MERCY UNIVERSITY HOSPITAL

Name:	**POLICY FOR THE MANAGEMENT OF EMERGENCY DEPARTMENT WORKLOAD (Escalation Policy)**	Ref. No.	
		Effective From	01/03/2010
Department:	Clinical Director		
Prepared by :	N.O'Sullivan, ADON, Divisional Lead ED		
Approved by:			
Stakeholders:	Clinical Director, Director of Nursing, Deputy CEO, All Consultants, ED Staff, Bed Management Staff		
Responsibility for implementation:	Clinical Director		
Responsibility for evaluation and audit:	Deputy Chief Executive Officer		

Revision History			
Date	**Changes**	**By**	**Version**

Relevant References
o Mercy University Hospital Policy for Management of Workload in the ED 2010.
● Admission Discharge and System Wide Escalation Framework Draft Limerick (December 2009) -
● Reconfiguration forum for Cork and Kerry– Review of Emergency Departments and Pre-Hospital Emergency Care in Cork and Kerry (November 2009)
● East Kent Hospitals, NHS Trust (December 2007) – Operational Escalation Policy and Plan 2007 – 2008
● Mercy University Hospital, Cork– Escalation Policy (November 2008)
● The way ahead 2008-2010 College of Emergency Medicine.(December 2008)
● Simuledge Ltd.– Simulation of Emergency Department in Letterkenny General Hospital(April 2007)
● West Suffolk Hospitals, NHS Trust– Bed Management and Escalation Policy (2006)
● Scarborough & North East Yorkshire Healthcare, NHS Trust– Escalation Policy (October 2003)

• UK Department of Health– Clinical Exemptions to the 4 Hour Emergency Care Target. (December 2003)

Expert Review sign-off			
Post	Signature	Post	Signature
Clinical Director	*C. Henry*		
Director of Nursing	*B. O'Sullivan*		
Deputy Chief Executive Officer	*J. Corbett*		

1 POLICY STATEMENT

This policy provides detailed guidance for staff in implementing the Hospital's policy for Management of Workload in the ED. This policy constitutes the Hospital's Escalation Plan for managing long stays and/or overcrowding in the ED.

2 OBJECTIVES

The objectives of this policy are as follows:

(a) To define a graduated escalation response to be followed by staff when the ED is not meeting the
- **6 hour arrival to discharge/admission** standard (except where a longer period is clinically justified)
- and/or is becoming overcrowded and/or has patients **waiting for admission in excess of 24 hours.**

(b) To define the stages of escalation and prescribe action to be taken at each stage.

(c) To ensure a consistent approach to management of long waiting times or overcrowding in the ED.

(d) To ensure that prompt action is taken by the Bed Management Department and all consultants to promote early discharge and/or reduced elective admissions in a consistent fashion as required by the stages of escalation.

3 DEFINITION OF TERMS

The following terms and abbreviations are used:

CMT:	Crisis Management Team, this comprises the Clinical Director, Deputy Chief Executive Officer, Director of Nursing, the CMT will consult with colleagues of other disciplines as necessary
ED	Emergency Department
CEO	Chief Executive Officer
CD	Clinical Director
DCEO	Deputy Chief Executive Officer
DoN	Director of Nursing
BM	Bed Manager
SNM	Senior Nurse Manager on duty (Hospital wide)
CNM3	The Clinical Nurse Manager 3 in charge of the ED
CNM2	The Clinical Nurse Manager 2 (Team Leader) on duty in the ED
HSE	Health Service Executive
LAC	Local Ambulance Control
EDP	Emergency Discharge Protocol which is a plan for the early discharge of patients in severe emergency

Treatment spaces are the following:

- 7 formal trolley bays in the Spaces Main ED (includes 1 single room),
- 3 Observation Room spaces,
- 1 Therapy room,
- 3 Additional treatment spaces are other areas which can be used e.g. Back corridor (Accepting that the area is an undesignated area, this policy must be realistic in the designation of 'capacity' prior to defining 'overcrowding'),
- Alternatively the Ambulatory area (1trolley and the resuscitation room 2 Bays could be designated as part of the capacity),
- **Summary of Capacity: 14 treatment spaces.**

Communication:
The Senior Nurse on duty in the Emergency Department must communicate with the Consultant in Emergency Medicine or in the absence of the ED Consultant, communicate with the ED Registrar on duty before making a decision to escalate.

4. DEFINITION OF ESCALATION STAGES

The escalation stages are defined as follows although it is impossible to be prescriptive given that actual patient mix can vary, diagrams at Para 7 indicate possible combinations for each stage. NOTE: These stages exclude patients awaiting ambulatory minor treatments :

a. GREEN

This stage is defined as being a 'steady' state where the Hospital is maintaining the elective and emergency demand for its services without unusual pressure. A GREEN state exists when there are at least 3 free treatment spaces and not more than 5 patients who have been waiting for admission, from time of arrival, for more than 12 hours.

b. AMBER

This stage is defined as being a period when difficulty is beginning to be experienced in managing the emergency workload. An AMBER state exists when there are more than 6 patients awaiting admission in excess of 12 hours and there are less than 2 free treatment spaces.

c. RED

This stage is defined as being a period when significant difficulty in managing the emergency workload is being experienced and there is potential for severe pressure on staff. A RED state exists when there are more than 10 patients awaiting admission, to a ward bed, for more than 12 hours.

d. BLACK

This stage is defined as when normal workload management procedures have broken down and there is unsustainable pressure on staff and significant risk to patient and staff safety. In a BLACK state there will be no treatment or waiting space available in the ED.

5. ESCALATION PROCESSES

a. It should be noted that in a rapidly developing situation one or more stages can be skipped to take the hospital to a higher level. The Crisis Management Team must approve any accelerated escalation proposal.

i. GREEN

The GREEN state will be declared by the CNM 3/CNM 2 -Team Leader on duty in the ED who will **liaise with Consultant in Emergency Medicine and nursing staff of the Department before reaching a decision to escalate.**

ii. AMBER

The AMBER state will be declared by CNM 3/CNM 2 -Team Leader on duty in the ED who will liaise with the Consultant in Emergency Medicine and nursing staff of the Department, the bed manager , the Senior Nurse Manager, before reaching a decision to escalate.

iii. RED

The RED state will be declared by the CNM 3/CNM 2 -Team Leader on duty in the ED /Bed Manager /Senior Nurse Manager. The Bed Manager will liaise with CD, the DCEO and the DON before reaching a decision to escalate.

iv. BLACK

The BLACK state will be declared by the Crisis Management Team.

v. DE-ESCALATION

De-escalation will run in reverse order with the decision to suspend a current state being made by the officer who declared it.

vi. OUT OF HOURS

The CNM 2 Team Leader in liaison with the Senior Nurse Manager on duty for the hospital is authorised to declare an AMBER state out of normal hours. The SNM will contact the DCEO if a RED or BLACK state is proposed. The DCEO will convene the CMT if necessary to manage the emergency or may declare the RED state, if a BLACK state is proposed the CMT must be convened.

b. Escalation State Actions:
NOTE: In all cases the actions specified include those listed for a lower level state.

Roles and Responsibilities

i. GREEN

CNM3:	Ensure that the department is operating safely and appropriate actions are being taken to handle any patients who may be exceeding waiting times or are approaching established waiting targets.
CNM2: (Team Leader)	Take actions to resolve any waiting time problems in association with the CNM3. Liaise with the ED Consultant/ED Registrar. Monitor the situation and report to CNM3 when pressure is mounting.
Radiography: Services Supervisor	CNM2 Team leader should ensure that Radiography Services Supervisor is made aware of, and is taking appropriate action, in the event of delays in Radiology services.
Bed Manager:	Ensure ED CNM3 is kept appraised of the overall bed availability position in the hospital. The senior nurse in each ward will clarify reasons for delayed discharges and ensure patients are received from the Emergency Department within 30 Minutes of the bed being allocated.

ii. AMBER

CNM3:	Declare AMBER state after consultation with Divisional Leads ADON, DCEO and CD. Ensure staffing situation is adequate for demand.
ED Consultant/ Registrar:	Undertake rounds to discharge as many ED patients as possible and if necessary to accelerate progress through the system.
Radiography: Services Manager	CNM2 Team leader should ensure the Radiography Services Supervisor is made aware of and is taking appropriate action, in the event of delays in Radiology services.

CNM2
(Team Leader): Inform Bed Manager of the developing position. Notify Ambulance Control of developing situation. Contact Radiology if delays in obtaining imaging are a contributory factor. Request urgent attendance by NCHDs if assessment is a contributory factor.

- o ≥ 4 Patients awaiting assessment by the appropriate team (Medical /Surgical/Paeds etc). The CNM 2 Team Leader should request assistance from the Registrar on – call if available.
- o All GP referrals to be referred directly to appropriate team
- o Patient acuity will take precedence – Registrar may be called sooner in the event of a number of acutely ill patients waiting.
- o Ambulatory Patients: Minor injury/ambulatory patients waiting ≥3 hours to be seen. ED Medical staff working at full capacity.
  The CNM 2 Team leader should request front line assistance from the appropriate team.

In this situation, to relieve overcrowding, if the CNM 2 on Duty in the ED considers any patient suitable for streaming to the relevant service e.g. direct referral to an appropriate team e.g. surgical, urology, paediatric. medical, psychiatry team. The CNM should contact the team and request assistance.

To expedite patient assessment and treatment, other members of the team e.g. intern, may be called to assist the SHO/REG

To maximise the use of SHO/Reg staff. Utilise ‘intern’ to attend to ‘inpatients’ in the ED – writing up i.v. fluids etc.

In the event that assistance is unavailable / not forthcoming, the CNM 2 should contact the Clinical Director.

Clin. Dir.: Intervene with clinical teams to facilitate patient assessments if necessary. (ED and wards)
Discuss X Ray position with Radiologists if necessary. Establish whether elective admission / cancellations would be useful in early resolution.

Bed Manager:	Notify CD of the 'urgent discharge' list and the makeup of elective admission list.
DCEO:	Ensure support service deficits contributing to the situation are addressed.

iii. RED

CMT:	CD may declare a RED state following liaison with the CMT. The CMT will consult with CDs at other hospitals and network managers to seek assistance with transfers and staffing. The CMT may consider as follows; Notify Ambulance Control, requesting temporary Deferral of Ambulances and arrange for notification of ambulance control, to make an assessment of the position with regard to ICU bed availability; to authorise use of any hospital bed for emergency admissions except ICU, CCU and <16s to Paediatrics; to take action to redeploy staff as necessary.
CD:	Ensure that all patients in the ED have been assessed by clinical teams. Seek emergency ward rounds by Consultant teams to identify patients who can be discharged immediately or soon. To consider whether all elective cases except major cancer cases are cancelled.
CNM3:	Ensure patients are being cared for safely and that sufficient staff are in place. Liaise with CNM2 regarding the detailed operation of the department and maintain up to date position on the admissions board.
Bed Manager:	Hold all elective admissions pending decision on cancellation by CD. Cancel elective admissions when directed to do so by the Clinical Director.
DCEO:	Ensure sufficient support service staff are in place. Notify CEO of developing position. Notify HSE Regional Office of developing position. Assess in association with the CMT whether the declaration of a BLACK state is imminent. Establish resources necessary to transfer inpatients to other hospitals.

i.v <u>BLACK</u>

CMT: Meet to discuss situation following which a BLACK state might be declared. CMT assumes direct control of all admissions and implements emergency discharge protocol. ED closed to all new admissions on patient safety grounds. Establish Emergency Control Room in the Ground Floor Parlour.

Consultant Teams: Ensure rapid vacation of beds by discharging all pre-operative and early discharge patients.

v. DE-ESCALATION: As the situation improves de-escalation will occur in reverse order and the CMT will be stood down when the state is reduced to AMBER.

6. IMPLEMENTATION

a. In order to give effect to this procedure the DoN will ensure that Nursing Guidelines are developed to direct the detailed actions of nurses.

b. Before this procedure comes into effect the CD, DCEO and DoN will develop an Emergency Discharge Protocol

c. This procedure and the governing policy together with all protocols and guidelines developed to give effect to them will be reviewed on an annual basis in January.

<u>APPROVED BY THE OPERATIONAL MANAGEMENT BOARD ON</u>: 25.07.10

SIGNED: *J. Corbett* **DEPUTY CHIEF EXECUTIVE OFFICER**

<u>APPROVED BY THE EXECUTIVE MANAGEMENT BOARD ON</u>: 26.07.10

SIGNED: *P. Madden* **CHIEF EXECUTIVE OFFICER**