surgery and additional staff booked if required.

ii. All patients admitted to the ICU are the joint responsibility of the Anaesthetic team and the Consultant team under whom they were originally admitted to the hospital. The admitting team should provide medical care, unless
the patient is formally handed-over to another firm or to the anaesthetists. Anaesthetic staff will advise on respiratory therapy and aspects of intensive care. All patients must be visited at least once a day by the admitting team, or in the absence of the admitting team the on-call team must have a comprehensive hand-over and visit daily.

iii. A senior doctor (Registrar) should only institute any change to the treatment of a patient after consultation with the firms involved.

iv. A decision to transfer a patient out of ICU to the ward area will be made by the ICU team, in collaboration with the admitting team. (See Appendix 22)

4.1 TRANSFER OF PATIENTS FROM THE UNIT

a) When a patient is ready to transfer out of the ITU it is essential that the Capacity Manager be contacted or the Site Co-ordinator (out of hours), not the receiving ward. Patients should be transferred to a ward, which meets their specific speciality and nursing needs. The ITU nurse must give a full hand-over to a registered nurse from the receiving ward. All notes and X-rays must accompany the patient. Patients may outlie from the ITU to a ward area, in order to reduce delay in surgical emergency/elective intervention.

b) The patient must transfer as early as possible in order to minimize any delay of an admitting Intensive Care patient.

4.2 TRANSFER FROM ASHFORD HOSPITAL TO ST. PETERS ITU

i. The nurse in charge at Ashford CCU will contact the nurse in charge at St. Peter’s ITU, to check for bed availability.

ii. Only the nurse in charge of ITU can refuse a patient admission on the grounds of bed availability or staffing. The Anaesthetic Registrar needs to be made aware of this decision. If there is a problem regarding admission, the Head of Nursing or General Manager is to be consulted.

If a bed is available then:
- The referring doctor at Ashford Hospital needs to speak to the Anaesthetic Registrar at St. Peter’s Hospital to give details regarding the patient’s condition. The patient needs to be referred to a speciality team at St Peter’s Hospital by the admitting team at Ashford Hospital.
- Staff at Ashford Hospital will arrange transport and members of the transfer team (Anaesthetist, nurse, ODP) should be made aware.
- All notes and X-rays are to accompany the patient.

If a bed is not available:
- If there is no bed at St Peter’s Hospital ITU, the ECMS/NICBR should be contacted.

(For ITU Transfer flow from AH to SPH please see Appendix 25)

4.3 TRANSFER FROM A&E TO ITU

i. The nurse in charge in ICU should be contacted regarding bed availability.

ii. The Anaesthetic Registrar on-call for ITU needs to be contacted to go and assess the patient in the A&E department to check if it is an appropriate admission; prior to formally accepting the patient.

If there is a bed available:
- A&E staff are to liaise with ITU to admit the patient
- Where possible, a member of the ITU team (anaesthetist), should go to A&E to assess the patient
- ICU to be made aware of when the patient leaves A&E
- The patient should be accompanied to ITU by a registered member of the A&E team and a full hand-over must take place.
- All notes and X-rays must accompany the patient

If a bed is not available:
- ECMS/EBS is to be contacted by the nurse in charge of ITU, in order that a bed can be identified at an alternative site.
- Members of the transfer team should be notified
- ICU is to be contacted with the patient details for their “Refused Admission” data.
4.4 PRE TRANSFER DECISION
i. The Surrey Wide Critical Care Network (SWCCN) is committed to the safe transfer of all critical care patients who require transfer to a different critical care facility.

ii. Critical care transfers are necessary for clinical/specialist treatment. The SWCCN is committed to reducing, and hopefully negating, the need for non-clinical transfers.

iii. All attempts will be made to contain the critical care demand:
   a) within the individual acute Trusts
   b) within the SWCCN
   c) within the Transfer Groups

iv. All potential options will be explored within the individual Trusts’ critical care service prior to a decision being made to transfer a patient.

v. The following options should be explored by the nurse in charge of the critical care unit:
   i. Utilising an un-staffed bed in the critical care unit by the temporary use of:
      ➢ Moving appropriate nursing staff to critical care unit from Recovery or elsewhere in the Trust
      ➢ Nurse in charge caring for a patient
      ➢ Exploring Bank/Agency/Overtime options
      ➢ 1 nurse caring for 2 patients (1 nurse:2 patients ratio)
      ➢ Moving a nurse from another critical care unit in the SWCCN if possible and appropriate

   ii. Holding the patient in Recovery or an alternative safe place

   iii. Creating a bed in the critical care unit by discharging a patient to a step down area with Outreach support if appropriate

   iv. Re-evaluating patient/nursing dependency within the critical care unit

vi. Patient to be assessed by a Critical Care Consultant as to requirement for transfer and to explore other potential treatment options with the patient’s team.

4.5 TRANSFER DECISION
i. Once the decision has been made that a non-clinical transfer is unavoidable, the final decision for which patient should be transferred lies with the critical care consultant in charge.

ii. All units must follow the SWCCN joint transfer protocols with Surrey and Sussex Ambulance Service NHS Trusts.

iii. The decision regarding which patient could take into account the following:

   Patient safety/stability for transfer
   The existing patients on the critical care unit and their care requirements
   The number of previous transfers an individual patient may have had
   Ventilatory weaning programmes of particular patients

iv. Wherever possible, all patients will receive their required surgical procedures prior to transfer i.e. following “treat and transfer” principle.

4.6 DURING TRANSFER
i. All transfers will take place using the SWCCN joint transfer protocol with Surrey and Sussex Ambulance Service NHS Trusts.

ii. The SWCCN Transfer Audit Form (SWCCN 1) will be used for all critical care transfers and is the legal record of transfer.
iii. Adherence to the principles of “the management during transport” section of “Intensive Care Society” Guidelines for the transport of the critically ill adult patient” (2002)

4.7 POST TRANSFER

i. The SWCCN 1 form must be completed and a copy returned to the Network Coordinator.

ii. All transfer forms will be reviewed by the Network Medical Lead and Network Coordinator.

iii. Any clinical incidents arising from transfer will be investigated by the Network Medical Lead in conjunction with the lead consultant for critical care of the referring trust.

iv. A database of critical care transfers will be established and be utilised for data analysis, information and audit purposes.

v. An annual audit of Network critical care transfers will be undertaken and a relevant action plan produced

vi. Trust critical care transfers must be reviewed at each Trust Critical Care Delivery Group meeting

4.8 TRANSFERS OUT OF TRANSFER GROUP AND NETWORK

i. All transfers out of transfer group must be reported on the Network Adverse Transfer Form (Appendix 24)

ii. A copy of this form must be sent to the Trust Critical Care Manager or Senior Nurse for action within the Trust according to individual Trust policy

iii. A copy of this form must also be sent to the Network Co-ordinator for information and investigation

iv. All adverse transfers must be reported on the Trust SITREP reports to the Strategic Health Authority and relevant PCT

4.9 FOLLOW UP AND INVESTIGATION

i. All adverse critical care transfers must be investigated and a short report produced on the Network proforma (Appendix 23)

ii. Investigation of all adverse transfers will be initiated by the relevant Critical Care Manager or Senior Nurse and the Network Coordinator

iii. Feedback from these investigations will be provided to the Trust Critical Care Delivery Group

4.10 MANAGEMENT OF OUTLIERS (TRANSFERRED PATIENTS)

i. It is the responsibility of each individual critical care unit to monitor their outliers within each hospital they were transferred to on a regular basis or as decreed by local operational policy

ii. It is the principle ethos and responsibility of each individual critical care unit to facilitate repatriation of transferred patients as a priority if appropriate

4.11 TRUST/HOSPITAL TRANSFER GROUPS

The Department of Health requires Trusts to have identified specific groups of hospitals/ Trusts to contain transfers for non-clinical reasons, and therefore reduce the numbers of long distance transfers.
The agreed transfer groups for the Surrey Wide Critical Care Network are:

<table>
<thead>
<tr>
<th>Trust/ Hospital</th>
<th>Hospitals in Transfer Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford/ St. Peter’s</td>
<td>Frimley Park Hospital</td>
</tr>
<tr>
<td></td>
<td>Royal Surrey County Hospital</td>
</tr>
<tr>
<td></td>
<td>East Surrey Hospital</td>
</tr>
<tr>
<td></td>
<td>Crawley Hospital</td>
</tr>
<tr>
<td></td>
<td>Royal Surrey County Hospital</td>
</tr>
<tr>
<td></td>
<td>West Middlesex Hospital</td>
</tr>
<tr>
<td></td>
<td>Hillingdon Hospital</td>
</tr>
</tbody>
</table>

4.12 TRANSFER TO ITU ST. PETER’S HOSPITAL FROM OTHER AREAS OF THE TRUST

i. The nurse in charge of ITU should be contacted for bed availability
ii. The Outreach Team for ITU should be contacted to go and assess the patient to see if it is an appropriate transfer prior to formally accepting the patient.

If a bed is available:
- The ward or department must liaise with ITU for transfer of the patient
- Where possible a member of the ITU nursing team should go and assess the patient.
- A doctor and nurse from the relevant area must accompany the patient to ITU to give a formal hand-over.

If a bed is not available:
- The person in charge of ITU should contact ECMS/EBS in an attempt to transfer the patient to an alternative site.
- Members of the transfer team are to be notified by the nurse in charge of ITU.
- ICU is to be contacted with the patient details for their “Refused Admission” data.

Appendix 21: Criteria for & Admission to Critical Care; 21a: Guidelines for the Transfer of Patients to Critical Care.
Appendix 22 contains information relating to Transfers from Critical Care at Ashford, to ICU and Discharge from ITU
Appendix 23: Surrey Wide Critical Care Network (Report Proforma)
Appendix 24: Adverse Incident Form
Appendix 25: ITU Transfer from AH (CCU) to St Peters ITU

NB: The Capacity Manager is to be kept informed of all patient movements.

Section 5

ADMISSION POLICY FOR PAEDIATRICS

Information on admission to the paediatric areas is given in the table below.

<table>
<thead>
<tr>
<th>Age Range (years)</th>
<th>Merlin Day Unit (Day Surgery)</th>
<th>Oak/Ash</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 – 15 (cut off age is child’s 16th birthday (1-3 only when clinically urgent).)</td>
<td>0 – 16th birthday – if in full time education</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bed Capacity</th>
<th>Merlin Day Unit (Day Surgery)</th>
<th>Oak/Ash</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
<td>Oak</td>
</tr>
<tr>
<td></td>
<td>12 day beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 cubicle for medical/surgical admissions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opening hours 7.15 – 7.45 Monday – Friday</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ash</td>
<td></td>
</tr>
<tr>
<td></td>
<td>29 of which:-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 dedicated to 13-15 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 cubicles</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access</th>
<th>Merlin Day Unit (Day Surgery)</th>
<th>Oak/Ash</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned admission only</td>
<td>1) Planned admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Day care (Medical &amp; Surgical)</td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td>Transfer of patients requiring overnight stay from Merlin to Oak/Ash  Please see Appendix 26</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

**Guidelines For The Use Of Cubicles On Ash Ward**

<table>
<thead>
<tr>
<th>Children who require a cubicle for their own protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children with febrile neutropenia</td>
</tr>
<tr>
<td>• Children with severe immune deficiency</td>
</tr>
<tr>
<td>• Babies up to 6 weeks</td>
</tr>
</tbody>
</table>

**Note:**
- On some occasions it may be appropriate to put twin infants in one cubicle.
- Children with IgA deficiency do not require a cubicle.

<table>
<thead>
<tr>
<th>Children who are a risk to others</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chickenpox</td>
</tr>
<tr>
<td>• Gastroenteritis e.g. salmonella, rotavirus</td>
</tr>
<tr>
<td>• Bronchiolitics</td>
</tr>
<tr>
<td>• MRSA</td>
</tr>
</tbody>
</table>

**Note:**
- Care must be taken to avoid admission of highly infectious children, such as those with chicken pox, wherever possible and arrangements should be made to expedite their safe discharge home.
- Children with infection such as meningitis may leave the cubicle after 48 hrs of treatment providing this has been discussed with the medical staff. (Provided that nasal carriage has been treated with either Ceftiaxone or Rifampicin).
- In certain circumstances consideration should be made for “targeted” isolation: example the avoidance of having a child with whooping cough in contact with un-immunised infants.
- Patients with CF may require a cubicle.

<table>
<thead>
<tr>
<th>Children who require a cubicle for privacy for themselves or their family</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are several situations where a cubicle may be appropriate. This would include the dying child.</td>
</tr>
<tr>
<td>If a cubicle is utilised for a child who does not absolutely require one, please make it clear to the parents on admission, that the child may have to be moved out of the cubicle during their stay.</td>
</tr>
<tr>
<td>It is the responsibility of the person in charge of each shift, to re-assess the situation and act accordingly, in order to avoid moving families unnecessarily during the night.</td>
</tr>
</tbody>
</table>

**NB:**
- Pregnant adolescents (of whatever age) under the care of the Obstetricians will not be admitted to Oak ward.
### Neonates

Neonates requiring phototherapy or with a weight loss greater than 10% may be admitted to the Transitional Care area, based on Joan Booker Ward, Abbey Wing. The precondition is that the mother lives in.

### Adolescents

i. No planned overnight admissions of children aged 15 or under should be made to any adult ward at either hospital.

ii. No emergency admissions of children aged 15 or under should be made to any adult ward at either hospital.

iii. Guidance on the management of adolescents referred from Child and Family Psychological Medicine can be found in Appendix 27.

iv. On rare occasions, children who attend Merlin ward (AH) may require admission to an inpatient bed. These children will be transferred to Ash Ward (please see Appendix 26).

### NB:

Children under 16 years Please also see Policy and Procedure Manual. Vol. 8, Patient Care, No 4 Guidelines for Admission of children aged 15 years and under.

### Guidelines for admission of patients from Paediatric A&E

- The paediatric bleep (119) should be kept with the Nurse in Charge on Ash ward, or her deputy, at all times. Check that the bleep is working – if not, the battery can be changed by the staff on switchboard.

- If A&E have a patient that requires admission, the bleepholder must be contacted to assess the bed/cubicle state. Overnight, the main A&E department must liaise with the bleep holder about admissions and bedstate.

If the doctor admitting would like to inform the ward directly about the patient, this should be done through the bleepholder.

- The bleepholder should inform the appropriate nurse/s of details of the admission. The child’s name should be added to the board so that all nurses are aware of expected patients.

- When A&E are ready to admit the patient, the bleepholder must be contacted to confirm that the ward is ready for the admission. A&E can be informed of the allocated bed space for easier admission to the ward.

- If more than one patient is ready for admission, liaison between A&E and the bleepholder can determine if they can be escorted to the ward at the same time.

- Occasionally, A&E only have one nurse, so assistance may be required from the ward in escorting patients for admission. A&E should inform the ward when they have only one nurse available.

- If the ward is full and no discharges are expected, A&E must be informed to transfer of patients can be arranged, if required, after assessment by the on-call paediatricians.

A&E should contact the bleepholder around 1700 hours to assess the bed availability for the evening. If there are any further admissions to the ward after this time, i.e. from Merlin/ Ashford A&E/OPD, then paediatric A&E should be informed of a reduction in bed availability.

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### Section 6

**ADMISSION POLICY FOR INFECTED PATIENTS**
Please see the Infection Control Policy and Procedure Manual for information regarding different infection types.

**Guidelines for Admitting Patients with Methicillin Resistant Staphylococcus Aureus (MRSA)**

**St. Peters Hospital**

At times of bed shortage when empty beds in the special designated nursing areas have to be used by other patients, those with the following conditions, in this order of priority, should be excluded if possible:

1. Immunological compromised e.g. leukaemia, lymphoma and those receiving cytotoxic drugs or high dose steroids
2. Diabetes mellitus
3. Chronic wounds e.g. leg ulcers, pressure sores or those with broken skin/exfoliate skin conditions
4. Patients liable to require ITU care during this admission
5. Surgical patients unless already colonised
6. Patients with invasive devices (e.g. drips, drain catheters)
7. If you are unsure about carrying out this risk assessment please contact one of the Infection Control nurses via bleep: 5205 (SPH); 5547 (AH) Monday to Friday 9.00am to 5.00pm, or via Site Co-ordinator out of hours: 5001 (SPH) 5530 (AH).

**Ashford Hospital**

The Admission criterion for the placement of infected patients is the same for both Ashford & St. Peters Hospital. Side rooms (approx. 4 on every ward) for patients that are infected or require isolation. At Ashford & St. Peters Hospital there are “Ante” rooms for the care of TB infected patients. There is a Neutropenic side room on Wordsworth (Ashford) and Cedar (St. Peters) for those patients requiring isolation.

<table>
<thead>
<tr>
<th></th>
<th>St. Peters Hospital</th>
<th>Ashford Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Immunological compromised e.g. leukaemia, lymphoma and those receiving cytotoxic drugs or high dose steroids</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Chronic wounds e.g. leg ulcers, pressure sores or those with broken skin/exfoliate skin conditions</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Patients liable to require ITU care during this admission</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Surgical patients unless already colonised</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Patients with invasive devices (e.g. drips, drain catheters)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>If you are unsure about carrying out this risk assessment please contact one of the Infection Control nurses via bleep: 5205 (SPH); 5547 (AH) Monday to Friday 9.00am to 5.00pm, or via Site Co-ordinator out of hours: 5001 (SPH) 5530 (AH).</td>
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</tbody>
</table>

**NB.** Please refer to the Infection Control Policy and Procedure manual for further details. The Microbiologists, Dr. Grundy and Dr. Kirk, may be contacted out of hours via Switchboard if the above cannot be dealt with by the Site Co-ordinator.
Section 7

POLICY FOR PATIENTS ADMITTED WITH SPECIAL NEEDS

This section of the policy outlines the special additional needs of disabled people being admitted to the acute hospital. It specifically applies to people with sensory, physical, speech difficulties as well as clients with mental health problems or learning difficulties. (For Protocol for Admission of Patients with Learning Disabilities, please see Appendix 28)

7.1 EVERY DISABLED PATIENT, VISITOR OR HOSPITAL EMPLOYEE HAS THE RIGHT:

- to be treated in the same way as any other person, without pre-judgement about disability or the quality of life of disabled people
- to make use of hospital services and facilities
- to relevant and accessible information, especially about the hospital’s provision for disabled people

7.2 ALL DISABLED PATIENTS HAVE THE RIGHT:

- to be asked about their personal need in advance of a pre-arranged appointment or admission, or at the first encounter on an emergency visit or admission
- to be consulted directly about their treatment and all arrangements made on their behalf

7.3 EVERY DISABLED PATIENT, VISITOR OR HOSPITAL EMPLOYEE MAY REASONABLY EXPECT:

- that hospital staff recognise and respond to the needs of disabled people
- that all aspects of the hospital’s provision for disabled people are regularly reviewed

7.4 ALL DISABLED PEOPLE MAY REASONABLY EXPECT:

- That the disabilities they experience are not increased by inflexible regulations or routines.

NB It is essential that patients with mental health needs/learning difficulties have their community psychiatric nurse/key worker notified (within 24hrs) of their admission.

All patients with special needs should have their care workers/ carers involved in their treatment to provide support and specialist advice if they wish.

All ward/clinic areas have a “special needs” directory of information to help them assist you with useful contacts etc. (For Special Needs Directory, please see Policy Guidance on the Trust Intranet. Search in: - ‘Documents’; Policies & Procedures’; ‘Special Needs Patients’)

Section 7a POLICY FOR ADMISSION OF PATIENTS WITH LEARNING DISABILITY (See Appendix 28)

Section 8

ADMISSION OF PATIENTS UNDER A SECTION OF THE 1983 MENTAL HEALTH ACT.

See Appendix 29 for the Admission of Patients Under Section
See Appendix 30 for information on the Crisis Response Team
Section 9

ADMISSION OF PRISONERS

This policy relates to prisoners of Police, Prison Service and the Customs and Immigration Service. Prisoners present a series of challenges to hospital staff who must balance three overriding principles:

• The rights and needs of the individual to be properly cared for;
• The security of the Trust;
• The right of the patient to confidentiality

The balance must be reached in collaboration with the custody staff on duty.

All Times
The security officer must be informed of the arrival of any prisoner to a hospital department. This is for information only.

Confidentiality
Hospital staff must give careful consideration to the patients’ rights to confidentiality when asking for or giving information in the presence of custody officers. Whenever possible, sensitive information should be managed in a way which maintains the rights of confidentiality and dignity of the prisoner.

Prisoners as inpatients
• When a patient is admitted via A&E or ED, the nurse in charge should notify the Security Office, the Capacity Manager in normal office hours, or the Site Co-ordinator at all other times.
• Prisoners should be treated preferably in a side room if accompanied by a prison officer.
• All Necessary clinical observations and procedures will be carried out while seeking to maintain the dignity of the patient whenever possible.

Removal of restraints
See Appendix 31 for flow chart, detailing the proposed procedure for custody officers in relation to the removal of restraints from patients.

Section 10

ADMISSION OF OLDER PEOPLE

10.1 URGENT CARE FOR OLDER PEOPLE (See Appendix 32 for flow chart)

10.2 PERSONAL INFORMATION FORM (See Appendix 33 for; Hospital Admission – Personal Information Sheet)

Section 11

ADMISSIONS APPENDICES

References

Mental Health Act 1983, Secretary of State for Health in exercise of power conferred on him by Section 16 (1) of the National Health Act of 1977.

Your Guide to the National Health Service, Department of Health, Jan 2001

NICE (Pre-assessment Guidelines 2003)

“Intensive Care Society” Guidelines (management during transport) section.
ADMISSIONS APPENDICES
Section 11
Admissions Appendices

1. Guidelines for the Treat and Transfer of Patients
   1a. Treat and Transfer Flow

2. Admission of Medical Patients - MAU (Medical Assessment Unit)
   2a. Capacity Management Flow for Medical Patients (SPH)
   2b. Capacity Management Flow for Medical Patients (AH)
   2c. A&E/Ward Communication Guidelines

3. Capacity Management Policy (flow diagrams) – In & Out of Hours

4. Pre-cancellation Guidelines
   4a. Explanation of Pre-cancellation and Cancellation (on the day)
   4b. Cancellation of Weekend Electives & Guidelines in the event of a Threatened Cancellation

5. Admission Criteria for Patients Transferred to Day Surgery Requiring In-patient Care

6. Guidelines for NHS Admissions to Private Hospitals
   6a. Guidelines for the transfer of NHS Patients to Private Hospitals (Runnymede & Shakespeare Suite)

7. Admissions Office Case note Retrieval

8. Guidelines on the use of the Observation Bay (AH & SPH)

9. ECMS Scheme – Guidance notes

10. Coronary Care Unit Flow Charts: 1-4

11. Chaucer Ward – Stroke Unit

12. Inpatient Coronary Angiography - Inpatient Stay

13. Flow chart AH Patient transfer to SPH for day case Angiography/plasty

14. Physiotherapy Emergency On-Call

15. Flow Chart for Admission to the Trauma & Orthopaedic Unit
   17a. Pathway for Adult Trauma Patient (Flow)

16. Flow Chart for Admissions to the Surgical Unit

17. Protocol Gynaecological, Surgical And Orthopaedic Emergencies at Ashford Hospital-

18. Pre-operative Fasting Policy

19. Guidelines for Anaesthetic Suitability for Day Surgery


21. Criteria for & Admission to Critical Care
   23a Guidelines for the Transfer of Patients to Critical Care

22. Discharge of Patients to the Ward from Intensive Care/HDU

23. Surrey Wide Critical Care Network (Report Proforma)

24. Transfer of Critically Ill Patients Out of Transfer Group (Adverse Incident Form)

25. ITU – Transfer Flow

26. Flow Chart Overnight Stay (Merlin to Ash)

27. Admission Guidelines – Adolescents with Episodes of Self Harm

28. Protocol for Admission of Patients with Learning Disabilities

29. Admission of Patients Under Section

30. Crisis Response Team

31. Removal of Restraints

32. Urgent Care for Older People

33. Information Form
GUIDELINES FOR THE TRANSFER OF PATIENTS

TRANSFER OF PATIENTS

- Patients may be transferred for treatment to or from other hospitals. Reasons for transferring patients include:
  - Bed shortages
  - Patient wishes to receive private treatment
  - Tertiary referrals
  - All requests for transfers should be directed through the Capacity Manager, or Site Co-ordinator out of hours.

Criteria for Patient Transfer (see flow diagram)
The following criteria are to be used when there is a need to transfer patients as “outliers” within the main site of Ashford or St. Peter’s hospitals, or transfer NHS patients to the Shakespeare Suite/Runnymede Hospital.

PATIENT

Confused
Aggressive
Medically unstable
Heavy
Requires intense rehab

NOT SUITABLE FOR TRANSFER

MEDICALLY STABLE

Minimal assistance with self-care
For imminent/uncomplicated discharge

NOT SUITABLE FOR TRANSFER

TRANSFER OF PATIENT

Inform Doctor of transfer
Inform Capacity Manager
Notify on-call team if after 5pm and before 9am
Notify Capacity Manager for a Weekend transfer via CSNP’s Office
Ensure all property is with the patient on transfer
Full hand-over must take place

YES

NO

PATIENT

Confused
Aggressive
Medically unstable
Heavy
Requires intense rehab

NOT SUITABLE FOR TRANSFER

MEDICALLY STABLE

Minimal assistance with self-care
For imminent/uncomplicated discharge

NOT SUITABLE FOR TRANSFER

YES

NO

NB For patients transferred within the main hospital site of SPH, please refer to guidelines on “Buddy System”

<table>
<thead>
<tr>
<th>PATIENTS NOT SUITABLE FOR TRANSFER:</th>
<th>PATIENTS SUITABLE FOR TRANSFER:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Significantly confused/aggressive patients</strong></td>
<td>Patients who are for “next day” uncomplicated discharge (within 1-2 days, ideally)</td>
</tr>
<tr>
<td>Patients whose confusion/aggression may be further aggravated by such a move.</td>
<td></td>
</tr>
<tr>
<td><strong>Complicated discharges</strong></td>
<td>Patients who do not require high nurse care (minimal assistance required with self-care)</td>
</tr>
<tr>
<td>Otherwise there could be a breakdown in communications, leading to delayed discharges</td>
<td></td>
</tr>
<tr>
<td><strong>Medically “unstable” patients</strong></td>
<td></td>
</tr>
<tr>
<td>E.g. cardiac, multiple IV infusions, patients requiring intense medical nursing care.</td>
<td></td>
</tr>
<tr>
<td><strong>Patients who are moribund or requiring intense rehabilitation</strong></td>
<td></td>
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<td></td>
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</tbody>
</table>
Treat and Transfer Flow for Medical Patients (SPH to AH)

1. **Patient arrives at SPH A&E/ED**
2. **Patient seen by Cas doctor or Medic Take Team SPH**
3. **Decision to admit patient**
   - Capacity Manager/Site Coordinator informed
4. **Patient needs Acute Ortho/Surgical Admission**
5. **Transfer - SPH**
6. **Patient needs acute Medical Admission and is appropriate for Treat and Transfer?**
7. **Transfer AH**

---

- **A&E/ED Shift leader hands-over patient to receiving ward**
- **Capacity Manager arranges transfer from A&E/ED to appropriate Ward at.**
- **Take Reg to Reg hand-over and transfer agreed.**
- **On Take Teams agree that Patient fit for transfer to and beds available.**
- **Patient to be received by accepting Take Team on post-take round and subsequently taken over by speciality ward based Team**
Appendix 2

MEDICAL ASSESSMENT UNIT (SPH)

A&E Admission

- Patient attends A&E: Need for further assessment required

- A&E Request transfer of appropriate patient to MAU

- MAU shift leader confirms trolley available in MAU

- If no trolley available, MAU staff to list patients pending transfer

- A full hand-over between A&E and MAU

- Patient details recorded in MAU admissions book and trolley reserved

- Ward Clerk obtains patient’s notes and x-rays (Out of hours via A&E reception)

- If notes unavailable, temporary pack used

- Patient reviewed by MAU team
  Decision to discharge or admit made

- If DTA, Capacity Manager to be informed

- Patient transferred to Medical bed under care of most appropriate team, based on Clinical presenting condition

- Full hand-over between MAU staff and receiving ward staff

GP Admission

- Patient seen by GP: decision to refer to MAU

- GP contacts Emergency Capacity Centre (see appendix), to request direct admission to MAU and is given ECC number

- ECC informs MAU of expected admission

- MAU to log incoming patients on board. Ward Clerk to make notes and X-rays available

- GP to liaise with MAU Dr. regarding potential admission

- MAU Dr. assesses patient

- Patient arrives on MAU with GP letter via ambulance or own transport

- Decision to discharge or admit made

- If no bed available, MAU staff must update Capacity Manager of changes to bed state. GP admission may be redirected to A&E
SPH

Capacity Management Flow for Medical Patients

(Including Buddy Wards)

A&E

MAU

(28 beds)
Maple
Stroke & COE

(26 beds)
Birch
Cardiology

(29 beds)
Holly
Respiratory

(30 beds)
Cedar
Gastroentology

(25 beds)
May
C of E

Falcon
Surgery

Juniper
(Ortho)

Kestrel
(Surgery)

Chaucer Ward - AH

Appendix 2a

Appendix 2b

Volume 8
Patient Care
First ratified March 2005
Issue 1
Part I (Admissions)
Ashford

ED
(Medicine)

(30 beds)
Arnold Ward

(16 beds)
Chaucer
Stoke Unit

(30 beds)
Wordsworth
COE

(28 beds)
Keats
Endocrine Rheumatology

(30 beds)
Bronte
Respiratory

Surgery

(28 beds)
Eliot Ward
Surgical

Orthopaedic

(30 beds)
Dickens


A&E/ED and Ward Staff - Communication Guidelines

Ashford & St Peter’s Hospitals

In an attempt to avoid delays in the transfer of patients from the A&E and Emergency Department to a Ward area the following guidelines should be adhered to.

All requests for beds must be made (as soon as decision to admit known or as soon as it is recognised patient will need a bed) to the Capacity Manager/Site Co-ordinator who will allocate accordingly. The Capacity Manager/Site Co-ordinator will then inform the receiving ward of the allocation.

1. Following agreed allocation, the Capacity Manager/Site co-ordinator will agree with the ward shift leader a definite transfer time. This time must ensure that all patients reach the ward/MAU within the 4 hour target.

2. The Capacity Manager/Site Co-ordinator will contact A&E/ED and inform them of the agreed time for transfer. A&E/ED should transfer the patient at the agreed time unless otherwise contacted by the receiving ward (i.e. in the event of a crisis situation).

3. A&E/ED will then transfer the patient at the agreed time. (A&E/ED staff to give a full hand-over on arrival to ward area). (If an A&E/ED staff member cannot accompany the patient, a full hand-over should take place via the telephone).

4. Following assessment by a qualified staff member in the A&E/ED Department those patients deemed to be medically stable may be transferred to the ward area either by a qualified nurse or HCA/student if assessed to be appropriate. However, the ward must be informed beforehand and a full telephone handover given from registered nurse to registered nurse.

5. If there is a delay in the transfer of patients from the A&E/ED Department to the ward, (due to a lack of nurse/porter availability) A&E/ED will inform the Site Co-ordinator, who should organise to help to escort the patient to the appropriate area. Ensuring that the transfer of patients is carried out at intervals to avoid patients arriving at the same time.

6. If there is a delay in transfer by the ward (for any reason other than clinical) the Head of Nursing (HON) designated to the area will be contacted by A&E/ED.

7. A&E must ensure patients are notified in advance of transfer to a mixed gender area. In the event a patient refuses to go they should, where possible be placed in the Observation Bay A&E/ED.

8. Where patients are transferred from A&E/ED to Ashford to a ward area it should be explained we are one organisation on 2 sites and the bed allocation has been decided upon in order to manage their care needs.
Ashford & St Peter’s Hospitals NHS Trust

CAPACITY MANAGEMENT POLICY

March 2005
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<td>9</td>
<td>Treat and Transfer Flow for Medical Patients St. Peter’s to Ashford</td>
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</tr>
<tr>
<td></td>
<td>Avoiding 12 hour Trolley Wait</td>
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# Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency (SPH)</td>
</tr>
<tr>
<td>CC</td>
<td>Critical Care</td>
</tr>
<tr>
<td>CCU</td>
<td>Coronary Care Unit</td>
</tr>
<tr>
<td>CM</td>
<td>Capacity Manager</td>
</tr>
<tr>
<td>CSNP</td>
<td>Clinical Site Nurse Practitioner</td>
</tr>
<tr>
<td>DC</td>
<td>Discharge Co-ordinators</td>
</tr>
<tr>
<td>DL</td>
<td>Discharge Lists</td>
</tr>
<tr>
<td>DM</td>
<td>Duty Manager</td>
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<tr>
<td>DPM</td>
<td>Daily Planning Meeting</td>
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<tr>
<td>DTA</td>
<td>Decision to Admit</td>
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<tr>
<td>ECC</td>
<td>Emergency Capacity Centre</td>
</tr>
<tr>
<td>ECMS</td>
<td>Emergency Capacity Management System</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Dept (AH)</td>
</tr>
<tr>
<td>GM</td>
<td>General Manager</td>
</tr>
<tr>
<td>HAD</td>
<td>Head of Admissions &amp; Discharge</td>
</tr>
<tr>
<td>HON</td>
<td>Head of Nursing</td>
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<tr>
<td>ICT</td>
<td>Intermediate Care Team</td>
</tr>
<tr>
<td>MAU</td>
<td>Medical Assessment Unit</td>
</tr>
<tr>
<td>PP</td>
<td>Private Patient</td>
</tr>
<tr>
<td>SC</td>
<td>Site Co-ordinator</td>
</tr>
<tr>
<td>SpR</td>
<td>Specialist Registrar</td>
</tr>
<tr>
<td>SSM</td>
<td>Senior Support Manager</td>
</tr>
<tr>
<td>TCI</td>
<td>To Come In</td>
</tr>
<tr>
<td>OCC</td>
<td>On-Call Consultant (Med/Surg/Ortho/ED)</td>
</tr>
</tbody>
</table>
Capacity Management Plan

(In hours)
8.00 am – 8.00 pm
(Not including weekends and bank holidays)

**Capacity Manager**
To establish bed availability and potential discharges with Ward Managers
- Medical including MAU/CCU
- Surgical, Ortho, Critical Care
- Additional beds opened

**NB:** HON/Matron & Discharge Co-ordinator work with CM to achieve the above

**Capacity Manager**
To establish:
- DTA’s in A&E/ED including breech times.
- Elective TCI’s
- Outlyers
- Repatriations via other hospitals
- Update bed score (minimum twice daily)

**A&E / ED Shift Leader**
To establish:
- Divert Status
- DTA’s including projected demand
- Delays according to 4 hour escalation plan
- Update 2 hourly dependency score to ECMS

**Daily Planning Meeting**
Attendance and Responsibility (*See Appendix 1*).
- HAD • Critical Care Rep
- GMS • MAU SpR/Consultant
- HON’s • A&E/ED Shift Leader/Manager
- CM • Intermediate Care
- SC

**Action Plan**

**Escalation**
? If necessary

- Additional Capacity required – (*See Appendix 2*)
- Cancellations Deferments of elective activity as required (*See Appendix 5*)
Capacity Management Plan
(Out of hours)

→ Night 8pm – 8am (7-day per week)
→ Weekends and bank holidays – (8am – 8pm)

NB: At night, Capacity will be managed by the clinical Site Nurse Practitioner (CSNPS)

Weekends and bank holidays will be managed jointly by the Site Co-ordinator/CSNP’s, Capacity Manager and the Duty Manager

Capacity Manager to establish:-
(8am - 8pm)
• A&E/ED DTA’s (actual)
• Bed State/Outlyers
• Actual and Projected Discharges
• Elective Demand
• Critical Care Capacity
• Community Beds

A&E/ED Shift Leader to establish:-
(24hours)
• Actual and Projected DTA’s in department breech times
• On-Call Teams response times and any other delays i.e. diagnostic/assessment
• Escalate to On-Call ED:A&E Consultant/Speciality Team as per 4hrs Escalation Policy (See Appendix 9)

CSNPS/Site Co-ordinator to establish:-
(24hours)
• Ward Pressures
• Ward Short-falls/Staffing Issues
• Other Site Influencing Factors

Day – Sat/Sun, Bank Hols
Capacity Manager to chair meeting. Team escalate according to capacity and demand. (See Appendix 2)

Depending on circumstances Duty Manager may go and support AH site.

Escalate?
(See Appendix 2)

NB: Meeting times: 10.30 & 3 pm – AH
10.30 & 3 pm - SPH
Escalation to Opening Additional Capacity
(in hours and out of hours)

At 3pm; if projected demand is greater than bed availability, consider opening additional capacity

SPH

Carpet Beds – Medicine

Maple – 1
CCU – 1
Holly – 1
Cedar – 1

Surgery

Falcon – Physio Bay – 5

Day Ward – 5/10

AH

Shakespeare – 4 +
ED – Back Theatre – Area - 4
Day Ward – 5/10/16 (To be agreed at Director level only)

NB: (See Appendix 4) for additional information regarding appropriate staffing for these areas.

Trolley Waits:

In the event of potential 12 hour Trolley Waits (from decision to admit – timed and dated by clinician) to leaving the department, the Duty Manager/Director on-call should be informed at hour 10. (See Appendix 7)
## Responsibilities for Daily Planning

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E/ED</td>
<td>Actual and projected demand including breech times. Divert status. On-call Teams response times and awareness of current wait times; according to 4 hr escalation plan</td>
</tr>
<tr>
<td>CC</td>
<td>Bed state (cross-site), number of wardable patients, demand from own and other hospitals</td>
</tr>
<tr>
<td>CM</td>
<td>A&amp;E actual DTA’s, elective admissions, patients from other hospitals (inc priority rating) (status at other site). At the weekend, chair the daily planning meetings at 10.30 and 15.00 hours</td>
</tr>
<tr>
<td>DC</td>
<td>Produce ‘next day’ discharge list for each speciality (ASPH) and communicate to all via hard copy to all ward areas and Site Co-ordinator.</td>
</tr>
<tr>
<td>DU</td>
<td>Confirm Discharge Unit Nurse cover and number of patients expected in unit</td>
</tr>
<tr>
<td>DM</td>
<td>Attend Weekend Planning Meeting (10.30 and 15.00 hours) and escalate accordingly, working with the Site Co-ordinator and Capacity Manager</td>
</tr>
<tr>
<td>HAD or Deputy</td>
<td>Chair week day meetings at ASPH. Projected demand for each Speciality, Communicate to ECMS</td>
</tr>
<tr>
<td>HON/Rep</td>
<td>Actual and projected discharges</td>
</tr>
<tr>
<td>ICT</td>
<td>Number of Community beds. ICT Capacity – cross site</td>
</tr>
<tr>
<td>MAU</td>
<td>Actual and projected discharge including GP demand</td>
</tr>
<tr>
<td>SC</td>
<td>Ward short-falls/pressures</td>
</tr>
</tbody>
</table>
**Escalation Responsibilities**

*(in and out of hours)*

**Capacity Manager**

- Defer/cancel non-urgent elective activity *(See Appendix 5)*
- Call 2nd on SHO for wards to ensure all potential discharges are seen (weekends)
- Check with Sister A&E/ED to see if patients can be treated and transferred (from A&E/ED direct to a ward)
- See Treat and Transfer Policy – *(See Appendix 8 & 8a)*
- Assess if private capacity can be obtained. Via Runnymede - 3006 or Shakespeare Suite - 4111
- Ring on-call Intermediate Care Nurse to assess capacity in Community Hospitals – 01932 722929 (ASPH)
- Inform Pharmacy of escalation
- Inform Transport of escalation
- Call on-call Consultants to inform of pressured areas in order to facilitate additional discharge
- Update bed status every 2 hours (per site)
- Update SC/CSNP prior of actual capacity going into the night including all escalation processes in place

**Site Co-ordinator (in/out of hours)**

- Transfer staff between sites dependent upon area of greatest pressure, (Liaise with Matron/HON if available)
- Support the transfer of patients out of A&E/ED as required.
- Put out for additional staffing to support opening of additional capacity (Liaise with Matron/HON if available)
- Support wards where pressure is greatest.

**Head of Nursing/Matron (in hours)**

- Support wards in the identification of additional discharges.
- Ensure all Directorate Consultant Teams have carried out emergency ward rounds in response to demand.

**Head of Admissions and Discharge (in hours)**

- Communicate with ECMS regarding Divert Status. Inform PCT, overall manage escalation action plan

**A&E/ED Shift Leader**

- Escalate to A&E (on-call) Consultant who should be called in to support department.
- Inform ECMS of dependency of department including any additional areas opened.
- Inform Medical Reg/SHO of divert status
- Ensure 4 hrs Escalation plan is adhered to
**Discharge Co-ordinator**

- Inform Pharmacy, Transport and other Diagnostic areas of escalation, to escalate patient throughput.

**Clinical Site Nurse Practitioner (CSNP)**

- Transfer staff between sites dependent upon area of greatest pressure, (Liaise with Matron/HON if available)
- Support the transfer of patients out of A&E/ED as required.
- Put out for additional staffing to support opening of additional capacity, (Liaise with Matron/HON if available)
- Support wards where pressure is greatest.
- Communicate with the Duty Manager/Senior Support Manager, issues relating to avoiding long waits in A&E/ED

**Intermediate Care:**

- Manage the transfer of appropriate patients to the Community hospital (9-5pm).
- 5-9pm A&E/ED to contact 01932 872929, if there is an appropriate patient for transfer to Community Hospital or ICT – discharge home.
- 9pm – 6.30 am – Contact to be made with the Night Nursing Service via 01932 722929 – i.e. for patients requiring district/community nursing and /or discharge home with ICT

**NB:** In the event additional capacity required in hours page 8359out of hours via 01932 722929. If there are unused Community beds these should be declared to A&E/ED.

**ECMS Divert**

During times of increased pressure A&E/ED Manager/HAD/CSNP/Site Coordinator, will review/change divert status dependent upon the site with greatest demand.
- Telephone supervisor on 01737363885 and request change of divert of next 2 hour, follow up conversation with Fax 01737360393.

**Site Co-ordinator/ CSNP Duty Manager (10-18.00 Sat /Sun)**

- Escalate to Senior Support Manager in the event of Critical Delays in Assessment, Treatment and Transfer within 4hr Escalation Plan.
- On-site to attend capacity meeting at 10.30am & 3pm. Support CM/site co-ordinator in the escalation process when necessary
- Communicate with the Senior Support Manager, issues relating to avoiding long waits in A&E/ED

**Senior Support Manager/Emergency Head – A&E**

- Communicate with Senior Clinicians/Departments to avoid potential 12hr breeches.

**On-Call Consultant (A&E/ED (in/out of hours)**

- Support ED/A&E in the event there are delays in assessment of major/minor patients.
Structure of the Daily Planning Meeting ASPH

<table>
<thead>
<tr>
<th>SPH</th>
<th>AH</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.30 am</td>
<td>10.30 am</td>
</tr>
<tr>
<td>3.30 pm</td>
<td>3 pm</td>
</tr>
</tbody>
</table>

1. A&E/ED position including projected Demand
2. Medical/CCU capacity/Demand
   Surgical capacity/ Demand
   Orthopaedic capacity/ Demand
3. MAU/ Demand/Capacity
4. Community hospitals
5. SPH = Ashford Position
6. Critical Care – ITU & HDU- Capacity/Demand

SPH

| Carpet beds (Holly, Cedar, Birch, Maple) | = 3 |
| CCU | = 1 |
| Day Surgery | = 5/10 |

AH

| Shakespeare | = 4+ |
| Day Surgery | = 5/10 |
| Theatre Area (ED) | = 4 |

NB: 2 additional beds on Birch (bay 1 & bay 2) only to be used to avoid 12 hr Trolley waits

3. Elective demand including urgent patients that must come in
4. Staffing pressures
5. Divert position Yes / No
6. Action plan

NB: Dependency for both departments must be updated by the A&E/ED shift-leader every 2 hrs. If additional areas are open these must be included in the dependency scores per site.
**Additional Information**

During normal working hours 8.00 am to 8.00 pm the Heads of Nursing for Medicine, Surgery and Orthopaedics and Discharge Co-ordinators will be responsible for managing the discharge process (with Capacity Managers) across their wards and bringing the relevant activity information to the Daily Planning Meetings.

Out of hours 8.00 pm to 8.00 am (including bank holidays) the capacity management process will be led by the CSNP/Site Co-ordinator supported by the A&E/ED shift leader, unless the Capacity Manager is on duty and then they will work together with the site/CSNP and A&E/ED shift leader.

Bank holidays and weekends the Site Co-ordinator/CSNP, Capacity Manager, Duty Manager will manage the Capacity Management process. The site Co-ordinator/CSNP or Duty Manager will liaise with the Senior Support Manager as necessary.

In relation to additional staffing to support the Escalation Plan detailed below is the ratio of additional staff to manage additional beds.

<table>
<thead>
<tr>
<th>Site:</th>
<th>No. of Additional Beds</th>
<th>Additional Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPH:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carpet beds</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Falcon</td>
<td>5</td>
<td>1xRN</td>
</tr>
<tr>
<td>Day Surgery</td>
<td>5/10</td>
<td>(1/2x E/D Grade &amp; 1 x HCA)</td>
</tr>
<tr>
<td>NB: Birch – (Only to be used to avoid 12hr breeches)</td>
<td>2 (Bay 1 &amp; 2)</td>
<td>0</td>
</tr>
<tr>
<td>AH:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shakespeare Suite</td>
<td>4</td>
<td>(No additional Staff)</td>
</tr>
<tr>
<td>DSU</td>
<td>5/10</td>
<td>(as for DSU, SPH)</td>
</tr>
</tbody>
</table>

**NB:** Fielding as overspill needs to be approved at Director Level. Please note requires lead-in/preparation time as no phones, call bells, drugs, reduced equipment etc. In the event additional capacity is required in DSU plus 1 Trained will be necessary and Director to agree.
Management of Elective Activity (Capacity Management Team)

- 24 hours in advance of TCI date prioritisation established
  - Clinically urgent
  - Long waiters
  - 28 day rule

- 24 hours in advance of TCI date patient is pre-cancelled

- Undertake on the day cancellations in accordance with the following criteria:
  - Clinically non urgent
  - First time cancellations

**Key targets and standards: cancelled operations DOH 2003-04**

**NB:** Where there is high probability that the patient’s operation cannot be carried out on the date originally agreed it is acceptable to cancel the patient in advance. This is not warning the patient of a likely cancellation but an actual cancellation.
Avoiding 12 hour Trolley Waits

There must be No 12 hr Trolley waits in A&E. It is imperative that at hr 10 if there is a potential Trolley Wait contact the on-call manager/Director on-call

Definition:
The DoH defines a Trolley Wait as ‘The waiting time for an emergency admission via A&E is measured from when a clinician decides to admit a patient or when treatment in A&E is completed (whichever is the later) to the time when the patient is admitted’.

- Establish waiting time following a DTA for all patients.
- Establish longest waiting patients
- Establish patients requiring specialist beds i.e.
  - Critical Care – (These patients will usually fall into the exception category)
  - Coronary Care
  - Cardiac – Birch and Arnold Wards
  - Non – Invasive Ventilation – Holly/Bronte Ward
  - Gastroentrology – Cedar

- Establish bed status – Open additional capacity if possible.
- Ascertain patients suitable for outlying (see next day discharge lists)
- Ensure all additional capacity is open

NB: If patient requires specialist intervention and it is deemed inappropriate to outlie to a non speciality bed direct from A&E i.e. Medical patient to Surgery/Ortho or Visa Versa. Transfer existing inpatient from ward to outlying area.

Patient should be transferred according to discharge/outlying list.

- DoK wing can accommodate patients requiring telemetry – satellite cardiac monitoring i.e. Juniper; Elm; Holly; May; Cedar
- Medical patients requiring Bipap/Nippy must go to Holly/Bronte. Surgical/Ortho patients requiring Nippy/Bipap must go to HDU.
- Patients requiring intensive Cardiac Support must go to Birch/CCU/Critical Care AH

<table>
<thead>
<tr>
<th>Buddy Wards:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPH</strong></td>
</tr>
<tr>
<td>Holly → Juniper/Elm</td>
</tr>
<tr>
<td>Cedar → Surgery (Kestrel)</td>
</tr>
<tr>
<td>Birch (GM) - Falcon</td>
</tr>
<tr>
<td><strong>AH</strong></td>
</tr>
<tr>
<td>Any patient can be outlyed to either Dickens (non-infected patients) or Eliot Wards</td>
</tr>
<tr>
<td>NB: See appendix 8 for appropriate criteria for patients suitable for transfer</td>
</tr>
</tbody>
</table>
TRANSFER OF PATIENTS

Patients should be transferred to outlying areas in the event there is no bed (within required speciality area or to avoid a 12-hour breech in A&E/ED). All requests for transfers should be directed through the Capacity Manager. In the absence of the Capacity Manager, through the Site Co-ordinator/CSNP.

Criteria for Patient Transfer (see flow diagram)

The following criteria are to be used when there is a need to transfer patients as “outliers” within the main site of Ashford or St. Peter’s Hospitals, or transfer NHS patients to the Shakespeare Suite/Runnymede Hospital.

NB: There will be daily lists for all specialities of ‘next day’ discharges these patients should be transferred in the first instance.

For patients transferred, please refer to guidelines on “Buddy System” Appendix 7

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**Flow Diagram**

1. **PATIENT**
   - Confused
   - Aggressive
   - Medically unstable
   - Heavy
   - Requires intense rehab
   - Medically stable
   - Minimal assistance with self-care
   - For imminent/uncomplicated discharge
   - EDD within 48hrs

2. **Decision Point**
   - YES
   - NO

3. **YES**
   - Transfer
   - NOT SUITABLE FOR TRANSFER

4. **NO**
   - NOT SUITABLE FOR TRANSFER

---

**NB**
**Treat and Transfer Flow for Medical Patients**

- **Patient arrives at A&E/ED**
- **Patient seen by A&E Doctor or Medic Take Team SPH**
- **Decision to admit - Capacity Manager, Site Co-ordinator/CSNP (out of hours) informed**
- **Patient needs Acute, Ortho/Surgical Admission -**
  - **Transfer – SPH**
  - **Transfer to AH**

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- **Capacity Manager arranges transfer from A&E to appropriate Ward at AH. **
- **Take Reg to Reg hand-over and transfer agreed.**
- **On Take Teams agree that Patient fit for transfer to AH and beds available.**

---

**Note:** *In the absence of Capacity Manager Site Co-ordinator/CSNP’s liaise re: beds*
Escalation in the Event of Speciality Review Delays

A&E/ED Shift Leader
Informs Reg. On-Call

Further delay

Reg. and Team respond to manage delays

Shift Leader informs General Manager (inhrs) of delay. Out of hours inform site/CNSP/duty Manager of delay

GM/site/CSNP/duty manager calls On-Call Consultant

If delay in On-Call Consultant attending – Emergency, Lead/Senior Support Manager informed of delay

On-Call Consultant attends A&E/ED to support assessment of patients
Pre-cancellation Guidelines

Capacity: If there are to be provisional cancellations, they must occur before the TCI date – usually the day before.

- Liaise with the appropriate medical team (SpR or above) and or the Consultant secretary, to confirm which patients must not be cancelled under any circumstances – e.g. life-threatening illnesses – and agree order of priorities.
- Liaise with the appropriate wards. Discuss possible discharges, early bed vacation.
- Daily meeting at 3pm with designated discharge co-ordinator and Head of Nursing, A&E/ED to forward plan depending on situation in A&E/ED on both sites, and predicted number of discharges over next 24 hours.
- Finalise and agree number of patients to be provisionally cancelled before TCI date with Head of Admissions, or in her absence, General Manager for Surgery, Assistant Manager for Orthopaedics & Trust Waiting List Manager (Carol Hearn).
- Contact all those patients according to priority rating and inform them of the actual/potential need to cancel their operation.
- Cancel all of these patients on the P.A.S. system or record actions on PRL sheet for admissions.
- On the TCI day review bed availability for all these patients and those in A&E/ED requiring admission after early morning bed state has been confirmed.
- Once numbers of available beds have been confirmed and you are satisfied it is correct and up-to-date, a decision can be made on how many of the provisionally cancelled patients can be admitted.
- For any patient that has to be definitely cancelled, follow usual hospital procedure.

N.B. Telephone or email out of hours Consultant secretary and Theatres. In hours the Consultant must be informed. (See Appendix 20 for advice on fasting)

Footnotes

Important to be at least 24 -48 hours projected overview of the number of patients TCI on each day and their priority rating.

Sunday admissions should be prioritised on Fridays at the 3pm meeting and the Capacity Manager on duty Friday, Saturday should telephone patients to advise them of potential/actual cancellation.

N.B. ONLY IN COMPLETELY UNFORSEEN CIRCUMSTANCES SHOULD PATIENTS FOR ELECTIVE SURGERY (who have not been pre-cancelled) BE CANCELLED ON THE DAY
**Explanation of Pre-cancellation & Cancellation (on the day)**

**Pre-cancellation:** Contact has to be made with the patient by the Capacity Manager the day before TCI date. Priority to ensure appropriate (in the event required) cancellation is essential. Clinically urgent must not be cancelled i.e. CAS; long waiters; 2hrs time cancellation.

**Cancellation on the day:** Patient is cancelled on the day of admission or day of surgery.

**28 Day guarantee:** Patient is “cancelled on the day” for a hospital reason, e.g., no beds, overrun in theatres, surgeon sick, etc and should have a TCI date negotiated in less than 28 days.

**CEA:** This method of recording PAS only occurs when the patient is physically on hospital grounds and is cancelled for either a patient (e.g., patient is unwell) or hospital reason and they still need to have the surgery.

*Flow diagram to illustrate PAS recording of cancellation methods.*

Please remember all PAS entries must include a history of events to facilitate exception reporting, e.g., CEA Patient cancellation – patient’s blood pressure high return to OP clinic.

All dates must be agreed with the patient and recorded with the correct booking type code (BAP and BK).

**NB:** If the Capacity Manager cannot pre-cancel the patient prior to admission and the patient is subsequently cancelled “on the day”. This will be a 28 day cancellation. IT department to be informed.
Weekend Electives and Threatened Cancellations Policy

If there are a number of patients waiting for a bed in A&E or the Emergency Department and no projected 'same day' discharges, consideration should be given to the cancellation or deferment of booked admissions.

The following guidelines should be used:

- Every Friday, a PAS printed copy of all Sunday booked admissions to come in (TCI) should be left for the attention of the Site Co-ordinator by the Capacity Manager.

- The Capacity Manager will pre-cancel all appropriate patients (in the event of no beds being available) and outline those patients who must not be cancelled. These patients will be highlighted on the TCI list, following consultation with the appropriate speciality team.

- N.B. Where possible, major/clinically urgent/long wait cases should be a priority not to be cancelled.

- If patients are cancelled, a record should be kept and given to the Capacity Manager on the Monday morning.

- Those patients who are “not to be” cancelled, should be deferred, contacted at home and given advice regarding ‘Nil By Mouth’ (NBM) status from midnight (unless the patient is a diabetic, in which case, a light breakfast should be advised, no later than 7.00 a.m. on the day of the operation).

Theatres should be contacted and informed

N.B. If there are any clinical concerns or queries regarding a patient’s cancellation, the on-call Speciality Team should be contacted for advice.

Wherever possible, urgent TCI’s should be cleared on the Sunday following agreed escalation (with the site co-ordinator and GP) to open additional capacity. The Runnymede/Shakespeare suite should be used if at all possible in the event of NHS staff shortages.

Guidelines to Follow in the Event of a Threatened Urgent Cancellation

Urgent cancellations are defined under the DOH definition (2003) as those procedures which are considered “Life or limb Threatening”. These patients will usually require a HDU/ITU bed. For such patients it is essential that the Capacity Manager ascertains potential Critical Care Capacity at least 24hrs in advance of the operation date by transferring patients ready for a ward bed out. In the event that Critical Care Capacity cannot be obtained through these actions the potential for opening additional capacity within ITU should be ascertained by the Capacity Manager and the ITU Lead Nurse.

Capacity Managers and Head of Admissions & Discharge in consultation with clinicians to ascertain number of patients to come in, 1-2 days in advance of the TCI date. (If there are to be cancellations these should occur before the TCI date).
ADMISSION OFFERS - CANCELLATION PROCEDURE

AN OVERVIEW

This is an overview of the procedures used when cancelling an offer of In-Patient admission. The procedures are normally performed by the Admission Office staff,
either at Ashford or St Peter’s Hospitals, using information generally provided
by the ward or secretarial staff or by capacity managers.

1) Cancellation before the admission of a patient - (PRC.)

An admission offer can be cancelled before the admission date, or on the actual day of admission, using the PRC screen on PAS. The cancellation can be made for the primary reason of either Patient-Related, or for Hospital-Related reason. Having entered which of these two primary reasons apply, the more detailed secondary reason for cancellation can be selected from a list of pre-defined codes available from the PRC screen on PAS. Finally a choice has to be made to return the patient to the waiting list (for a new TCI date to be arranged) or to cancel the waiting list entry, (so no further TCI date will be sent.)

If the primary reason is Hospital-Related, the PAS system automatically retains the original waiting list starting date (or the date of the most recent Patient-Related cancellation if later.) If the primary reason is Patient-Related, the waiting list starting date is automatically changed to the date that the cancellation was recorded.

2) Cancellation after admission of a patient – (CEA.)

When a patient’s admission is cancelled after a patient has been admitted to a ward, the CEA procedure has to be followed instead. The CEA screens on PAS are used to record
the primary Patient-Related or Hospital-Related reason and the more detailed secondary reason code as described above. However the CEA procedure then automatically generates a new waiting list entry starting from the date the admission was cancelled. If the cancellation was Patient-Related nothing further needs to be done on PAS. However if the cancellation was Hospital-Related, then the waiting list starting date has to be amended. The date has to be changed to either the original waiting list starting date or to the date of the most recent Patient-Related cancellation – whichever is the latest.

3) Additional Comments.

A decision to suspend the patient may be appropriate following cancellation of an admission offer. The suspension procedure is not described here.

When recording cancellations or postponements, it is the reason in each case that is required (not who made the decision.) Thus if any Hospital-Related reason is given on the day of admission, a new admission date must be agreed within 28 days. This is not the case for Patient-related Reasons.

From the above summary it is clear that it is most important that the accurate primary and secondary reasons for admission cancellation are determined and then passed to admission staff, to ensure the PAS record is correct, enabling the appropriate subsequent waiting-list and admission management decisions to be made.
4) **Definitions.**

TCI  ‘To come in date’ (the proposed admission date)

PAS  The Patient Administration System

PRC  The Pre-Admission Cancellation Screen on PAS

CEA  The Cancel Elective Admission (following admission) screens on PAS
Admission Criteria for Patients Transferred To SPH Day Surgery Requiring Inpatient Care

SUITABLE CRITERIA

- Clinically stable patients direct form A&E/ED
- Orthopaedic/Surgical inpatients due for discharge following day
- Orthopaedic/Surgical inpatients who are due for surgery the following day
- Medical inpatients due for next day discharge.

**NB:** Patients must be deemed clinically stable prior to transfer.

UNSUITABLE CRITERIA

- Confused patients are **EXCLUDED** from Admission Criteria
- High dependency patients are **EXCLUDED** from Admission Criteria
- Patients with infections or diarrhoea of unknown cause are **EXCLUDED** from Admission Criteria
- Patients who are MRSA Positive or are known to have had MRSA without a negative clearance are **EXCLUDED** from Admission Criteria
- Insulin dependent patients diabetic patients on diabetic clamp treatment regime are **EXCLUDED** from admissions criteria.
- Patients with Epidural are **EXCLUDED** from admissions criteria.

1. Head of Admissions/Capacity Manager will contact the Day Surgery Head of Nursing/Shift Leader (Day Surgery) to agree the use of Day Surgery as additional capacity.
2. In exceptional circumstances, where appropriate elective/next day discharge cannot be identified A&E Dr. (with the Day Surgery shift leader) will agree suitable patients for transfer i.e., next day drainage of an abscess etc.
3. All patients will be accompanied by a nurse escort and a detailed hand-over given to the Day Surgery staff.
4. All relevant documentation must be transferred with the patient including observations, blood glucose monitoring records, drug charts, fluid chart, admission details, patient medical notes and x-rays.
5. A&E staff must transfer patients to Day Surgery Unit via the PAS system.
6. All patients admitted to the Day Surgery Unit will be nursed on a bed to reduce any risk to pressure areas.
7. Patients for next-day surgery should arrive late pm.
8. For planned admissions, Capacity Manager/Admissions to inform ward to transfer Notes & x-rays
9. Patients admitted over the weekend will be discharged before 8am on Monday mornings.

**NB:** Patients admitted over the weekend will be discharged before 8am on Monday mornings to free up sufficient capacity for the patients undergoing eye surgery. In the event it is anticipated that Day Case activity maybe affected. Patients must be pre-cancelled and Consultants/Secretaries informed.
Runnymede Hospital & the Shakespeare Suite

Purpose
• Private hospitals will accommodate NHS patients within the following guidelines:-
• Planned private admissions are not cancelled as a result of NHS admissions.
• NHS admissions will be arranged after discussion and agreement with the Senior Nurse and Consultant.
• The environment is appropriate for the care of the patient and staff are available in the Suite in sufficient numbers to safeguard the care needs of all patients.
• A bed will not be considered as being available where it has been allocated for a planned private admission for the following day.
• On the Shakespeare Suite one bed on the Suite will be ring-fenced at all times (not considered as available for NHS admissions) in anticipation of an emergency private admission. When on Red Alert this may be over ruled

Criteria for admission
• Pre-elective Patients
• NHS patients requiring post-operative care,
• In exceptional circumstances (major incident, severe bed crisis) the policy may be over-ruled by the On Call Manager in discussion with the Private Patient Manager, or if out of hours, with the Senior Nurse on Duty on the Shakespeare Suite.
• Short- term emergency admissions e.g. minor Trauma, IV antibiotics x 2 days, etc.
NB: AT NO TIME should emergency admissions jeopardise PP admissions.

Patients not suitable for transfer
• those patients requiring lots of visits from junior doctors
• confused patients (as transfer would make them even more confused)
• patients requiring social input etc. prior to discharge

Procedure
• The Capacity Manager/Site Co-ordinator/A&E/ED Shift Leader will contact the Senior Nurse on duty/bleep holder, prior to arranging admission or transfer of an NHS patient(s).
• The Nurse/bleep holder in charge will check the current bed-state and the admission diary and agree to admission or transfer of the NHS patient(s).
• The Nurse/bleep holder in charge will obtain details of the proposed number of NHS admission(s), time of admission or transfer, anticipated length of stay, proposed discharge time and clinical condition.
• The Nurse in charge/ bleep holder will inform the Capacity Manager/ Site co-ordinator of the decision to accept or reject the NHS admission(s).

NB: Notes and x-rays must go with patients and all appropriate teams should be notified of patient transfer.

Patient Transfer
□ Responsibility for arranging transfer from other wards and departments, arranging porters, informing patients, relatives and clinicians rests with the Capacity Manager/ Site Co-ordinator.

• Where possible, porters will be responsible for transfer with nurse to nurse hand-over
• If the Runnymede Hospital is quiet and can help, Runnymede staff can collect patients or take patients back
• If the patient is being transferred from NHS to private the Runnymede will collect as appropriate.

Property
• The nurse in charge will ask relatives to take all unnecessary property and leave only the essentials
• They will also ask relatives to list the property and will include the list in the patient’s notes.

X-rays
• The Runnymede Hospital will perform any necessary X-rays at agreed prices.
Transfer of NHS Patients from St Peter’s Hospital to Private Hospitals

Guidelines for Capacity Manager, Site Co-ordinator/A& E/ED

- Check insurance; obtain as much information as possible.
- Ensure Consultant has sanctioned transfer of patient and a Consultant has accepted care of patient in private hospital.
- Contact Reservations on ext. 3001 Runnymede and ext. 4111 Shakespeare Suite, or bleep holder.
- Liaise with reservations/bleep holder to check bed state.
- If bed available, agree ward for transfer time.
- Nurse and Porter with bed, trolley or wheelchair to collect patient from St Peter’s Hospital. If transfer of NHS patient to help capacity as a result of severe NHS bed shortage, St Peter’s nurse will be expected to escort patient to Runnymede bed and to/from theatre.
Ashford & St. Peters
Admissions Office Case note Retrieval Guidelines
Protocol

1. Admissions to collect case notes for elective and emergency inpatients (admitted via the A&E/ED or as a booked admission/pre-admission

2. Notes retrieved directly from health records/relevant departments/other hospitals and sent to wards

3. Utilise tracking system via PAS to ascertain whereabouts of notes and re-track when found

4. Daily elective printout produced to identify case notes required for both SPH and AH inpatients and day cases allowing for last minute “add-ons”.

5. Daily faxes’/pinkies’/phone calls received from ASPH/peripheral hospitals requesting case notes for admissions/clinics/emergencies

6. Throughout each day case notes retrieved for MAU, A&E/ED & all wards

7. In the event elective patients (on day of admission) have a ward change, the admissions office must ensure case notes are redirected in a timely manner.

8. SPH only - (Sundays) paperwork collected from A&E for all emergency admissions between Friday pm and early am Sunday. Urgent Ashford faxes received Sundays to be processed.

9. For all inter-ward/site (including community hospitals) transfers, notes should accompany patients and be tracked as appropriate

A&E/ED to ensure all Cas cards are filed in the notes of patients admitted as an emergency

COB May 04
Guidelines on the use of the Observation bay

Patients may be admitted to the Observation Bay if the A&E/ED Consultant or Senior Nurse considers it appropriate. Such patients would include:

- Minor head injuries requiring 12 to 24 hour neurological observations
- Those requiring assessment by Social Services, Home from Hospital, OT or Physiotherapy
- Following reduction of a fracture or dislocation under sedation
- Those requiring observation following overdose.

The Observation Bay is not for patients waiting for an inpatient bed. However, if the main A&E/ED Department is under strain due to the amount of patients waiting for beds, it is acceptable to use the Observation Bay. Certain patients should not be admitted to this area - these would include:

- Any patient requiring cardiac monitoring
- Patients requiring their oxygen saturation levels monitored
- Those needing post operative care
- Patients with a Glasgow coma scale below 15.
The Emergency Capacity Management Scheme (ECMS) is responsible for controlling all GP and 999 generated emergency admissions. Patients who live in areas that are equidistant from more than one hospital are transported to the one under the least pressure at the time of call.

The scheme ensures that patient workload is shared more equally whilst protecting the interests of patients and their relatives.

The scheme is designed to minimise the time spent dealing with tasks associated with the management of movement of patients, allowing time to concentrate on clinical issues. It is not however purely automatic; the scheme is managed and is responsive to clinical or practical reasons for sending a patient to a particular hospital.

What you need to know

- GPs who use Surrey Ambulance Service as their transport provider, who require admission for a patient to an acute Trust, MUST telephone the ECC prior to contacting the on call teams. The destination site will be decided dependent upon activity at the Trusts and the location of the patient. Transport is arranged if required.

- The ECC then informs the agreed Trust of the patient’s details by computer link.

- The GP MUST then contact the on call team at the receiving site to exchange clinical details, and they MUST send a full referral letter with the patient. If any of the three component parts of the referral process are omitted, please inform the ECC via A&E/ED links.

- Any patient with an EC Ref number is considered to have been accepted on behalf of the relevant on call team, and therefore should be treated as such – these patients should not be treated as walk in cases for the Casualty Officers.

- The Trust will inform the ECC of their A&E/ED activity status regularly throughout the day. This information is used to inform the GPs as to which Trust is most appropriate.

- The scheme only affects patients who are served by Surrey Ambulance Service NHS Trust, requiring emergency admission to Acute Trusts in Surrey.

- The scheme operates 24 hours a day, 7 days a week.

- The on-call doctor should not accept a patient from a GP without an EC reference number. If the GP contacts the on-call doctor without a reference number, they are bypassing the system, which ultimately defeats the concept of equalising patient workload across the County. In this case please refer the GP to the ECC on 01737 363885 before accepting the patient.
CCU1 – Admission from A&E

A&E

Medical assessment (inc. ECG)

MI?

Yes

Thrombolysis (See Thrombolysis procedure)

No

Admit

No

End

Yes

CCU bed available?

No

Alert Capacity Manager

Yes

Porter + CCU/A&E Nurse transfer patient to CCU.

CCU

Capacity Manager

Patient delayed in A&E

No

Medical Bed Available

Yes

Transfer stable CCU patient to a medical bed
CCU2 – Admission Post Cardiac Arrest (ASPH)

Ward

Patient stabilises after an arrest

CCU

Porter + CCU Nurse if available. Otherwise A&E/ED Nurse transfer patient to CCU.

Capacity Manager

Transfer stable patient out of CCU to make bed

No

Medical bed available

Yes

Transfer stable CCU patient to a medical bed

Porter + CCU/A&E Nurse transfer patient to CCU.

CCU bed available

Yes

Medical bed available

Yes
CCU3 – Admission from Outpatients (ASPH)

**OPD**

+ve exercise test patient slow to recover

Porter + CCU Nurse if available. Otherwise A&E/ED Nurse, transfer patient to CCU.

Patient stable

Consultant phones CCU re. bed

**CCU**

CCU bed available

Alert Capacity Manager

No

Medical bed available

Yes

Transfer stable CCU patient to a medical bed

**Capacity Manager**

No

Patient delayed in OP

Porter + CCU/A&E Nurse transfer patient to CCU

Inform Capacity Manager

Yes
CCU4 – Cardioversion admission (ASPH)

CCU/Theatre

Patient booked in for Cardioversion (every day except Thursdays)

DAY BEFORE ADMISSION
Bloods taken: U&Es and INRs checked

Normal blood results?

No

Patient cancelled and rebooked following dose change

Yes

DAY OF ADMISSION
Patient phones in to check bed availability

Bed available?

No

Rebooked to closest available date

Yes

Patient comes in for Cardioversion

Discharge same day
Chaucer Ward – Stroke Unit

Admitting Medical Team

Patient requires admission

Contact Stroke Nurse Specialist/ward

Patient meets admission criteria

See section 2.1.3 “Criteria for admission”

Yes

Bed available

Yes

Patient admitted

No

Admit to medical ward

No

Admitted to medical ward. (patient logged in Chaucer diary)

Stroke Nurse Specialist

Site Co-ordinator/ Capacity Manager

Yes

Patient admitted

Admit to medical ward
Protocol for Deciding on Inpatient Stay at St Peter’s Hospital Following Coronary Angiography
(Ashford and St Peter’s patients)

Statement: Following pre-assessment, 24 hours post Coronary Angiogram there must be a responsible adult who can stay with the patient.

1 Criteria for an arranged inpatient stay
   • No relative or friend to stay with the patient at home.
   • No relative or friend’s house where the patient can stay.
   • Following pre-assessment, any medical condition or any other circumstance where it is in the patient’s interest and safety to stay overnight (discussed with Doctors).
   • No telephone where patient will be staying.
   • No emergency care bed in sheltered accommodation.

NB. Patients will be informed why an inpatient stay is required, and that in extreme circumstances, the procedure may be cancelled.

1 Booking procedure for an inpatient stay
   In exceptional circumstances where all options have been exhausted, including Night Sitting Service the following process will be put into operation.
   • Pre-assessment Nurse will document and inform the Angiography Suite receptionist who will inform the admissions office supervisor of the patient’s name, hospital number, date and approximate time of procedure. This will be recorded.
   • The Capacity Manager will be informed of the requirement for overnight stay by the Angio pre-assessment Nurse.
   • Day Ward will also be informed by Angiography Suite receptionist.

2 The patient will attend and be admitted to the Day/Birch Ward/MAU and be processed as any other day case patient, including the recovery period following the Coronary Angiogram. Ashford patients will be scheduled for the morning to facilitate before 4pm return to Ashford.

3 EPS/ICD patients who have their procedure in the afternoon. Bed should be booked on CCU, (daybed) for overnight care. Patient to be discharged home either same evening (EPS) or next day (ICD).

   Note: If in extreme circumstances due to pressures in A&E, the Capacity Manager, knowing the requirement for a bed and taking all options into consideration, decides it is not possible to guarantee a bed, then the Angiography Suite /Day Ward will be notified by the Capacity Manager.

   In this event, the Capacity Manager will notify the Day Ward as early as possible on the day, preferably before 9am, prior to the procedure commencing. The Angiography Suite receptionist will then rebook the patient for a Coronary Angiogram at a later date.
**Flow of Patients to SPH for Inpatient Angiography/plasty**

Source of referral: - ASPH inpatient, Frimley Park Hospital inpatient

- **AH – Angiography Inpatient bed required SPH (Birch Ward)/CCU**
  - YES
  - AH Reg. to contact Capacity Manager (AH) for transfer of patient to Birch (Angio Bay) within 24hrs of request
  - YES
  - Bed available
  - YES
  - Patient transferred
  - Proceed to Angioplasty?
  - YES
  - Angio Suite to contact Capacity Manager and liaise with CCU
  - YES
  - Capacity Manager to transfer patient direct to CCU for post procedure care
  - YES
  - 24hrs post procedure, plan patient discharge from CCU or return to AH
  - YES
  - Contact Capacity Manager (AH); Patient returned to AH
- YES
  - Frimley Park Angiography/plasty? (all patients to be managed as day cases)
  - YES
  - Frimley Park Bed Manager to contact Angio Suite direct for transfer of patient to DSU, including booking details
  - NO
  - Patient awaits transfer according to priority. Capacity Manager to liaise direct with Angio to ascertain availability of beds in DSU.
  - NO
  - Routine Angiogram
  - NO
  - Transfer patient (following plasty) to CCU
  - YES
  - Patient returns to Frimley Park from Day ward
  - YES
  - 24hrs post plasty Frimley Park patient to be reviewed by ASPH Cardiologist for discharge or return to Frimley Park bed
- NO
  - Transfer patient to Birch Ward or remain in CCU if clinically necessary
EMERGENCY ON CALL

The physiotherapy Service provides 24-hour cover for emergency duties on an ‘on call’ basis. There is a Physiotherapist covering the service who is on-call from 4.30 p.m. to 8.00 a.m. A list of on-call Physiotherapists is available at switchboard. There is a named person on-call each evening.

The Physiotherapist reserves the right, on judgement, whether it is a necessary call-out or not after speaking to the referrer.

EMERGENCY CALLS MUST MEET THE FOLLOWING CRITERIA:

a) The patient’s medical condition would significantly deteriorate without Physiotherapy intervention.

b) The call-out has been initiated by a registrar or above, or in ITU by Senior nursing staff that have a genuine and knowledgeable concern about the patient’s condition. OR

Where a patient’s condition deteriorates, or in the event of a new admission who needs treatment before 8.30am the next working day, an emergency call may be made by a registrar/ITU nurse of Consultant. (Please note calls will be not accepted from nursing staff or house officers).

c) Patients already receiving physiotherapy for respiratory conditions are assessed by the ward physiotherapist during the day, and, if necessary, evening physiotherapy treatment will be arranged.

QUESTIONS ASKED BY ON CALL PHYSIOTHERAPIST

- The name, position and bleep number of the referring doctor.
- Patient details: Name, Age, Ward, Diagnosis and History.
- Investigations: CXR, ABG’s, Sa O₂.
- Symptoms: Temperature, BP, Respiratory rate, Sputum production – amount.
- Breath sounds on auscultation.
- Fluid balance.
- Treatment plan: O₂, Analgesia, Bronchodilators, Humidification, ? ventilation.
- Indication of reason for deterioration: e.g. a change which physiotherapy may help.

TYPICAL EMERGENCY CONDITIONS

- Respiratory failure, with retention of secretions
- Broncho-pneumonia (productive)
- Atypical pneumonia (productive)
- Severe COPD, with retention of secretions
- Collapsed lung (from obstruction)
- Aspiration
- Chronic Bronchitis (productive)

CONDITIONS NOT FOR EMERGENCY PHYSIOTHERAPY

- Unstable heart conditions i.e. recent MI, sudden onset arrhythmias
- Congestive cardiac failure
- Pulmonary oedema
- Surgical emphysema
- Severe bronchospasm
- Unresolving pneumonia, where patient is non-productive
- Consolidation of lung
- Patient not for active treatment
- Pleural effusion
- Pneumothorax
- Recent Pulmonary Embolism

Appendix 14
CRITERIA FOR ADMISSION TO THE TRAUMA & ORTHOPAEDIC UNIT

PATIENT

Emergency Admission

Yes

No

Elective Admission

Yes

No

Review patient in OPD clinic or refer to GP

Via A&E

Via OPD

Assessed by Ortho SHO or higher

Sanctioned by Ortho Reg or higher

ALL OPD admission to be admitted via Capacity Manager

Admit patient to an orthopaedic ward (where possible) under on-call consultant & transfer to care of specialist on instruction of admitting consultant

Patient put on waiting list in order of priority:

- URGENT
- SOON
- ROUTINE

Patient attends pre-assessment clinic within 6 weeks prior to admission

Yes

No

Ensure patient has confirmed TCI date following receipt of letter

Refer to appropriate consultant for review
PATHWAY FOR ADULT TRAUMA PATIENT

1. **ADMITTED VIA A/E UNDER CARE OF ON-CALL CONSULTANT**
   - **NO SURGERY**
   - REMAINS WITH ON-CALL CONSULTANT EXCEPT HR → DSE & RSI → KJN
   - PREVIOUS SURGERY → FOLLOW UP
   - REVERTS TO OPERATING CONSULTANT (DISLOCATED HIPS, ETC) → FOLLOW UP

2. **SURGERY**
   - Care taken over by OPERATING CONSULTANT
   - FOLLOW UP
   - IN THE AGREED CONSULTANT # CLINIC (SEE LIST)
   - CONSULTANT ORTHO CLINIC

3. **PATIENTS ADMITTED FROM TRAUMA BOARD WILL BE UNDER THE CARE OF OPERATING CONSULTANT**

4. **PATIENTS ADMITTED FROM CLINIC WILL BE UNDER THE CARE OF THE CLINIC CONSULTANT EXCEPT WHEN CONSULTANT ON LEAVE THEN IT WILL BE THE ON – CALL CONSULTANT**

Appendix 15a

- MR ELLIOTT (DSE) DSE # CLINIC
  - MR ROUSHDI (HR) RSI # CLINIC
  - MR SINNERTON (RSI) RSI # CLINIC
  - MR NEWMAN (KJN) KJN # CLINIC
  - MR SIMONIS (RBS) CBS # CLINIC
  - MR SCHOFIELD (CBS) CBS # CLINIC
  - MR NEWMAN (KJN) KJN # CLINIC
  - MR BUCHAN(MB) AH # CLINIC
  - MR BUCHAN(MB) AKH ORTHO CLINIC
  - MR BLOOMFIELD (MDB) AH # CLINIC
PATIENTS WHO REQUIRE ADMISSION TO THE SURGICAL UNIT

EMERGENCY
via A&E

ASSESSMENT
by Doctor

Bed Required

No

Discharge

Yes

ACUTE
via OPD

ASSESSMENT & SANCTION
by Registrar/Consultant

ELECTIVE
Waiting list

ASSESSMENT
at OPD clinic and priority status given

PRE-ASSESSMENT

TCI DATE & ADMISSION

SURGICAL WARD/DSU

All patients admitted as surgical emergencies will be admitted under the care of the admitting Surgical Team. Where possible, Surgical patients will be admitted to a Surgical ward.

If patient needs transfer from AH to SPH, ensure Reg. to Reg. hand-over and contact with Capacity Manager.
Protocol for Gynaecological Surgical and Orthopaedic Emergencies at Ashford Hospital

Gynaecological Surgical and Orthopaedic emergency patients will not be brought into Ashford Hospital by ambulance. The only admissions will be self referrals who should be seen and dealt with in the usual way, i.e. the Casualty Officer/Emergency Nurse Practitioner (ENP) will triage the patient and then refer to the SHO. If admission is considered necessary the pathway below should be followed.

GYNAECOLOGICAL SURGICAL AND ORTHOPAEDIC EMERGENCIES

Patient requires transfer to SPH for further specialist opinion

↓

Nurse arranges transport (via SAS) to SPH A&E and informs the shift leader at SPH

↓

All case-notes, ultrasound reports and x-rays MUST be sent with the patient

↓

Patient arrives at SPH A&E and the A&E Shift leader will inform the appropriate team

↓

Specialist Team review the patient

↓

1. Team will decide

  ? admit

  ? refer → other speciality
           EPU Outpatient

  ? discharge

If admission is necessary, the nurse will liaise with the Capacity Manager Or Site Co-ordinator

NB: Unstable gastroenterology patients i.e. active GI bleed, should be transferred to SPH A&E department
Appendix 18

PRE-OPERATIVE FASTING POLICY

DEFINITION

Fasting before surgery is necessary to avoid the risk of regurgitation and vomiting.

In order to avoid dehydration, electrolyte imbalance, malnutrition and general malaise it is important patients do not fast for longer than is necessary and evidence shows that patients can benefit from water only up to 2 hours before surgery.

POLICY

The Association of Anaesthetists of Great Britain and Ireland recommends fasting periods based on the American Society of Anaesthesiologists (ASA) Guidelines

- 6 hours for solid food, infant formula, or other milk
- 4 hours for breast milk
- 2 hours for clear non-particulate and non-carbonated fluids
- the chewing of gum should be treated as an oral fluid and prohibited for 2 hours pre-operatively

FASTING FOR AN AM OPERATING LIST

The patient will have nothing to eat from midnight on the night before the operation but may drink water only up to 07:00hrs for a 09:00hrs start and up to 06:30hrs for an 08:30hrs start.

FASTING FOR A PM OPERATING LIST

The patient may have a light breakfast (e.g. tea/coffee and toast) before 07:00am on the morning of the surgery. Nothing should be eaten after that although water only may be drunk until 11:30am for a 13:30hrs start.

FASTING FOR ANGIOGRAPHY PATIENTS NOT RECEIVING A ‘G.A.’

Morning list, light breakfast, tea and toast and jam at 6am or before. Afternoon list, light lunch before 11am.
1 AGE
There is no upper age limit for patients

2 GENERAL HEALTH
All patients should be classified according to the American Society of Anaesthesiologists (ASA) grading system:
Grade 1 Fit and healthy
Grade 2 Mild to moderate systemic disease with no limitation of activity
Grade 3 Severe systemic disease with some limitation of activity
Grade 4 Life-threatening disease with severe limitation of activity
Grade 5 Moribund patient with little chance of survival

Unless specifically excluded by any of the following criteria, all patients of ASA grade 1-3 should be acceptable for
day surgery.

3 WEIGHT AND BODY MASS INDEX
Body Mass Index (BMI) is the weight in kg divided by the (height in M)\(^2\)
Patient with a BMI < 35 are suitable for day surgery
Patients with a BMI of 35-40 should be acceptable for most procedures but should be discussed with the relevant
anaesthetist wherever possible.
Patients with a BMI above 40 are not suitable for day surgery

4 EXISTING MEDICAL CONDITIONS
-2 Cardiovascular Disease
Hypertension
This needs to be well controlled prior to surgery.
A blood pressure of greater than 170mmHg systolic or 100mmHg diastolic will need to be treated.
The patient should be referred back to their GP. Any changes in anti-hypertensive mediation should be given at
least 2 weeks to work prior to the date of surgery.

Ischaemic Heart Disease
A myocardial infarct within the last 6 months is a contraindication.
Those patients with New York Heart Association (NYHA) angina grade 1 are suitable
(see appendix 1)

Cerebrovascular accident (CVA) and Transient Ischaemic Attacks (TIA)
Unsuitable if any episode has occurred within the past year.

-1 Respiratory Disease
Asthma
Needs to be well controlled. Those patients requiring frequent hospital admissions, frequent oralsteroids or
oral steroids within the past 3 months are not suitable.

Dyspnoea
Those patients with New York Heart Association (NYHA) functional classification 1 are suitable (see
appendix)

0 Endocrine Disease
Diabetes Mellitus
Well controlled diabetes mellitus is acceptable for short procedures providing there will be no
Significant disruption to a patients appetite and food intake.

Please see a list of procedures suitable for diabetic patients, Appendix 2.

1 Neurological disease
4.5 Epilepsy
Patients with epilepsy controlled on treatment should be suitable

ANESTHETIC HISTORY
Wherever possible, where there is a history of or a family history of problems with anaesthesia, the relevant notes or details should be obtained and the appropriate anaesthetist contacted. A history of problems with anaesthetics does not necessarily mean that the patient is unsuitable for day surgery.

LENGTH OF PROCEDURE
Previously, an arbitrary limit of one to two hours was set as the limit for operations considered to be suitable for day surgery. Absolute length of an operation is now considered less important than pain and postoperative problems. Patients need not be admitted solely because their operation has been longer than anticipated.

HOME SUPPORT
The patient must have:

- A responsible adult with tem for the first 24 hours after a procedure involving a general anaesthetic or sedation.
- Access to a telephone
- General Practitioner and nursing back-up available.

Previously it was recommended that patients should live within 1 hours travelling time of the hospital. Some patients will live further away and wish to go home on the day of surgery. Where appropriate this should be possible. However, the possibility of pain, nausea and vomiting during an extended journey should be explained to the patient and documented.

NEW YORK HEART ASSOCIATION FUNCTIONAL CLASSIFICATION OF ANGINA OR DYSPOEIA. Ref: (Contemporary Management of Angina) Published by American Family Physician.(Dec 1999)

1 No limitation of ordinary physical activity. Angina or Dyspnoea with strenuous or rapid prolonged exertion.

2 Slight limitation or normal activity. Angina or dyspnoea with rapid walking, climbing stairs, emotional stress.

3 Significant limitation of normal activity e.g. angina or dyspnoea climbing a flight of stairs. No angina at rest.

4 Incapacitation. Angina or other symptoms of cardiac insufficiency with mildest effort or at rest.
DIABETES AND DAY SURGERY

Procedures Suitable for Day Surgery in Diabetic Patients

ORTHOPAEDIC SURGERY
Carpal Tunnel decompression
Excision of ganglion
Excision of exostoses and other lumps
Manipulation of spine
Manipulation of other joints
Injections into joints

GENERAL SURGERY
Excision of skin lesions
Excisions of subcutaneous lesions
Simple excision of breast lump
Excision of toenail

UROLOGICAL SURGERY
Cystoscopy
Cystodiathermy
Excisions of epididymal cyst
Lithotripsy
Vasectomy

ENT SURGERY
Insertion of grommets
Antral washouts
Removal of foreign body from ear or nose

GYNAECOLOGICAL SURGERY
Hysteroscopy
D & C

ORAL SURGERY
Simple extraction of teeth (not wisdom teeth)

ANGIOGRAPHY PATIENTS
All procedures where patient is well controlled and does not require Diabetic Clamp

Other procedures may be suitable in certain patients, but should be discussed with the anaesthetist involved.
Annex A

The Audit Commission “Basket of 25”

1. **Orchidopexy** – correction of undescended testes
2. **Circumcision** – removal of foreskin
3. **Inguinal Hernia Repair** – repair of outpouching of the abdominal sack of the groin
4. **Excision of Breast Lump** – removal of a lump in the breast
5. **Anal Fissure Dilatation or Excision** – treatment for tear of the skin at the anal region
6. **Haemorrhoidectomy** – removal for haemorrhoids from within the anal canal
7. **Laparoscopic Cholecystectomy** – removal of the gallbladder by means of an instrument introduced through a small hole in the stomach wall
8. **Varicose Vein Stripping or Ligation** – removal of tortuous and incompetent veins in the leg
9. **Transurethral Resection of Bladder Tumour** – removal of a tumour by an instrument inserted into the bladder
10. **Excision of Dupuytren’s Contracture** – removal of fibrous tissue under the skin of the palm that causes the fingers to become bent
11. **Carpal Tunnel Decompression** – incision in the wrist to relieve the pressure on the median nerve as it passes into the hand
12. **Excision of Ganglion** – removal of a lump usually around the wrist, hand or foot
13. **Arthroscopy** – the use of an instrument to look inside a joint for diagnosis and/or treatment
14. **Bunion Operations** – straightening of the big toe and removal of bony overgrowth causing it to bend
15. **Removal of Metal ware** – removal of pins or plates used to stabilise a fracture
16. **Extraction of Cataract with/without Implant** – removal of a cloudy eye lens and, if appropriate, replacement with a synthetic one
17. **Correction of Squint** – repositioning of the muscles of the eyeball
18. **Myringotomy** – relief of glue ear by making a small hole in the ear drum to release pressure and inserting a tube to avoid recurrence
19. **Tonsillectomy** – removal of the tonsils
20. **Sub Mucous Resection** – relief of nasal blockage caused by bent cartilage in the middle of the nose
21. **Reduction of Nasal Fracture** – repositioning of the bone in the nose
22. **Operation for Bat Ears** – removal of skin and cartilage at the back of the ears
23. **Dilatation and Curettage/Hysteroscopy** – examination of the inside of the uterus and removal of tissue if necessary
24. **Laparoscopy** – use of an instrument introduced through the abdomen for diagnosis and treatment of internal organs often by gynaecologists
25. **Termination of Pregnancy** – evacuation of the contents of the pregnant womb
Annex B

Maintaining the supermarket analogy, the British Association of Day Surgery proposed a “trolley” of procedures, which are suitable for day surgery in some cases.

Some have been adopted by the Audit Commission into their revised basket (2001). The others are:

1. **Laparoscopic hernia repair**
   Repair of abdominal hernias using minimally invasive keyhole technology

2. **Thoracoscopic sympathectomy**
   Keyhole chest surgery to reduce excess sweating of the hands

3. **Submandibular gland excision**
   Removal of the salivary gland under the jaw when affected by stones or inflammation

4. **Partial thyroidectomy**
   Removal of diseased thyroid gland in the front of the neck

5. **Superficial parotidectomy**
   Removal of the salivary gland in the cheek – usually for non-cancerous tumours

6. **Wide excision of breast lump with axillary clearance**
   Breast cancer operation removing up to ¼ of the breast, and the glands in the armpit

7. **Urethrotomy**
   Division of narrowing/stricture in the outflow from the bladder, often through a telescope

8. **Bladder neck incision**
   Division of the muscle in the bladder neck to relieve some cases of enlargement of the prostate gland

9. **Laser prostatectomy**
   Shrinkage of some cases of prostate enlargement using laser

10. **Trans cervical resection of endometrium (TCRE)**
    Removal of the lining of the womb through a telescope; to avoid hysterectomy in some cases of heavy periods

11. **Eyelid surgery**
    Correction of drooping or deformed eyelids

12. **Arthroscopic meniscectomy**
    Removal of damaged knee cartilage using keyhole technology

13. **Arthroscopic shoulder decompression**
    Use of keyhole surgery to correct abnormalities limiting movement at shoulder joint

14. **Subcutaneous mastectomy**
    Removal of swollen breast tissue in men, or some cases of very early cancerous changes in women

15. **Rhinoplasty**
    Plastic reconstruction of deformity of the nose

16. **Dentoalveolar surgery**
    Removal of impacted or complex wisdom teeth

17. **Tympanoplasty**
    Repair of perforated eardrum

Other proposals to change the basket were not accepted; details can be found in “Basket cases and trolleys” – day surgery proposals for the millennium (7)
Aim

To ensure that patients are provided with the appropriate level of care according to their clinical needs in order to facilitate the best possible outcomes from critical illness. This policy provides the criteria for three levels of care and these will indicate whether this care can be provided at the Runnymede or whether the patient should be transferred to St Peter’s HDU or ITU in line with our service level agreement.

Classification of critical care patients

<table>
<thead>
<tr>
<th>Level</th>
<th>Care required</th>
<th>Where is this provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>Patients whose needs can be met through normal ward care in an acute hospital</td>
<td>Runnymede</td>
</tr>
<tr>
<td>Level 1</td>
<td>Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support.</td>
<td>Runnymede</td>
</tr>
<tr>
<td>Level 2</td>
<td>Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those “stepping down” from higher levels of care</td>
<td>St Peter’s HDU</td>
</tr>
<tr>
<td>Level 3</td>
<td>Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.</td>
<td>St Peter’s ITU</td>
</tr>
</tbody>
</table>

Criteria

The table below is not a definitive list of criteria but rather a guide. Clinical judgement is vital. The Runnymede Hospital can provide Level 1 care. Should the patient’s requirements extend to level 2 or 3, transfer to St Peter’s Hospital must be arranged. See Critical Care Transfer Policy

<table>
<thead>
<tr>
<th>Level</th>
<th>Care required</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>Requires hospitalisation – needs can me net through normal ward care</td>
<td>• Oral medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bolus iv medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PCA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Observations required less than 4 hourly</td>
</tr>
<tr>
<td>Level 1</td>
<td>Patients recently discharges from a higher</td>
<td>• Observations required more than 4 hourly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stable Abnormal vital signs, requiring monitoring but not a higher</td>
</tr>
</tbody>
</table>
| Level of Care                                                                 | Level of Care - continuous cardiac and/or invasive arterial pressure monitoring and pulse oximetry. Intermittent CVP monitoring. Frequent blood glucose testing.  
|                                                                              | - Haemodynamically stable on intravenous infusions – inotropes, anti-arrhythmics, insulin.  
|                                                                              | - Chest physiotherapy or airway suctioning required at least 6 hourly but not more than 2 hourly  
|                                                                              | - Epidural analgesia  
|                                                                              | - Tracheostomy care  
|                                                                              | - Total parenteral nutrition |
| Level 2                                                                      | Respiratory  
| Patients needing single organ system monitoring and support                  | - Needing more than 50% inspired oxygen  
| Patients needing extended post-operative care and monitoring which cannot be provided at level 1 or below | - Requiring non-invasive ventilation or CPAP  
| Patients with major uncorrected physiological abnormalities                  | - Requiring chest physiotherapy or suctioning at least 2 hourly  
|                                                                              | - Respiratory rate >40breaths/min  
| Level 3                                                                      | Cardiovascular  
| Patients needing advanced respiratory system monitoring and support         | - Unstable requiring continuous ECG and invasive pressure monitoring  
| Patients needing monitoring and support for two or more organ systems        | - Haemodynamically unstable requiring infusions of vasoactive drugs  
| Patients with co-morbidity - chronic impairment of one or more organ system who require support for an acute reversible failure of another organ system. | - Heart rate >120bpm  
|                                                                              | - Hypotension systolic<80mmHg for>1 hour  
|                                                                              | Central nervous system  
|                                                                              | - CNS depression sufficient to prejudice airway and protective reflexes  
|                                                                              | - GCS<10 |
| Pre-booking for elective admission to Critical Care                         | Invasive mechanical ventilation or BIPAP.  
|                                                                              | At least 2 of the following:- Haemofiltration, Balloon counter-pulsation, IV vasoactive drugs |

Pre-booking for elective admission to Critical Care

If a patient is booked for a major or a simpler procedure for which their co-morbidity means that they will require a level of care greater than level 0, then critical care should pre-booked at the same time as the procedure.

The booking will be made by the Reservations Department in the relevant unit i.e. here or at St Peter’s Hospital HDU or ITU.

The surgery should not be commenced until the availability of the required critical care bed has been confirmed on the day.

Emergency admission to Critical Care

If a patient’s condition deteriorates and admission to critical care is required, this should be arranged by the admitting consultant and/or anaesthetist.

Stepping down from Critical Care
Patients who have been in ITU or HDU at St Peter’s may return to The Runnymede for Level 1 care once they no longer fulfil the criteria for level 2 or 3 care. This decision will be made by the Consultant in liaison with the Ward Sister.

**Consultant responsibility for Critical Care**

The admitting Consultant will give a comprehensive handover of the patient to the Nurse-in-Charge and the RMO.

The Consultant will ensure that if they are not familiar with critical care that the patient is referred to an appropriate anaesthetist or intensivist with admitting privileges for this aspect of care.

The patient receiving level 1 care at the Runnymede will be visited at least twice per day by an appropriate Consultant.

**References**


Guidelines for the transfer of patient to critical care

Runnymede Hospital

Aim

Patients who require level 2 or 3 critical care will need to be transferred to HDU or ITU at St Peter’s Hospital with whom we have a service level agreement for the provision of critical care. The aim is to transfer the patient with continuing medical treatment while minimising the detrimental effects to the patient.

Responsibilities

The decision to transfer the patient must be made by the lead consultant after full assessment of the patient and discussion between the appropriate consultants at the Runnymede and at St Peter’s.

The transfer process is the joint responsibility of the referring consultant and transfer staff.

Actual transfer procedure

Once the decision has been made, a full assessment of the patient’s needs during transfer must be made by the consultant. St Peter’s hospital will send a fully equipped retrieval team to fetch the patient.

The patient should be accompanied by the referring consultant and a ward nurse who can give a comprehensive handover to the receiving medical and nursing team.

Patients who are being transferred straight from theatre will be transferred according to the theatre policy.

The patient’s next of kin must be informed of the transfer as soon as possible with a full discussion of the reasons etc. when appropriate

Main Reception must be informed of the transfer to update Medax.

Charging

The Patient Liaison Officer must be informed of the transfer so that arrangements can be made for cover by the patient’s private medical insurance or the person responsible for the patient’s bill.

The patient’s account will be charged with the daily critical care rate.

References


**DISCHARGE OF PATIENTS TO THE WARD FROM INTENSIVE CARE/HDU (ASPH)**

With proper discharge planning in place the need to transfer to other hospitals or delay transfer out of ITU/HDU (CCU at AH) maybe significantly improved.

**LIAISON WITH CAPACITY MANAGERS.**

1. The shift leader or ward clerk (under the direction of the shift leader) should undertake discussion with the Capacity Managers **ONLY**.

2. As soon as possible in the morning inform the Capacity Manager of any potential discharge from the unit.

3. The Capacity Manager should be informed by 10.00 following the round.

4. The Capacity Manager will keep the unit informed of the progress being made with regard to capacity

5. The Capacity Manager will, wherever possible, give a time when a bed will be available when informing the unit of the name of the ward.

6. The Capacity Managers will ensure that at least one bed can be made available for ITU discharges so that a bed is available for emergency/elective admissions. This should reduce delay in accessing an emergency critical care bed and avoid urgent cancellations.

7. If a bed is not required for a discharge that day the Capacity Managers should be informed as soon as possible so that the bed may be used for another patient.

8. **Patients SHOULD NOT** be discharged from the unit after 20.00 hours unless in an emergency.

9. When receiving a patient, the units should inform the Capacity Manager of the admission, where the patient is coming from and what consultant they are under. If an emergency from theatre, the Shift Leader should ascertain what ward the patient had been on and inform the Capacity Manager.

10. Discharges from the unit should, wherever possible, be planned and under controlled conditions so that the patient (and relatives) can be made ready and a proper handover given to the ward staff.

11. Discharge to the Surgical HDU should also involve the Capacity Manager so that they are aware that a bed must be made available for a discharge from the HDU to accommodate the patient coming from ITU.

12. The senior staff on HDU should inform the Capacity Manager as soon as possible about admissions and agree discharges from the unit so that a good flow of patients is achieved between ITU and HDU.

13. In order to ensure capacity for planned admissions, the Capacity Managers will be required to liaise with ITU/HDU at least 24hrs in advance of electives TCI’s
SURREY WIDE CRITICAL CARE NETWORK

Report Proforma for all Patients being transferred from Network hospitals out of Transfer Group and Network (Adverse)

The proforma must be completed for the Critical Care Unit wherever the patient is being transferred from, e.g. A/E, Recovery

No. of beds open in the unit at time of transfer ………………………………………………………………

No. of beds occupied in the unit at time of transfer ………………………………………………………………

No. of nursing staff on duty in the unit at time of transfer ……………………………………………………………

No. of nursing staff on duty in the unit for following 2 shifts …………………………………………………………

Patients on unit ready for discharge ……………………………………………………………

Patients on unit waiting for transfer to specialist/long-term care ………………….

Additional comments in support of transfer:

Name of member of staff completing form:

Post held:

Signature:

Date:
**Adverse Incident Form**

**Transfer of Critically Ill Patients Out of Transfer Group**

Non-clinical transfers of patients to or from units outside these agreed groups or the Network should be recorded as adverse incidents, and the following documentation completed.

1. **Transfers from (your particular Trust)**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Hospital No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Patient:</td>
<td></td>
</tr>
<tr>
<td>Transferred from:</td>
<td>Receiving Hospital:</td>
</tr>
</tbody>
</table>

**Rationale for transfer:**

Name of Consultant approving transfer:

Name/ Signature of person completing the form:

On agreement of transfer, the General Manager responsible must be informed by the Consultant/most senior nurse on duty as soon as possible during working hours:

2. **Transfers into your particular Trust**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Hospital No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Patient:</td>
<td></td>
</tr>
<tr>
<td>Transferred from:</td>
<td>Accepting Consultant:</td>
</tr>
</tbody>
</table>

**Rationale for Transfer:**

On completion, please send this form to: Your Critical Care Manager or Senior Nurse for action

A copy should also be sent to the Network Co-ordinator.
Pre Transfer Decision

ii. The Surrey Wide Critical Care Network (SWCCN) is committed to the safe transfer of all critical care patients who require transfer to a different critical care facility.

iii. Critical care transfers are necessary for clinical/specialist treatment. The SWCCN is committed to reducing, and hopefully negating, the need for non-clinical transfers.

iv. All attempts will be made to contain the critical care demand:
   d) within the individual acute Trusts
   e) within the SWCCN
   f) within the Transfer Groups

v. All potential options will be explored within the individual Trusts’ critical care service prior to a decision being made to transfer a patient.

vi. The following options should be explored by the nurse in charge of the critical care unit:
   ii. Utilising an un-staffed bed in the critical care unit by the temporary use of:
      ➢ Moving appropriate nursing staff to critical care unit from Recovery or elsewhere in the Trust
      ➢ Nurse in charge caring for a patient
      ➢ Exploring Bank/Agency/Overtime options
      ➢ 1 nurse caring for 2 patients (1 nurse:2 patients ratio)
      ➢ Moving a nurse from another critical care unit in the SWCCN if possible and appropriate

N.B Any decision made is dependant upon skill mix and feasibility

iii. Holding the patient in Recovery or an alternative safe place

iv. Creating a bed in the critical care unit by discharging a patient to a step down area with Outreach support if appropriate

v. Re-evaluating patient/nursing dependency within the critical care unit

vii. Patient to be assessed by a Critical Care Consultant as to requirement for transfer and to explore other potential treatment options with the patient’s team.

Transfer Decision

2.1 Once the decision has been made that a non-clinical transfer is unavoidable, the final decision for which patient should be transferred lies with the critical care consultant in charge

2.2 All units must follow the SWCCN joint transfer protocols with Surrey and Sussex Ambulance Service NHS Trusts.

2.3 The decision regarding which patient could take into account the following:
   ➢ Patient safety/stability for transfer
   ➢ The existing patients on the critical care unit and their care requirements
   ➢ The number of previous transfers an individual patient may have had
   ➢ Ventilatory weaning programmes of particular patients

2.4 Wherever possible, all patients will receive their required surgical procedures prior to transfer i.e. following “treat and transfer” principle.

During Transfer

3.1 All transfers will take place using the SWCCN joint transfer protocol with Surrey and Sussex Ambulance Service NHS Trusts.

3.2 The SWCCN Transfer Audit Form (SWCCN 1) will be used for all critical care transfers and is the legal record of transfer.

3.3 Adherence to the principles of “the management during transport” section of “Intensive Care Society” Guidelines for the transport of the critically ill adult patient” (2002)

Post Transfer
4.1 The SWCCN 1 form must be completed and a copy returned to the Network Coordinator.

4.2 All transfer forms will be reviewed by the Network Medical Lead and Network Coordinator.

4.3 Any clinical incidents arising from transfer will be investigated by the Network Medical Lead in conjunction with the lead consultant for critical care of the referring trust.

4.4 A database of critical care transfers will be established and be utilised for data analysis, information and audit purposes.

4.5 An annual audit of Network critical care transfers will be undertaken and a relevant action plan produced.

4.6 Trust critical care transfers must be reviewed at each Trust Critical Care Delivery Group meeting.

**Transfers out of Transfer Group and Network**

5.1 All transfers out of transfer group must be reported on the Network Adverse Transfer Form (Appendix 23).

5.2 A copy of this form must be sent to the Trust Critical Care Manager or Senior Nurse for action within the Trust according to individual Trust policy.

5.3 A copy of this form must also be sent to the Network Co-ordinator for information and investigation.

5.4 All adverse transfers must be reported on the Trust SITREP reports to the Strategic Health Authority and relevant PCT.

**Follow up and Investigation**

6.1 All adverse critical care transfers must be investigated and a short report produced on the Network proforma.

6.2 Investigation of all adverse transfers will be initiated by the relevant Critical Care Manager or Senior Nurse and the Network Coordinator.

6.3 Feedback from these investigations will be provided to the Trust Critical Care Delivery Group.

**Management of Outliers (Transferred Patients)**

7.1 It is the responsibility of each individual critical care unit to monitor their outliers within each hospital they were transferred to on a regular basis or as decreed by local operational policy.

7.2 It is the principle ethos and responsibility of each individual critical care unit to facilitate repatriation of transferred patients as a priority if appropriate.

**Trust/Hospital Transfer Groups**

The Department of Health requires Trusts to have identified specific groups of hospitals/Trusts to contain transfers for non-clinical reasons, and therefore reduce the numbers of long distance transfers.

The agreed transfer groups for the Surrey Wide Critical Care Network are:

<table>
<thead>
<tr>
<th>Trust/ Hospital</th>
<th>Hospitals in Transfer Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford/ St. Peter’s</td>
<td>Frimley Park Hospital</td>
</tr>
<tr>
<td></td>
<td>Royal Surrey County Hospital</td>
</tr>
<tr>
<td></td>
<td>East Surrey Hospital</td>
</tr>
<tr>
<td></td>
<td>Crawley Hospital</td>
</tr>
<tr>
<td></td>
<td>Royal Surrey County Hospital</td>
</tr>
<tr>
<td></td>
<td>West Middlesex Hospital</td>
</tr>
<tr>
<td></td>
<td>Hillingdon Hospital</td>
</tr>
</tbody>
</table>

| Volume 8 | Patient Care | First ratified March 2005 | Issue 1 | Part I (Admissions) |
ITU: Transfer from Ashford (CCU) to St Peter’s ITU

Ashford
Doctor

Ashford
CCU
Nurse in charge

Contacts SPH to check bed availability

Bed available?

Yes

Contacts SPH Anaesthetic registrar to handover

No

Transfers care to speciality at SPH

Transfers patient

Contact EBS
Overnight stay
(Merlin to Ash)

Merlin nurse

Contact Paediatric Unit
bleep holder 5 119

Yes

Merlin nurse

Contact Surgical team

Inform
Site Co-ordinator AH
of transfer

Arrange transport
(including nurse escort)

Inform
Capacity Manager at SPH
5 227

Bed available?

No

Merlin nurse

Surgical team contact colleagues at SPH
(Reg to Reg)
(ENT contact Paediatricians as no junior
SHO cover for ENT)

Contact EBS
Guidelines for the Management of Adolescents aged 16 - 18 years with an Episode of Deliberate Self-Harm, Psychiatric Disturbance or Alcohol Intoxication.

1. Assess initially in A & E/ED by Casualty Doctor.
2. Refer to Specialist Psychiatric Registrar if required.

**IS MEDICAL ADMISSION REQUIRED?**

- < 16 Years: Admit to a paediatric ward
- > 16 years: Admit to a medical ward

**IS DISCUSSION WITH RMO NEEDED?**

- If **IN** full-time education: Discuss with Child and Adolescent Psychiatrist on-call
- If **OUT** of full-time education: Discuss with Consultant Psychiatrist on-call

**IS FOLLOW-UP REQUIRED?**

- If **IN** full time education: Department of Child & Adolescent Mental Health Service
- If **OUT** of full-time education: ACU

Contributors: Dr. Christine Masterson, Dr. Peter Martin, Dr. Jan Sebastik
Ratified by: Dr. Paul Crawshaw, Clinical Director
Joyce Winson-Smith, Director of Nursing
Date: June 2000
Review Date: October 2002
Flows From
“Protocol for the Care of People With Learning Disabilities Using Acute Hospital Services”

Core Principles

**PRINCIPLES OF INFORMED CONSENT**
- Patient consent is required in all areas of care and treatment.
- Consent *cannot* be given on behalf of another adult.
- All patients must be treated as equal, having the same rights to care.
- It should *not* be assumed that patients with a learning disability cannot give informed consent.
- Medical and nursing staff should assess the capacity of the patient to give consent along with people who know them best.
- All care given must clearly be in the patient’s best interests; ultimately the attending doctor may make a decision to proceed without consent.
- Liaise with people who know the patient e.g. main carer or parent.
- Assess the need to involve the Acute Liaison Nurse.
- An Advocate might help to assist a patient with a learning disability decide if they wish to consent to a procedure.
- Patients with a learning disability *should not be excluded* from treatment unless clinically indicated.

**Acute Liaison Service**

**Referrals to the Acute Liaison Nurse** can be made by:
- Primary Care Teams
- Community Learning Disability Team
- Acute Hospital Multidisciplinary Team
- Social Work Team
- Carers
- Family
- Self referral

**Patient referred for treatment or admission**
- Elective
- Investigations
- Outpatients
- Accident and Emergency and other Receiving Areas

**Pre-admission Planning** – liaison with:
- Patient and carer
- Patient’s community supports
- Other agencies e.g. Social Work
- Primary Care Team
- Community Learning Disability Team

**Admission to the Acute Hospital**

- Complete Nursing Assessment
  - Assess need for additional nursing resources
  - Ensure carer involvement at the level they desire
  - Ensure Good Communication between all parties

- Care delivered according to care plan and protocols

**Investigation and /or Treatment as an Out Patient**

**Refer to the Acute Liaison Nurse** for additional advice and support

**Discharge Planning**

Refer to Trust Discharge Planning Policy and follow appropriate flow chart.
Ensure involvement of:
- Patient
- Carers
- Other agencies e.g. social work
- Primary care team
- Community Learning Disability Team
Care of Patient with a Learning Disability in the Acute Hospital

Out-Patient Attendance

The patient or main carer should be advised to make contact with Clinic Nursing Staff to discuss details of the appointment and any specific needs/resources required for the first and future appointments.

Will the patient be a regular attendee?

YES

NO

FLEXIBILITY OF CLINIC APPOINTMENTS
For the safety and comfort of both the patient and other patients attending the clinic it may be necessary to alter the patient’s appointment time in order to minimise any patient anxiety that might be induced by lengthy waiting in an unfamiliar environment.

The Nurse-in-Charge of the clinic has the authority to take a flexible approach based on patient needs.

If an appointment at the beginning of a clinic list is preferable this should be marked on the Patient Administration System.

NOTE - if ambulance is the required mode of transport it may not be possible to guarantee the appointment time.

If a Health Care Assistant is responsible for co-coordinating a clinic, then the patient should be seen by a Registered Nurse prior to leaving the department to determine any further care requirements.

Does the outcome of the appointment indicate that investigation or admission to the acute care setting is required?

YES

NO

- Consider a referral to Community Learning Disability Team for support and assistance with preparation of the patient.
- Liaise with staff in the department responsible for the investigation.

- Does the patient require a follow-up clinic appointment?
- Ensure patient and carer understand the outcome of the consultation.

FLEXIBILITY OF CLINIC APPOINTMENTS
For the safety and comfort of both the patient and other patients attending the clinic it may be necessary to alter the patient’s appointment time in order to minimise any patient anxiety that might be induced by lengthy waiting in an unfamiliar environment.

The Nurse-in-Charge of the clinic has the authority to take a flexible approach based on patient needs.

Will the patient be a regular attendee?

YES

NO

- Consider a referral to Community Learning Disability Team for support and assistance with preparation of the patient.
- Liaise with staff in the department responsible for the investigation.

- Does the patient require a follow-up clinic appointment?
- Ensure patient and carer understand the outcome of the consultation.
Care of Patients with a Learning Disability in the Acute Hospital

Routine Planned Admission

Sister/Charge Nurse to be informed in advance by pre-admission staff or medical and/or secretarial staff of the patient’s:
1. Clinical needs
2. Admission date
3. Main carer

In the event of a named carer not being identified, contact
Learning Disability Liaison Nurse
Or Community Learning Disability Team
Tel 0 …………

Consider the use of an audio cassette recording the explanation of the clinical procedures, so that the patient may replay the tape.

Sister/Charge Nurse to identify a Named Nurse and ensure that they are on duty on the day of the patient's admission

Named Nurse to make contact with main carer or other prior to admission to discuss:
- Admission arrangements
- Current care needs
- Specific equipment that may be required
- Carer involvement during hospital admission

The Nurse should also:
- Seek consent from the patient for the carer to be involved in the admission process
- Undertake an assessment of the patient’s care needs to identify if the patient requires additional nursing support. The Community Learning Disabilities Nursing team may be able to provide additional advice for this assessment
- Where appropriate, ask for a copy of the patient's existing care plan and other relevant information from the carer, community team or social care team

DAY OF ADMISSION
- A full nursing and medical assessment is undertaken
- If the main carer is unable to be involved in the admission process then ascertain contact and document
- In circumstances where there is no identified named carer then contact the Acute Liaison Nurse and request involvement in assessment if required.
- With the patient's consent the Nurse should make an appropriate person aware of the patient's admission

Does the patient assessment identify that the patient required additional nursing support?

YES

Discuss with ……. Manager and arrange additional resources

NO

MEDICATIONS
Specific attention should be given to the patient’s medication regime including preparation, times and method of administration; these may have been tailored to the individual patient's needs and should continue while in hospital

DISCHARGE PLANNING
- Patients with a learning disability have complex discharge planning needs
- Discharge planning should be discussed at the time of admission
- The Acute Liaison Nurse should be involved in discharge planning at the point of admission. They can arrange appropriate referrals e.g. Clinical Psychology, assistance with independent living, District Nurse, GP etc
Care of Patient with a Learning Disability in the Acute Hospital

**Emergency Admission**

**Is the main carer/guardian in attendance?**

**YES**

Ensure that the patient gives consent to the main carer participating in the history taking and admission process.

**NO**

The admitting triage nurse should:

1. Identify the main carer/guardian as soon as possible and make contact
2. Assess the need for contact with the patient's Community Learning Disability Nursing Team (if involved) and make contact if appropriate. This nurse can assist with:
   - Patient Assessment
   - Communication
   - Liaison with other services

**COMMUNITY LEARNING DISABILITY NURSING TEAM CAN BE CONTACTED FOR ADVICE.**

**Is the patient to be admitted to the acute hospital setting?**

**YES**

Named Nurse in A&E should advise the Nurse in Charge of the receiving area of any potential additional care needs that the patient may present as a result of their learning disability.

Additional nursing resources may be required.

Refer to flow chart on Elective Admission procedures.

**NO**

If the named nurse/triage assesses that the patient requires further support refer the patient to the Learning Disability Team.

During normal working hours contact the Community Learning Disability Nursing Team.

**Is the patient to be referred for an Out-Patient appointment?**

**NO**

Refer to flow chart and protocol section on Out-Patient attendance.

**YES**

**IMPORTANT**

PATIENTS WITH A LEARNING DISABILITY WILL REQUIRE COMPLEX DISCHARGE PLANNING WHICH SHOULD COMMENCE AT THE TIME OF ADMISSION.

Adapted from Lothian University Hospitals Trust and Lothian Primary Care NHS Trust *A COLLABORATIVE APPROACH TO CARING FOR PATIENTS WITH A LEARNING DISABILITY IN THE ACUTE HOSPITAL*
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### Admission of Patients Under Section

**EASY GUIDE TO INFORMAL DETENTION OF PATIENTS UNDER THE MENTAL HEALTH ACT 1983**

<table>
<thead>
<tr>
<th>Circumstances Dictating Action</th>
<th>Legal Position</th>
<th>Section, Form and Leaflet</th>
<th>Duration</th>
<th>Further Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient is in Outpatient Clinic or Accident Centre (but not agreed for admission) who is causing a disturbance that might cause injury to themselves, others or cause damage to property</td>
<td>The patient may be restrained by staff using reasonable force under the provisions of Common Law</td>
<td>None – Common Law applies</td>
<td>None</td>
<td>Contact Security Staff to assist with removal from site. Police only to be involved if possible injury to others or damage to property has taken place</td>
</tr>
<tr>
<td>B. Patient is in Accident Centre and is to be admitted whom the managing team feels is at risk of causing injury to themselves, others or cause damage to property if they were allowed to leave under their own will</td>
<td>To detain a patient under Section 2 or 3 of the Mental Health Act, an application and a second medical opinion should be sought by the RMO</td>
<td>Section 5(2) Form 12 Leaflet 3</td>
<td>72 hours</td>
<td>Section 5(2) is not renewable, so the second opinion and formal sectioning must have taken place within the 72 hour period</td>
</tr>
<tr>
<td>C. Patient transferred from psychiatric unit for acute medical/surgical treatment</td>
<td>Need to continue MHA Section 2 or 3 arrangements during acute episode</td>
<td>Section 2 or 3 Form 24</td>
<td>Duration of acute episode</td>
<td>Patient Administration Manager or Red Star receive form and original Section papers from the referring unit. Form passed to nominated Trust Board member</td>
</tr>
<tr>
<td>D. Patient returned to psychiatric unit after acute medical/surgical treatment</td>
<td>(As C above)</td>
<td>Section 2 or 3 Form 24</td>
<td>(As C above)</td>
<td>(Reverse of C above)</td>
</tr>
</tbody>
</table>
Crisis Response Team (SPH)

The Crisis Response Team are part of the Abraham Cowley Unit, situated in the grounds of St Peter’s Hospital. The purpose of the team is to provide Rapid Nursing clinical Assessment (usually within 60 minutes) and follow up response to acute mental health and unexpected life altering events within the Bournewood Trust catchment area.

**Hours**

- 4pm - midnight weekdays
- 9am - 8pm weekends

In specific terms

1. Anyone can refer to the service.
2. The team accept self referrals.
3. They will assess and refer on to other agencies (often the local Community Mental Health team).
4. They offer an out of hours Casualty Liaison service to “dove tail” with the daytime service. This usually means Psychiatric follow up on self harm.
5. The team let the patient when possible; choose the location for consultation - home or hospital.
6. The team often will use the Internet to provide Psycho-educational resources to give to patients.
7. The team cannot work with people that are drunk and we will not enter situations where their personal safety will be unreasonably compromised.
8. The team can offer weekend packages of support, as part of ongoing plans of care.

Contact the team to discuss any possible referral on 01932 872000.
REMOVAL OF RESTRAINTS AT HOSPITAL DURING TREATMENT, CONSULTATION OR BEDWATCH

PROPOSED PROCEDURE FOR CUSTODY OFFICERS

- Restraints applied due to prior risk assessment or risk having changed on location
- Doctor or Senior Healthcare Professional wants restraints removed
- Does the clinician judge that either/or
  - The risk to life is immediate
  - Restraints interfere with treatment
  - Prisoner is in pain or discomfort due to restraints

**YES**

- Remove restraints IMMEDIATELY
  - Note name of person who directed removal in log and reasons

**NO**

- Does Custody Officer believe escape risk if restraints removed?
  - **YES**
    - Insist restraints remain
  - **NO**
    - Remove restraints
    - Note name of person who directed removal in log and reasons

- ? Inform Superior Officer IMMEDIATELY

- ? Inform Superior Officer IMMEDIATELY
Urgent Care of Older People

Before Crisis
Assessment of needs and health promotion

At Crisis
Identification of older people with complex needs

Emergency Presentation
Assessment - appropriate referral to speciality. Admit? or Discharge?

The First Few Days
Assessment and treatment
a. Acute medical/assessment unit
b. Other acute hospital units
c. Intermediate care service (hospital at home)

On-going Care During Recovery
Rehabilitation within intermediate care

Chronic Disease Management
Care management for people at high risk of re-current crises
### HOSPITAL ADMISSION – PERSONAL INFORMATION SHEET

<p>| <strong>My name is</strong> |  |
| <strong>I like to be called:</strong> |  |
| <strong>My Date of Birth is</strong> |  |
| <strong>My Address is:</strong> |  |
| <strong>My telephone number is:</strong> |  |
| <strong>I live in:</strong> (e.g. residential home with sleep-in staff) |  |
| <strong>CONTACTS</strong> My main carer is: <strong>Telephone:</strong> |  |
| <strong>My next of kin is:</strong> <strong>Relationship</strong> Any contact? <em>Yes/ No</em>* <strong>Address:</strong> |  |
| <strong>Telephone number:</strong> |  |
| <strong>In an emergency/to discuss my care, please contact:</strong> My GP is <strong>Telephone number</strong> Other contacts (e.g. Community Nurse/Social Worker) |  |
| <strong>MEDICATION</strong> My Current Medication is <em><em>(Medication record sheet attached: <em>Yes/ No)</em></em> I take my medication with: |  |
| <strong>MEDICAL HISTORY</strong> e.g. epilepsy, past operations Sight Hearing</em>* |  |
| I am allergic to: |  |
| <strong>COMMUNICATION</strong> I communicate by: (e.g. signing/symbols/speech) Communication profile attached – <em>Yes/ No</em>* |  |
| <strong>To help me understand and make decisions about my treatment, please talk to:</strong> |  |
| <strong>PAIN</strong> You may not be aware of my pain. Signs are: |  |</p>
<table>
<thead>
<tr>
<th><strong>DAILY LIVING SKILLS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating and Drinking – aids/ assistance/ special diet Likes/dislikes</td>
<td></td>
</tr>
<tr>
<td>Mobility – aids and assistance I need</td>
<td></td>
</tr>
<tr>
<td>Continence/Toileting – support I need, aids I use &amp; make, interim supply available? (*Yes/no)</td>
<td></td>
</tr>
<tr>
<td>Self-help skills when well Washing/bathing Dressing/undressing</td>
<td></td>
</tr>
<tr>
<td>Usual Sleep Pattern What aids sleep?</td>
<td></td>
</tr>
<tr>
<td>Challenging Behaviour *Yes/ No – describe. Behaviour which might worry people who don’t know me</td>
<td></td>
</tr>
<tr>
<td>Anxiety Signs of anxiety/interventions to reduce anxiety</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>Hair colour</td>
<td>Eye colour</td>
</tr>
<tr>
<td>My religion is:</td>
<td></td>
</tr>
<tr>
<td>Other information, e.g. phobia of needles, guidelines, normal daily routines</td>
<td></td>
</tr>
</tbody>
</table>

* Delete as appropriate

Name of person completing this form_________________ Title:_____________________
(Please Print)

Signature_________________ Date_________________ Contact number_________________
REFERENCES/BIBLIOGRAPHY


Appendix 20:- Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures A Report by the American Society of Anesthesiologists. Developed by the Task Force on Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration

Appendix 21:- (Contemporary Management of Angina) Published by American Family Physician.(Dec 1999)


Appendix 30:- Adapted from Lothian University Hospitals Trust and Lothian Primary Care NHS Trust A COLLABORATIVE APPROACH TO CARING FOR PATIENTS WITH A LEARNING DISABILITY IN THE ACUTE HOSPITAL