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Royal Cornwall Hospitals NHS Trust

Same Day Medical Assessment (SDMA) Unit Standard Operating Procedure

V2.0

February 2022

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. This procedure sets out the arrangements for the safe and appropriate referrals of patients to Same Day Medical Assessment (SDMA) Unit within the Trust ensuring staff involved understand roles, responsibilities, accountability, and mode of operation.

1.2. The aim of SDMA is to maximise access to same day services for medical patients that have seen a primary care doctor and hospital medical teams.

1.3. The benefits of SDMA include:

- Ensure right care in the right place, at the right time.
- Improve patient experience and satisfaction, enabling patients to return home the same day wherever possible.
- Reduce overnight admissions and pressure on acute and community inpatient wards.
- Improve patient flow through whole system.
- Reduce activity in the Emergency Department (ED).

1.4. Quality operational standards will be used to ensure a governance framework from which to measure effectiveness. The standards include a triage assessment within 15 minutes and consultation with a clinician within 60 minutes of arrival (see section 5).

1.5. This version supersedes any previous versions of this document.

2. Purpose of this Standard Operating Procedure

2.1. SDMA is part of the Urgent & Emergency Care Stream and is primarily for the use of clinically appropriate adult medical patients who have been referred directly by their GP, by the Acute GP (AGP) service or from ED.

2.2. The prompt supply of inpatient beds, transport and diagnostics capacity is vital to facilitate effective SDMA functionality and every effort must be made by the Trust's patient flow team to meet demand for inpatient beds to maintain capacity and ensure rapid turnover of patients through the unit. It is imperative to avoid congestion within SDMA to ensure the unit can function effectively.

2.3. **Location, Layout and Utilisation**

2.3.1. SDMA is located on the first floor of Trelawney Wing and utilises flexible accommodation with 16 treatment spaces. In addition, there are two spaces for rapid assessment and treatment and two consulting rooms. The accommodation is flexible but will be set up to provide 8 trolley bays, 6 seated treatment spaces and 1 isolation rooms and 1 procedure room.

2.3.2. In addition, the unit has a reception area, clinical office space, drugs preparation room and sluice.

2.3.3. In line with privacy and dignity requirements in a mixed bay area all patients should be fully dressed and not in night clothes.

2.3.4. For patient's wellbeing light refreshments and snacks will be available to patients throughout their stay in SDMA.

3. Ownership and Responsibilities

3.1. *Medical Responsibility*

- The overall clinical responsibility for standards and clinical care of medical patients resides with the Acute Medical Unit (AMU) Consultant Acute Physician when that person is present and is supervising / participating in the Unit. When the Consultant Acute Physician leaves then a hand over will take place with the duty registrar and Medical Consultant on call.

3.2. *Acute GP*

- The Acute GP (AGP) Service act as a "gatekeeper" for all GP referred patients, assessing, and treating patients that fall within the "low risk" criteria of ambulatory care and provide onward referral to the SDMA where appropriate.

- AGP referrals for medical patients to be assessed in SDMA are made by generic e-mail. The referrals are then communicated by the ward clerk to the SDMA Nurse in Charge.

3.3. *Nurse staffing and responsibility*

3.3.1. SDMA will be staffed by a Senior Nurse and Emergency Medical Technician (EMT) to Rapidly Assess and Treat (RAT) patients on arrival plus 6 registered nurses, 2 EMTs and 2 HCSW weekdays.

- 2 registered nurses and 1 HCA until 02:30 hrs

- 3 registered nurses and EMT / HCA on weekend days with to manage the treatment and care of patients through the unit.

3.3.2. Staffing will be supported with agency / Kernowflex staff to support safer staffing and mitigation made to ensure patient safety is maintained at all times.

3.3.3. The senior nurse manager is responsible for the SDMA Unit as a whole, supported by the Clinical Matron and will ensure safe nurse staffing levels at all times escalated through twice daily safer care meetings if appropriate.

3.3.4. There will be an identified Nurse in Charge (NIC) for every shift and designated and clearly identifiable nurses on duty for the Unit and they have responsibility for:

- Completion of the appropriate admission documentation for the individual patient and the recording of basic and relevant observations in the first instance.

- The day to day running of the SDMA including its organisational aspects and delivery of nursing care.

- Ensuring a smooth flow of patients through the unit and co-ordinating the movement of patients to other areas within the Trust.

- Gaining extra support from the site team should there be a high level of activity witnessed.

- Managing escalation within the unit in accordance with the escalation checklist (see appendix 4).

- Keeping white boards and SWIFTPLUS updated.

- Providing activity / performance reports and information as required.

- Monitoring ED occupancy and identifying and pulling patients appropriate for same day treatment and discharge from the Emergency Department and AMU.

3.3.5. The nursing staff will work with agreed competencies as outlined in their job descriptions

3.4. *Healthcare Support Workers (HCSW) / General Assistant*

- Healthcare Support Workers (HCSW)'s and General Assistants will operate within the SDMA Unit under the supervision of the senior Nurse in Charge to agreed competencies in accordance with their Job Description.

3.5. *Emergency Medical Technicians (EMT)*

- EMTs are staff trained to carry out ECG's, Venous Blood Gases, cannulation, and Venepuncture. They will operate within the SDMA Unit under the supervision of the senior Nurse in Charge to agreed competencies in accordance with their Job Description.

3.6. *Ward Clerk*

The ward clerk will be available on SDMA from 08:00 to 01:00 hours and will provide administrative support to the Unit. The ward clerk will be responsible for:

- Ensuring all referrals from AGP are received either through generic e-mail or paper copies by hand – the generic e-mail account must be checked every 15-minutes.

- Ensuring all medical expected patients are registered into the medical take list on referral.

- Registering all patients and booking them onto the unit on PAS and SWIFTPLUS.
- Print patient stickers and making up patient notes.
- Discharging and transferring patients as required.
- Keeping all paperwork filed appropriately.
- Ordering for the unit.
- Dealing with general enquiries.

3.7. *Therapy Support*

- Therapy support is available by switch via bleep. The service is available from 08.30 to 17.00 hours Monday-Friday and fits with the team cover and weekends/Bank Holiday via a rota. Weekends are currently 08.30 to 17.00 hours as part of the ED, AMU and SDMA cover.

3.8. *Porter*

- A dedicated porter will be available on the Unit between 14:00 and 02:30 Monday to Friday to support transfer of patients for diagnostic and imaging tests and movement of patients to inpatient areas.

3.9. *SDMA MDT*

3.9.1. SDMA operates an MDT approach to the management of the unit which is an integrated clinical team. The core team compromises of:

- SDMA Nurse in Charge
- Acute Physician
- Advanced Nurse Practitioner

3.9.2. Other key members of the MDT which the core team can call upon for additional support are:

- Acute GP
- Therapist
- Specialties as required e.g., frailty, chest pain etc
- Onward care
- Community services

3.9.3. A safety brief will be given at 10am each day when the whole staffing team are on duty by the NIC. Board rounds will take place at 12:00 and 18:00 or as requested by the NIC to ensure timely

escalation, prioritisation of investigations and best deployment of the team. These rounds will be focused and standardised with clear information requirements.

3.9.4. Board rounds will be attended as follows:

- 1200 NIC, Acute Medical Consultant, medical take team starting at 1200, 3002 bleep holders
- 1800 NIC, Acute Medical Consultant, GIM Consultant, take team, 3002 bleeps holders.

3.9.5. The MDT will use the board rounds to identify their case load to ensure patients are being assessed, diagnosed, and treated by the right clinician, at the right time, on the same day. Teams will be asked by the NIC to attend board rounds as required. The SDMA escalation checklist must be completed to ensure SDMA does not become crowded or unable to manage workload (see appendix 4).

4. Standards and Practice

4.1. *Operational Standards for the SDMA Unit*

Task	Role	Timeframe
'Meet-and-greet'	Receptionist	Upon arrival
Observations: NEWS	Senior nurse	Upon arrival
Rapid assessment and treatment	Senior Nurse	Within 15 minutes of arrival
Consultation with clinician and initial management commenced	Any of: • Consultant • Registrar • Senior Nurse • Junior doctor	Within 60 minutes of arrival
Initial management commenced		Within 90 minutes of arrival
Review test results (where appropriate) and final sign-off	Consultant or senior decision maker	Median time: 3h
Generation of SDEC discharge letter	Any clinician, countersigned by Consultant/Registrar	Within 15 minutes of final sign-off

Where KPIs are not being met escalation should follow the Escalation Checklist (see Appendix 3)

4.2. *AGP Referral to SDMA*

Following consultation by AGP with the community GP, the AGP will advise attendance to SDMA for all clinically appropriate patients.

- A referral is sent via e-mail to the medical admissions generic e-mail account.
- The ward clerk must check the e-mail account every 15minutes for any new referral.

- The ward clerk will pre-doc expected patients onto ward template on SwiftPlus.

- The referral is printed, and patient entered onto the medical on take register.

- The patient details are checked on PAS and updated or registered as required.

- The referral, wristband and printed patient labels are placed into a temporary set of patient notes.

4.3. *Referral from GPs to SDMA*

4.3.1. All patients being sent for assessment by their GP should be referred through the Acute GP service. If the decision is made to assess the patient in SDMA the AGP should ask the GP to advise the patient that:

- they are attending hospital for medical assessment and that following further tests a decision will be made to determine whether admission is required or not.

- To bring all current medication.

- Space in the SDMA Unit is limited and where possible to be accompanied by one person.

- To go directly to the SDMA Unit.

4.3.2. The AGP will forward all relevant information to the SDMA Unit for patient to be placed on the medical take register; this should include:

- Demographic details of the patient.

- Patient contact details.

- Problem or provisional diagnosis warranting the review.

- A referral including patient summary and past medical history.

- Method of transport e.g., self, hospital transport, ambulance etc.

4.3.3. If a patient presents with a GP letter but has not been referred through the Acute GP Service they will still be assessed in accordance with the process detailed in 5.5.

4.3.4. In view of the acute nature of the visit it is not essential that pre-existing notes are available but upon request every effort will be made to obtain them within the shortest time possible.

4.3.5. On arrival all patients and carers will be informed that they have been referred for assessment but that the aim is for same day anticipated discharge. They will also be informed that hospital admission is also a possibility.

4.3.6. An information leaflet will be provided.

4.3.7. **Medically expected Patients being conveyed by ambulance should be assessed by the crew and if treatment through the Emergency Department is deemed clinically appropriate then the patients will be taken directly to ED and not SDMA.**

4.3.8. Patients seen in ED should be assessed on arrival and observations documented. Following discussion with the ED Consultant the patient will either remain within the ED if clinically appropriate or be referred to SDMA through discussion with the NIC.

4.4. *Referrals from ED*

4.4.1. Where a patient is thought appropriate for same day treatment the referring clinician should contact the admitting Acute Medicine clinician through the 3002 bleep or the SDMA NIC. If the admitting clinician believes that the patient is suitable for same day treatment, they will add the patient to medical take list and contact the SDMA NIC to advise of the patient's arrival.

4.4.2. Patients presenting in ED with low-risk chest pain who require a second troponin test will be able to transfer to SDMA when the patient been accepted by an Acute Medical Consultant following a discussion with the referring clinician who will have discussed with an ED Consultant.

4.4.3. Patients suitable for same day treatment and discharge who are seen within the ED outside of SDMA hours of operation, should be referred to SDMA through the medical registrar, a Maxims referral completed. Where deemed appropriate the patient will be added to the on-take register. A copy of the patient's notes will be sent to SDMA along with the Oceano discharge summary outlining the reason for referral and time the patient has been asked to attend SDMA. A copy of the discharge summary will also be given to the patient.

4.5. *Referrals from OP clinics*

4.5.1. Referrals from OP clinics (except Onc & Chemo) hotline should be communicated to the NIC of SDMA by telephone (07900 227781), a Maxims referral completed in full with detailed referral and treatment plan included where appropriate. If accepted, the NIC will ensure details are added to the medical take list.

4.5.2. 'Deferred' referrals for return to SDMA for assessment and/or diagnostics the following day must be accepted by the medical registrar on-call. Once accepted patient's details should be added to

the medical take list and added to the SDMA diary (during operating hours) and notes left with the SDMA ward clerk ED receptionists out of hours.

4.5.3. **SDMA should not be used under any circumstances as a method of transferring patients from ED purely in order to circumvent the 4-hour total visit time target.**

4.6. *Operating capacity*

4.6.1. SDMA can only operate safely and effectively with sufficient capacity to accommodate patients throughout their stay on the Unit; this requires immediate access to the triage bay followed by a treatment space once complete. To facilitate this, patients assessed for admission should be moved to an inpatient area within 15 minutes of the decision to admit.

4.6.2. Where the Unit is unable to process patients due to capacity limitations resulting in ambulances being unable to handover within 15 minutes of arrival, subsequent arrivals should be diverted to ED in accordance with the escalation checklist (Appendix 3).

4.7. *Method of Assessment on SDMA*

- Upon acceptance to the unit a patient is not to wait for more than 15 minutes for triage which includes - observations ECG, bloods, and ordering of x-rays

- A patient is to wait for no longer than 1 hour before they receive a medical assessment and a management plan which is to be communicated to them and accompanying persons if appropriate.

- Nursing staff will complete the nursing assessment and facilitate the management plan and make prompt referrals to support services where required.

- A cohort of patients will be independently managed by nurse practitioners on the unit.

- The nursing staff will safely discharge patients when blood results become available (for example troponin), provided the medical plan is carefully documented using a ‘criteria led discharge’ sticker.

- All admissions, transfers and discharges must be recorded electronically on PAS/Swift Plus within 15 minutes of the patient leaving the Unit.

4.8. *Discharges from the SDMA Unit*

On discharge patients will be provided with a full discharge summary at the point of discharge. If, for operational reasons, it is not possible to produce a discharge summary at this time, it will be processed by a junior doctor within 24 hours. The discharge summary will also be electronically communicated to the patient’s GP within 48 hours.

4.9. *Medical Follow-up Appointments in SDMA*

4.9.1. Patients may be seen in SDMA for follow-up appointments no later than 48 hours following discharge from an inpatient area. The referring clinician must be available to review results.

4.9.2. If patients are to be reviewed in SDMA as follow-ups in order to review progress or results of investigations, then they are given a time and date prior to them leaving the unit with a Maxims referral completed. All follow-up appointments will be booked using the appropriate clinic codes

4.10. *SDMA Hours of Operation*

4.10.1. New patients will be accepted between the hours of 08:00 and 20:00 hrs Monday to Friday, 08:00 and 18:00 hrs at the weekend.

4.10.2. The clinical site team will be informed as soon as a bed is required to facilitate admission to either AMU or the base wards. Patients will remain in SDMA either seated in A Bay or in B Bay on trolley until discharged home or admitted for continuing care and treatment. Patients will be allocated a bed in a time order by the clinical site team but will have the flexibility to break this order to facilitate preparedness of SDMA for the medical take at 08:00 hrs every morning.

4.11. *Clinical Exclusion Criteria for Referral to SDMA*

- If a patient requires level 2 care or above
- If a patient is under the age of 16 years
- If a patient is not on a medical pathway

4.12. *Services Supporting SDMA*

4.12.1. **Diagnostics**

All imaging requests are to be made through Order Communications (Comms) and discussed with a Radiographer/ Radiologist as required. Imaging requests are managed with the same urgency as in ED. Time to imaging and reporting are monitored and included in monthly performance reports.

4.12.2. **Pathology**

All pathology requests are to be made through Order Comms and discussed with a pathologist as required. Pathology requests are managed with the same urgency as ED.

4.12.3. **Pharmacy**

During opening hours patients will take To Take Out's (TTO's) from Electronic Prescribing and Medicines Administration (EPMA) to Lloyds (as ED patients already do).

SDMA to use TTO packs where possible. If not possible, use FP10HNC prescriptions which can be taken to a community pharmacy.

For all other situations, the on-call pharmacist would need to be contacted. This is the same as the current arrangements in ED.

4.12.4. **Patient Records**

All medical patients will have notes made up and these will accompany the patient in the Unit. To ensure confidentiality and ease of access locked notes trolleys are to be used and based outside the treatment bays. Nursing records are to be maintained at all times.

4.13. *Medicines Management*

4.13.1. To ensure medicines are handled and administered properly, the Medicines Policy sets the standards and procedures required to ensure the safe and secure handling of medicines. Among the procedures described are the prescribing, administration, recording, ordering and storage of medicines. This is supplemented by policies such as the Policy for Self-Administration of Medicines (SAM) by Competent Patients, the Delayed and Omitted Medicines Procedure, the Policy for the Rules Relating to All Activities Involving Controlled Drugs, the Antibiotic Stewardship Protocol, Clinical Guidelines for Ward Medicines Management, Guidance on Governance Arrangements Relating to Medicines, Injectable Medicines Policy, Non-medical Prescribing Policy and the Policy for the Prescription and Administration and Monitoring of Oxygen in Adults.

4.13.2. If patients managed in the SDMA are not intended to stay for more than 4-6 hours full medicines reconciliation will not usually be performed by pharmacy unless specifically requested by the clinicians. Designated pharmacists and ward pharmacy technicians are attached to the Acute Medical Unit (AMU) but will not normally review patients on the SDMA Unit unless specifically requested. A regular pharmacist service will be allocated to SDMA to include a clinical pharmacist and technician visiting the SDMA for a period of time. Their role mainly involves medicines reconciliation and general medication-related advice where needed.

4.13.3. If a supply of medication is needed on discharge, either a TTO pack will be issued from SDMA or a TTO will be generated from EPMA which should be taken to Lloyds Pharmacy. Out of Hours (after 18.00 hours), or an FP10 (HNC) prescription will be issued which can be taken to a community pharmacy for dispensing.

4.14. *Infection Control*

It is important that this policy is read in conjunction with the Infection Prevention and Control Policy. Patients requiring isolation will be transferred into the 2 side rooms available on SDMA. If both side rooms are full, patients will be redirected to ED on arrival following a conversation with the ED NIC. Any changes to the unit or process must be discussed with Infection control to ensure compliance.

5. Dissemination and Implementation

5.1. **Training requirements for SDMA staff:**

- IV additives course
- Cannulation and phlebotomy
- Mentorship
- Trust mandatory study days
- Ionising Radiation Medical Exposures (IRMER) course
- X Ray requesting
- Immediate Life Support (ILS)
- Maxims Order Comms
- ECG + interpretation
- Other courses identified for the role in the job description and competency framework.

5.2. **Dissemination to Trust staff:**

- Presentations to senior managers and Clinicians
- Attendance at Sisters meetings
- Education on daily ward visits
- Presentation of AEC activity at educational meetings.

It is the responsibility of Urgent, Emergency & Trauma Care Group to ensure that.

- staff are aware of any new or newly revised policies.
- Policies are appropriately filed and that old ones are removed and destroyed (keeping one copy for archiving purposes on shared drive).

6. Monitoring Compliance and Effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Whole process monitoring
Lead	Acute Medicine – Service Lead and Service Manager
Tool	• Emergency Assessment Checklists to ensure that all possible steps are being taken to improve and streamline the care of patients presenting to emergency care. • Internal audits • Incident reporting and monitoring • Complaints/Datix's Outcome measures to be included: • Total activity • Quality operational indicators • Patient mortality over 28 days • Re-admission rates • Quality of patient experience including satisfaction surveys, Friends and Family • Number of patients managed with a '0' day Length of Stay (LOS) • Number of patients treated under individual pathways as identified by the AEC Network • Number of patients discharged from unit Diagnostic waiting times.
Frequency	• Weekly dashboard for exception reporting • Monthly Performance Assurance Framework (PAF)

Information Category	Detail of process and methodology for monitoring compliance
Reporting arrangements	The results of the aforementioned monitoring methods will be presented, analysed and discussed at the 2-weekly operational meeting, monthly governance meeting and monthly Care Group Board, Quality, Performance and Compliance Board meeting. Actions, interventions and action plans resulting will be logged and implemented. Subsequently the operational policy can be amended as required.
Acting on recommendations and Lead(s)	The Nurse in charge is required to work closely with the Care Group Governance team and is responsible for the timely response to: • Complaints • Incidents [Datix, & Serious Incident's (SI's)]. **Operational Management** • Daily exception reporting and escalation if required • Weekly performance monitoring Monthly SDEC Governance meetings
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

Joint reporting for Acute Medicine and AGP will form part of future developments with one a system approach

7. Updating and Review

7.1. This guidance will be reviewed at least yearly.

7.2. Version Control Table as part of the document control process.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

8.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Same Day Medical Assessment (SDMA) Unit Standard Operating Procedure V2.0
This document replaces (exact title of previous version):	Same Day Emergency Care (SDEC) Operational Guidelines V1.0
Date Issued/Approved:	11th January 2022
Date Valid From:	February 2022
Date Valid To:	February 2025
Directorate / Department responsible (author/owner):	Nina Penkethman, Unit Manager David Friedericksen, Consultant
Contact details:	01872 253221
Brief summary of contents:	This policy sets out the arrangements for the safe and appropriate referrals of patients to SDMA within the Trust. The policy is also intended to ensure that staff from RCHT clearly understand their responsibilities to ensure safe referral, admission, and management of the patient.
Suggested Keywords:	AEC / AECU / Ambulatory Emergency Care/ SDEC / Same Day Emergency Care / SDMA
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Acute Medicine Governance Board UET Business & Governance Board
General Manager confirming approval processes:	Johanna Floyd
Name of Governance Lead confirming approval by specialty and care group management meetings:	Paul Evangelista
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	Department of Health (2003). *Emergency Care Checklists*, London, The Stationary Office. Institute for Innovation and Improvement. *Delivering Quality and Value. Directory of Ambulatory Emergency Care for Adults.* Department of Health (2005). *Our health, our care, our say,* London. The Stationary Office. Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time.* Report of the Acute Medicine Task Force. London: RCP, 2007.
Training Need Identified?	Yes
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Emergency Department

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
11/07/2019	1.0	Initial issue	Katy Wallace, Consultant Jane Michell, Clinical Matron Nick Masters, Service Manager
11/01/.2022	2.0	Section 5.10 and transposed to latest accessible Trust template	Nina Penkethman, Unit Manager David Friedericksen, Consultant

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Same Day Medical Assessment (SDMA) Unit Standard Operating Procedure V2.0
Directorate and service area:	Emergency Department, UEE
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Nina Penkethman, Unit Manager David Friedericksen, Consultant
Contact details:	01872 253221

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This policy sets out the arrangements for the safe and appropriate referrals of patients to SDMA within the Trust. The policy is also intended to ensure that staff from RCHT clearly understand their responsibilities to ensure safe referral, admission and management of patients to the unit. This in turn will reflect the need of the individual, their relatives and carers.
2. Policy Objectives	The arrangements for the safe and appropriate referrals of patients to SDMA within the Trust. The policy is also intended to ensure that staff from RCHT clearly understand their responsibilities to ensure safe referral, admission and management of the patient.
3. Policy Intended Outcomes	Evidenced based standardised practice
4. How will you measure each outcome?	Audit and review
5. Who is intended to benefit from the policy?	Patients, their relatives and carers

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** UEE Care Group
6c. What was the outcome of the consultation?	Policy Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Nina Penkethman, Unit Manager , David Friedericksen, Consultant

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. SDMA Escalation Checklist

Criteria	Green Default	Amber Two or more triggers	Red Three or more triggers	Black Two triggers
Time to Triage	**< 15 mins (Average per hr)**	**15 – 30 mins (Average per hr)** • Monitor number of arrivals per hour • Utilise all appropriate areas within the Unit to ensure triage times are managed effectively • If more than 5 patients for 2 consecutive hours: review current staffing and front-load senior assessment/treatment	**> 30 mins (Average per hr)** • Escalate to Matron • Divert staff from other areas to expedite triage until time to triage has reduced to <15 minutes	**N/A**
Wait to be seen by clinician	**< 1hour** • Monitor number of arrivals per hour and treatment status	**> 1 hour and < 3 hrs** • Review teams in ED, AGP and SDMA and realign to demand • Allocate doctors to ensure flow is maintained • Escalate patients requiring admission	**> 3 hours** • Nurse in Charge to identify patients for immediate doctor review and escalate to senior Acute Medical Consultant / GIM Consultant / Registrar • If OOH, assess if Consultant advice/attendance is needed	**> 4 hours** • Escalated to Consultant and Matron in hours or Site Co out of hours for immediate response • Matron / Site Co to discuss with AD Medicine or SMOC to gain senior clinician support
Time to Decision	**< 2 hours** • Monitor wait to be seen and number of arrivals.	**> 4 hrs** • Doctor in Charge to chase decisions – delegate if necessary. • Check for imaging/lab delays and inform Site coordinator • Escalate admissions awaiting review	**> 6 hours** • Escalated to Consultant and AD Medicine in hours and SMOC out of hours for immediate response	**N/A**
Delay to bed allocation following DTA	**<15 mins** • Monitor times for bed allocation	**>1 hr** • Liaise with CSM and confirm number of beds required, specialties and gender of patients • Ensure Swift+ updated with bed request times	**>2 hrs** • Escalate to Clinical Matron and Head of Patient Flow in hours and SMOC out of hours for immediate response • Consider prioritising bed allocation to SDMA to ensure effective flow	**>4 hrs** • Escalate to Clinical Director, Head of Nursing and Care Group GM in hours and Executive On-Call and GIM On-call Consultant out of hours for immediate response and to agree plan to recover or restrict unit activity

Criteria	Green Default	Amber Two or more triggers	Red Three or more triggers	Black Two triggers
Transfer delays	**< 15 mins** • Ensure timely discharge preparation: SBARD, notes prepared	**15 mins – 30 mins** • Escalate to Site Co-ordinator • Request transfer support if multiple beds available simultaneously	**> 30 mins** • Escalated to Matron in hours and Site Co out of hours for immediate response • Matron / Site Co to work with teams to divert resource to support transfers	**N/A**
Number of patients in SDEC	**< 12 patients**	**12-16 patients** • Escalate to Clinical Site Team • Maintain space to be seen by appropriate patients not receiving direct care/treatment to wait in the waiting area • If beds not allocated by Clinical Site Team within 2 hrs of requesting, NIC to inform Matron/Service Manager, Acute Medical Consultant in hours; out of hours re-escalate to Clinical Site Team. • If, following re-escalation beds are not allocated, NIC to contact On Call Manager	**16-18 patients** • Escalate to Acute Medical Consultant, Matron and Service Manager in hours and SMOC and Clinical Site Team out of hours for immediate response and to agree plan to recover or restrict unit activity • If unable to complete initial triage within 15 minutes of arrival, transfer new arrivals to ED for clerking (record on OCEANO the time of arrival to SDMA and triage information) • Record any risk on DATIX • Escalate to Clinical Site Team and request priority be given to transfer of patients from SDMA	**18 patients** • Escalate to Clinical Director, Head of Nursing and Care Group GM in hours and Executive On-Call and GIM On-call Consultant out of hours for immediate response and to agree plan to recover or restrict unit activity
<u>Note</u>: Where the medical take has been redirected to ED, upon re-opening of SDMA the referral process detailed within this Policy will apply for medical patients in ED, i.e., those patients deemed appropriate for same day treatment and discharge will be referred through the medical bleep and if accepted transferred to SDMA. Patients requiring admission will be clerked in ED and transferred directly to an inpatient area.				
Comments & Actions detail				
Names of all that completed escalation				
Date and Time				

Appendix 4: SDMA Administration Guidelines

The Unit will accept patients from 08.00 until 22:00; medically expected patients arriving after 22:00 will be directed to ED. The Unit will close at 23:59 and all patients will be transferred out of the Unit by this time. (The nursing staff will use Swiftplus).

The Acute GPs will e-mail referrals to a generic e-mail address. The ward clerk must check the GP referral admission e-mail account every 15 minutes. On referral receipt the ward clerk must process them immediately and place the patient on the medical take register. – predoc, create a temporary folder and request main notes. The completed notes MUST be hand delivered to AEC or ED reception (depending on where the patient is to present) once they have been made up. The ward clerk will admit the patient on their arrival to SDMA.

If the patient changes location in the Unit, SwiftPlus will be updated accordingly. The nursing staff will keep the ward clerk informed of the patient's location.

Patients will either be transferred to AMU, the base wards or discharged home and it will be the responsibility of the ward clerk to tidy the notes for discharge. The notes will go to the AMU Secretaries for discharges summaries to be dictated.

The main notes must be forwarded to the secretary as appropriate if they arrive after the patient has left the Unit or follow the patient to the ward if they are admitted.

At times of short notice leave SDMA, AMU1 and AMU2 administrative staff will be required to flex across all areas to ensure cover is provided where the need is greatest. Priority will be given to where patients are presenting.

Processes will be constantly reviewed, and issues addressed as they arise. There will be periodic admin reviews in line with SDMA reviews.

Patients that have not been post-taked can be transferred to SDMA before 8pm, but they must have been clerked, EPMA completed, results reviewed, management plan in documented and commenced. These patients can only be transferred to AMU.

If patients are being admitted to base wards direct from SDMA, before 8pm they must have a post take review completed prior to transfer.

After 8pm and if there is a clear-cut admission for specialty, patients can be transferred to base wards if they are clerked and discussed with a core medical trainee or greater, they have a NEWS <4, EPMA completed, investigations reviewed, and a documented management plan in place.

Appendix 5: referral flowchart