



Royal Cornwall Hospitals
NHS Trust

Making internal professional standards work for our patients



Outstanding
Care for One+All

Performance

RCHT ED & SDEC Assessment Areas



Triage should be undertaken within **15 mins** of arrival.



Initial clinical assessment and treatment within **60 mins** of arrival
(*ECDS acuity 1-3 patients in ED*)



A decision-making clinician (e.g. ST3/4+) should review new patients within **120 mins** of arrival.



ED Diagnostics

ED emergency CT scans (stroke/trauma) within **60 mins**

ED urgent CT scans within **120 mins**

ED X-rays (plain film) within **60 mins**

ED pathology (haematology/clinical chemistry) within **60 mins** (from lab receipt)



SDEC Diagnostics

Urgent CT scans within **120 mins**



SDEC XRs (plain film) within **120 mins**

SDEC pathology (haematology/clinical chemistry) within **60 mins** (from lab receipt)





To avoid unnecessary admission, specialty reviews in ED can be undertaken within **30 mins** and treatment and discharge within **60 mins**, before transfer to specialty SDEC or admission areas for ongoing care.



Once clinically ready to proceed, patients should be admitted to an inpatient bed within **30 mins**.



Patients should be admitted or discharged from ED within **4 hours** of arrival.



SDEC assessment areas should be developed to accept incoming patients **until 10pm** every day.



RCHT Level 2 and 3 Beds



Agreed ITU expedited patient flow pathway cases (Diabetic ketoacidosis, Asthma, Uncomplicated Sepsis, Drug overdose) still meeting ITU criteria for admission after **2 hours** of emergency treatment will be admitted for **12 to 18 hours** level 2 care on ITU.



Once patient meets criteria for step-down care under acute medics, the RCHT site team will prioritise the next available AMU bed (within **2 hours** of request)

RCHT Acute Admission wards



All patients to have a documented expected discharge date (EDD) within **24 hours** of admission, set by a consultant or senior decision maker (fixed at **48 hours**)



Where working diagnosis changes at initial consultant Post-Take Ward Round from medicine to surgery a rapid review by the accepting team should take place on the same day or within **14 hours** of referral.

RCHT Specialty Base wards



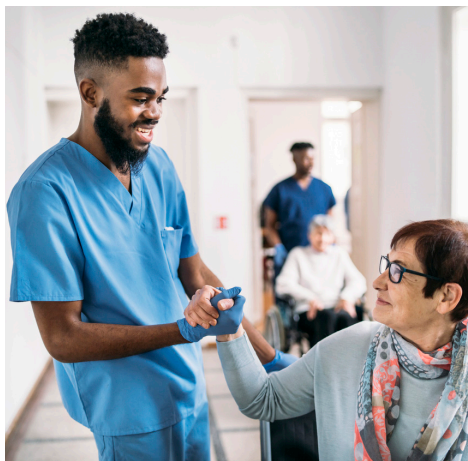
Inpatient scans for Clinical Imaging will be clinically prioritised. Reports to facilitate **same day** discharge will be expedited where possible.



Inpatient teams should develop SDEC services to optimise the use of next day outpatient diagnostics and facilitate same day discharge where possible.



Following ST4+ decision or criteria-led discharge (CLD), patients should be discharged home or via discharge lounge within **60 minutes** (or by **8am** if discharged after **11pm** and unsafe to go home at night)



Expectations

ED & SDEC Assessment Areas



The ED team should not admit a patient likely to be able to go home just to avoid a breach of the emergency care standard.



Patients referred from primary care (or any other clinical service) should be routed directly to specialty SDEC assessment or admission areas. If this does not occur and the patient attends the ED, the patient should be transferred to the receiving specialty, unless immediate medical intervention is required. Patients should only be sent to the ED because of advice by specialty teams if immediate clinical intervention is required (e.g. ED wound/fracture management or resus-level care).



If a specialty expected patient is to attend ED for assessment, the ED Consultant or Nurse in Charge should be informed on extension 3115.



No specialty should refuse a request to assess any patient following review by an ED ST4+ and will be escalated to the specialty consultant for resolution



Patient care and admission should not be delayed by inter-specialty dispute over clinical ownership or placement. ED consultants have the authority to discuss with the consultants involved and make a 'best decision' to allocate immediate clinical ownership and ensure timely care and admission (within **60 minutes** of initial referral).



Any problems identified by the receiving specialty should be fed back via the consultant concerned, who should liaise with the Specialty Lead / Clinical Director for the referring team.



The ED team should identify any patient presenting with the same condition who has been recently discharged from an inpatient admission (within 7 days) or is under current investigation or treatment for assessment by the suitable specialty. This should help the specialty team to avoid unnecessary admissions.



Patients who may require tertiary centre referral or opinions are the responsibility of the appropriate on-call team, unless ED has determined they require immediate or emergency transfer.

RCHT Level 2 and 3 Beds



Transfer of patients from level 2+ beds should take priority for inpatient bed allocation over and above any other calls for that available bed.

RCHT acute admission wards



Patients should be seen and reviewed by a consultant or senior decision maker (ST4+) at least twice a day (once a day on trauma and orthopaedic (T&O) admission wards)



Patients referred to specialty teams should be reviewed by 11am each day and the specialty destination, and priority updated on Nervecentre to support timely base ward admission.

RCHT specialty base wards



Patients should be seen and reviewed by a consultant or senior decision maker (ST4+) at least once a day (unless medically optimised). Any patient identified as not needing a consultant review on that day should be verbally discussed by the reviewing junior doctor and the consultant at the end of the ward round and discussions documented in the notes.



Undertake daily board rounds from **8am** and ward rounds from 9am using SHOP priority and 4 ECIST questions. Ensure use of discharge lounge to facilitate pull from admission wards from **9am**.



Update Nerve Centre with PDD, CLD, Medically Optimised and decide P0 or not, if not P0 – start submitting a Strata as the ITOC will decide on the discharge pathway.



Identify specialty patients awaiting transfer to base wards through Nervecentre; specialist destination and priority. Liaise with admission wards to pull patients at earliest opportunity.



Undertake daily rapid rounds by **2.45pm** to ensure all planned treatment, diagnostics, and care activities have occurred. Escalate outstanding actions and use Next Day Emergency Care diagnostics where possible to facilitate same day discharge.



Plan for tomorrow's discharges and update Nervecentre with any changes to CLD etc.

Right care
Right place
Right time



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