University Hospitals of Morecambe Bay NHS Foundation Trust

Document Type: **Standard Operating Procedure**	**Unique Identifier:** CORP/SOP/012
Document Title: **Outlying Patients**	**Version Number:** 3.1
	Status: Ratified
Scope: All Clinicians, Nurses, Operating Department Practitioners and support staff that are involved in the coordination of patients across the hospital site	**Classification:** Organisational
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Replaces: version Version 3, Outlying Patients, Corp/SOP/012	**Head of Department:** DGM,A.CN. Acute medicine, Women's and Children's and Surgery & Critical Care
Validated By: SCC, Medicine, WACS, Core Clinical	**Date:** 08/09/2016
Ratified By: Procedural Documents and Information Leaflet Group Chairman's Action	**Date:** 21/06/2017
Review dates may alter if any significant changes are made	**Review Date** 01/09/2019

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 3	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** 5

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: No

References Checked by……Joanne Phizacklea…. Date……23/06/2017…..

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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

This Standard Operating Procedure highlights the decision making that needs to take place when considering transferring an inpatient for ward-based care outside of their clinical identified specialty.

It also provides guidance for the steps that should be taken to maintain safe care for higher level care patients who are cared for in the recovery setting.

2. PURPOSE

Outliers are patients that are moved from their speciality inpatient beds into beds in a different speciality ward/department during times of peak bed pressures. Whilst it is accepted that the placing of patients in beds appropriate to their clinical condition is the ideal way to manage care, there will inevitably be times when this cannot happen because of excessive capacity pressures. At such times it is essential that clinical teams work together to identify the most appropriate patients who can be outlied to ensure that acutely ill patients can be nursed within suitable clinical areas.

It is essential patient care is not compromised as a result of location and all wards/depts should provide holistic care regardless of the speciality.

Patient flow meetings should be used to escalate any issues /concerns that cannot be resolved at ward level. These can be accessed through the clinical site managers/matrons and are held at 07:30, 09:00, 12:00, 16:00. An extra patient flow meeting is held at 2000 at times of pressure.

3. SCOPE

All Clinicians, Nurses, Operating Department Practitioners and support staff that are involved in the coordination of patients across the hospital site.

4. STANDARD OPERATING PROCEDURE

4.1 For Level 0, 1a and 1b Patients (Shelford tool definition, see Appendix 1)

Please refer to the following inclusion/exclusion criteria which is by no mean exhaustive and all patients are to be considered on an individual basis:

4.1.1 To support the Clinical Site Managers, the site clinical teams will identify as part of their ward/board rounds patients suitable to outlie if required to decrease the time and the clinical decision making required out of hours. These patients should be identified by the ward teams to the Clinical Site Managers.

4.1.2 Patients who are due to be discharged the following day should be considered first as they are the less at risk and will avoid delays in other specialty areas.

4.1.3 Patients who have been assessed as medically fit for discharge should be considered first, although dependency and discharge planning and the impact this may have on the receiving ward should be considered.

4.1.4 Appropriate patients who may not have been assessed as medically fit for discharge may still need to be identified as suitable for outlying in the event that acutely ill patients from ED/MAU/AMU/ASU need to be accommodated into specialist areas.

4.1.5 The following criteria should be used as guidance. Any deviation from this should be justified in the patient record with steps taken to reduce any risk present.

- Patients must have a clear management plan that can be followed on the outlying ward.
- Patients should be medically stable wherever possible, circumstances where acuity is high, patients who are less stable require an overview from a competent person and a full management plan in place to enable escalation of the patients condition if required. In conjunction with the ward team, the Clinical Site Manager (CSM) will make this decision.
- Patients who have an elevated National Early Warning Score (NEWS) outside of the patient's normal physiological state should not be transferred.
- Paediatric wards will accept children up to the age of 17 and 364 days but they must remain under the care of the specialty team. This decision should take place with the patient and family if appropriate.
- Patients may be moved directly from medical or surgical assessment areas onto an outlying ward and the above criteria should still apply.
- Patients will have their Consultant clearly noted on their documentation. Teams will review patients daily (Monday to Friday) and if required by a medical consultant out of hours.
- Any concerns, at any time, should be escalated to the team doctors on shift that day, failure to respond by the team doctors should be escalated to the consultant without delay. Any concerns in relation to the existing management plan should be escalated to ST3 and above or consultant.
- Patients will continue to have timely, on-going treatment or continued discharge planning whilst on the outlying wards.
- The patients nursing care should not be compromised as result of being outside of speciality. The patient should not feel like an outlier due to the way they are treated or the standard of care they receive.
- The number of patient moves outside a patient's base ward or specialty should be limited so as to avoid delays in clinical care and compromises in clinical quality, safety and experience.
- If the patient's clinical need dictates, additional moves for specialist care i.e. rehabilitation, CCCU or if the patient deteriorates then this should be excluded from the above criteria.
- In instances where patients are transferred after 10pm, the CSM should submit a patient safety incident and supported rationale included as to the reason for transfer.
- Any patient being admitted directly to a ward from ED (outside of assessment areas) should have a senior (ST3 and above) management plan in place.
- The patient handover should be conducted using SBAR and documeneted on the trust handover sheet.

4.1.6 Patients who are not suitable for outlying, should have this clearly documented in the medical records, together with the reason, so that in the event that this situation has to be reassessed in response to more critical capacity pressures, all

staff understand the issues associated with the assessment of individual patients.

4.1.7 The following categories of patients are not suitable to be outlied:

- Patients on wards where there is a confirmed outbreak of infection.
- Previously known or current MRSA positive patients must be transferred in accordance with Meticillin resistant straphylococcus aureus (MRSA) management procedure (see Section 6 for link).
- Patients in the late terminal stages of their disease may be transferred to an appropriate setting after discussion with patient and family.
- Patients with dementia who are disruptive and/or aggressive
- Patients who have an elevated NEWS outside of the patient's normal physiological state should not be transferred.
- Patients with an elevated NEWS at risk of deterioration.

4.1.8 Outlying patients and the name of the responsible consultant team must be highlighted to the CSM by the ward coordinator each time a bed state is obtained.

4.1.9 The CSM will keep a log of any patients that require post take ward round and ensure this information is passed onto the oncall consultant. The Acute Matron/CSM will obtain a list of all outliers before 9am daily and distribute these to the relevant teams.

4.1.10 The number of outliers and their location will be discussed at each bed meeting to ensure their profile and treatment remains a priority.
Any issues must be reported via the Safeguarding system for the attention of the Matrons and Clinical Lead.

4.1.11 The CSM should report at each bed meeting on the patient flow reporting template the decisions made during the shift and the rationale attached to those decisions. This ensures an audit trail of such decisions.

4.2 For Level 2 and 3 Patients (ITU Society definition Appendix 2)

4.2.1 Once a level 2 or 3 patient is identified as requiring admission to the ITU, the coordinator and consultant should start planning how to accommodate the unit care requirements. If the unit cannot accommodate the patient immediately recovery should be notified an outlier may be required in recovery.

4.2.2 A discussion between ITU and recovery including the theatre coordinator should take place to establish skills available in recovery to support the type of care an ITU outlier may require.

4.2.3 The first option should always be to review existing patients and assess suitability to step down either into a ward area or into recovery.

4.2.4 The most stable patient should be selected by the MDT to step down to the recovery area. A full explanation should be provided to the patient's family and a clinical incident report submitted for monitoring purposes. (All patients who outlie in recovery are reported as moderate harm incidents and receive a rapid review of the situation and care provided)

4.2.5 In circumstances where a bed is becoming available, an assessment of the available environment and staffing skill should take place and in these circumstances it is sometimes more appropriate to hold the patient temporarily in the recovery setting to avoid moving multiple critical care patients and minimise the risk.

4.2.6 If the skill mix in recovery cannot meet the needs of the patient identified to step down, a member of the recovery team will transfer to ITU to care for a patient they are suitably skilled to do so and the ITU nurse will care for the patient in recovery. It is expected the leaders in each department remain in regular contact, assessing patient requirements and staff skill and adjusting the team according to available skill set.

4.2.7 ITU documentation should be utilised in the recovery area. Patients will receive all personal care and treatment as they would on the ITU.

4.2.8 The Clinical Site Manager /Matron should be made aware of any circumstances where an outlier in recovery takes place so suitable support can be made available. This information will be raised at the patient flow meetings and the senior manager on call made aware of the situation.

4.2.9 The ITU coordinator at this point should communicate with ITU on the opposite site to establish a situation report for the opposite site so they are briefed on any options should the escalation of critically ill patients occur.

4.2.10 In the event of further escalation of unwell patients (more than 1 patient requiring care) the consultant and coordinator will contact the critical care network to request a bed state in anticipation of a clinical transfer.

4.2.11 The site managers are available and should be contacted at any time should staff require support in managing any situation.

5. ATTACHMENTS	
Number	**Title**
1	Shelford Definitions of levels
2	ITU Society definition
3	RLI Twinning Scheme
4	Medical triage of patients to appropriate wards
5	FGH Twinning Scheme
6	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Proc/023	MRSA Management, Screening and Suppression http://uhmb/cs/tpdl/Documents/CORP-PROC-023.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Number	References
1	The Shelford Group (2013) Safer Nursing Care Tool: Implementation Resource Pack.

Bibliography

The Nursing and Midwifery Council (NMC) (2015) The Code : Professional standards of practice and behaviour for nurses and midwives (incorporating record keeping) London: NMC. Available at: http://www.nmc.org.uk/standards/code/ (accessed 23/06/2017)

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
CSM	Clinical Site Manager
ACS	Acute Coronary Syndrome
ICD	Intercardiac device
COPD	Chronic Obstructive Pulmonary Disease
NIVV	Non-Invasive Ventilation
LTOT	Long Term Oxygen Therapy
PSI	Patient safety Incident
SBAR	Situation, background, assessment, recommendation

9. CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
Hilary Birch Ian Holroyd Fiona Bowery	Clinical Site Management Team	
Roz McMeeking Mary Shimwell Lynn Dack Janet Towers Heather Bendall Allyn Dow Claire Rawes Laura Armitage	Matron WACS, Acute Medicine, Surgery Matron Matron Matron ITU Unit manager ITU Unit manager Matron Recovery Lead	
Leanne Cooper Sarah Cullen Carol Park	Clinical Service Manager Assistant Chief Nurse, SCC Assistant Chief Nurse, Acute Medicine	
Louise McCracken	Core Clinical Services DPDG	02/03/2017

10. DISTRIBUTION PLAN	
Dissemination lead:	Assistant Chief Nurses
Previous document already being used?	Yes
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	Email instruction with new document
To be disseminated to:	All senior divisional teams, Clinical Site Managers and SMOC distribution list
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING Is training required to be given due to the introduction of this procedural document? Yes		
Action by	**Action required**	**Implementation Date**
All matrons	To disseminate and share with ward teams	30.9.16
All CSM	For dissemination	30.9.16

12. AMENDMENT HISTORY				
Revision No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.5			Full Review	March 2015
3	May 2017		Full Review	01/09/2019
3.1	10/10/2017	Page 3	BSF page added	01/09/2019

Appendix 1 - Shelford Definition of Levels[1]

Levels of Care	Descriptor
Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • **Early Warning Score** is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** • Increased level of observations and therapeutic interventions • **Early Warning Score** - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation/invasive monitoring
Levels of Care	**Descriptor**
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	**Care requirements may include the following** • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with spinal instability/spinal cord injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration/post-administration care) • Patient and/or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit	• Deteriorating/compromised single organ system • Post operative optimisation (pre-op invasive monitoring)/extended post-op care. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway **and** protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and/or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/systems • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection

Appendix 2 – ITU Society Levels of Care Definition

Critical Care Level 2	
Patients needing pre-operative optimisation	• Cardiovascular, renal or respiratory optimisation required prior to surgery. • (Invasive monitoring inserted to assist optimisation (arterial line, and CVP as a minimum)
Patients needing extended postoperative care	• Immediate care following major elective surgery. • Emergency surgery in unstable or high risk patients. • Where there is a risk of postoperative complications or a need for enhanced interventions and monitoring.
Patients stepping down to Level 2 care from Level 3	• Requiring a minimum of hourly observations. • At risk of deterioration and requiring level 3 care again.
Patients receiving single organ support **(exceptions: Basic Respiratory and Basic Cardiovascular Support occurring simultaneously without any other organ support should be considered as Level 2 and Advanced Respiratory Support alone is Level 3).**	
Patients receiving Basic Respiratory Support **(NB: When Basic Respiratory and Basic Cardiovascular support are provided at the same time during the same critical care spell and no other organ support is required, the care is considered to be Level 2 care)**	Indicated by one or more of the following: • Mask / hood CPAP or mask / hood Bi-level positive airway pressure (non-invasive ventilation) • Patients who are Intubated to protect the airway but needing no ventilatory support • CPAP via a tracheostomy • More than 50% oxygen delivered by face mask. (Note, more than 50% has been chosen to identify the more seriously ill patients in a hospital). Short-term increases in FiO2 to facilitate procedures such as transfers or physiotherapy do not qualify. • Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support. (e.g. severely compromised airway or deteriorating respiratory muscle function).

Patients receiving Advanced Cardiovascular Support (NB: Basic Cardiovascular support will frequently occur prior to Advanced Cardiovascular support and should not lead to both Advanced Cardiovascular support and Basic Cardiovascular support being recorded at the same calendar day. Advanced Cardiovascular support supersedes Basic Cardiovascular support where this occurs.)	• Indicated by one or more of the following: • Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ / tissue perfusion, (e.g. inotropes, amiodarone, nitrates). To qualify for advanced support status, at least one drug needs to be vasoactive. • Continuous observation of cardiac output and derived indices (e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal Doppler, impedance and conductance methods). Intra-aortic balloon pumping and other assist devices. • Insertion of a temporary cardiac pacemaker
Patients receiving Renal Support	Indicated by: Acute renal replacement therapy (e.g. haemodialysis, haemofiltration etc.) or provision of renal replacement therapy to a chronic renal failure patient who is requiring other acute organ support in a critical care bed.
Patients receiving Neurological Support	• Indicated by one or more of the following: • Central nervous system depression sufficient to prejudice the airway and protective reflexes, excluding that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. deliberate or accidental overdose, alcohol, drugs etc.). • Invasive neurological monitoring or treatment e.g. ICP, jugular bulb sampling, external ventricular drain. • Continuous intravenous medication to control seizures and / or continuous cerebral monitoring. • Therapeutic hypothermia using cooling protocols or devices
Patients receiving Dermatological Support	• Indicated by one or more of the following • Patients with major skin rashes, exfoliation or burns. (e.g. greater than 30% body surface area affected). • Use of complex dressings (e.g. large skin area greater than 30% of body surface area, open abdomen, vacuum dressings or, large trauma such as multiple limb or limb and head dressings).

Critical Care Level 3	
Patients receiving Advanced Respiratory Support alone (NB: Basic Respiratory support will frequently occur prior to Advanced Respiratory support and should not lead to both Advanced Respiratory support and Basic Respiratory support being recorded at the same calendar day. Advanced Respiratory support supersedes Basic Respiratory support where this occurs.)	Indicated by one of the following: Invasive mechanical ventilatory support applied via a trans-laryngeal tracheal tube or applied via a tracheostomy. Bi-level positive airway pressure applied via a trans-laryngeal tracheal tube or applied via a tracheostomy CPAP via a trans-laryngeal tracheal tube.
OR Patients receiving a minimum of 2 organs supported (NB: Basic Respiratory and Basic Cardiovascular do not count as 2 organs if they occur simultaneously (see above under Level 2 care), but will count as Level 3 if another organ is supported at the same time)	Examples: Basic Respiratory and Neurological support. Basic Respiratory and Hepatic Support. Basic Respiratory and Renal support. Basic Cardiovascular and Hepatic support. Basic Cardiovascular and Renal support. Advanced Cardiovascular and Renal support. Advanced Cardiovascular and Hepatic support. Advanced Cardiovascular and Neurological support.

Further detailed explanations can be found at:

https://www2.rcn.org.uk/__data/assets/pdf_file/0005/435587/ICS_Levels_of_Critical_Care_for_Adult_Patients_2009.pdf

Appendix 3 - RLI Twinning Scheme

Outlier Twinning Scheme – for medical patients on surgical wards V4

This arrangement pairs each non-medical ward with a Medical team who will be responsible for care of all medical patients in this area unless a particular medical specialty team would like to maintain continuity in those sent out from a ward i.e.

A patient with oesophageal varices awaiting discharge plans.
A patient with complex diabetes awaiting discharge plans.

This scheme is hoped to enable nurses to allow working relationships to develop and allow access to the correct clinical staff. Out of 9-5 Mon-Fri the on call team for medicine should be called.

The scheme involves all the medical team including the Nurse Practitioner and FY1/CMTs. Cover for absence will be the same arrangement as exists internally.

Ideally these clinicians should be proactive and visit the paired ward daily.

The on-call consultant should be the person who is responsible for seeing the new patients on non-medical wards within 24 hours (who did not go through AMU unless it is clear that the team will be seeing within the working day).

The patients should be put under one of the consultants for that speciality:
Aiming for an even distribution between the consultants.
I.e. Mr J comes into ASU. Go under Chadwick or McGowan on Lorenzo. Even at weekend. Please ensure AMU aware about this patient as particularly at weekend/BH the ON Call consultant will need to see.

Ward	Tel no.	Medical	Sec Tel no.	ANP/Medical staff
16	53820	Gastroenterology:Dr Higham	53246	Jayne Jones/Lancaster Suite/ gastro staff:FY1/ST1/ST3
34	53433	Gastroenterology:Dr Higham	53246	Jayne Jones/Lancaster Suite/gastro staff:FY1/ST1/ST3
33	53434	Diabetes: Dr Smith	53322	Deborah Whittle/Lancaster suite staff:FY1/ST1/ST3
35	53435	COTE: McGowan	53602	Kate Morton/ward 20 staff
36	53436	Respiratory: Jifon/Bari/Gatheral	53316	Alison Calvert/ward 37 staff FY1/ST1/ST3
ASU		COTE: Chadwick	53602	Kate Morton/ward 22 staff
CCU	46250	COTE: Kumar	53602	Sharon Ross/ward 23 staff :FY1/ST1/ST3

The following advice may assist:

Relating to paired wards:

- We must still make every effort to get the right patient under the right speciality (see triage criteria. Appendix 1. For people already on a medical ward who we 'lodge out' we should preserve continuity of care wherever possible. Therefore where possible, choose the patient to move to an available bed according to the speciality / present consultant needs.
- If new patients arrive on days without senior cover on site for the firm team the consultant teams will need to be flexible to cross cover each other. The on-call consultant will be the one to see these patients if it is apparent by midday that no-one senior has seen them

Appendix 4 - Medical Triage of Patients to Appropriate Wards

This is a guide for CSMs as to the specialty ward best placed to receive these patients

Respiratory-ward 37

1. Acute severe asthma NOT mislabelled COPD or uncertain asthma,
2. Pneumothorax
3. Patients on Long term oxygen therapy (not those on home O2 cylinders for prn use)
4. Any patient requiring NIPPV for a respiratory reason (except those requiring brief Rx for excessive O2 administration
5. Unilateral pleural effusion
6. A strong likelihood of underlying lung cancer as a diagnosis i.e. clear mass on x-ray
7. Acute Alveolitis/ Exacerbation of Interstitial lung Disease
8. Pneumonia with more than one lobe involved in young adult
9. Type II Respiratory Failure not improving in 48 hours

Care of Older People and Stroke team-Med unit 2

1. Frail elderly patients who have fallen– immobile and with no bony injury.
2. Stroke
3. Advanced dementia
4. Care home residents - as a marker for frailty.
5. Parkinson's Disease - where PD issues are a major factor in the admission.
6. Delirium - rapid onset, fluctuating cognitive impairment with disturbance of concentration and alertness.

Cardiology-CCU

1. Acute coronary Syndrome especially NSTEMI – not all chest pain
2. Complicated arrhythmias, ones which do not respond to first line therapy, ones where Internal cardiac defibrillators may be appropriate
3. Atrial Fibrillation where rhythm control to be considered i.e. with cardioversion
4. Heart failure: Unless severe comorbidity all should be considered for review; those when still symptomatic on max therapy.
5. Endocarditis
6. Symptomatic valvular heart disease
7. Cardiomyopathies

Endocrinology Lancaster Suite

1. Diabetic ketoacidosis/non-ketotic coma/hypoglycaemia
2. Diabetic foot ulceration requiring hospital admission
3. Pituitary and adrenal problems
4. Hypercalcaemia where no obvious malignancy

Gastroenterology Lancaster suite

1. Jaundice
2. Liver failure
3. Inflammatory bowel disease
4. Variceal bleed

Oncology Lancaster suite

1. Patients under current Oncologist receiving chemotherapy(whether neutropenic or not)

Rheumatology Lancaster suite

4 Current rheumatology patient and joint problems or problems relating to treatment
5 Septic arthritis
6 Autoimmune immune disease strongly suggested
7 Acute polyarthritis

Gynaecology Ward 16 and Ward 1
Female patients only:

1. Surgical patients/suitable patients

Appendix 5 - FGH Twinning Scheme

Ward	Tel No.	Medical team
1	51505	AMU physician
2	51008	Dr Cook/Jolley/Barton
4	52094	Dr Mitchell, Wood, Respiratory team
5	51014	Dr Keating/Davies

Appendix 6: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Surgery and Critical Care			
Lead Assessor	Sarah Cullen			
What is being assessed?	Outlying Patients			
Date of assessment	9 September 2016			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details: Clinical site managers and matrons			

1) What is the impact on the following equality groups?

Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	Impact (Positive / Negative / Neutral)	Comments ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	There is no impact identified that will affect any one patient more than others. Movement will depend on clinical condition only.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.