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| SOP Title | | Management of the Deteriorating Patient in the Emergency Department (ED) Standard Operating Procedure (SOP) | | | | | |
| SOP Number | |  | | | | | |
| Version Number | | v1 | | | | | |
| Effective Date | |  | |  | | |  |
| Author | | Jayne Robinson | | | | | |
| Approved by | |  | | | | | |
| Approval date | |  | | | | | |
| Distribution | | All ED staff, Critical Care Outreach Team (CCOT) Hospital out of Hours Team (HOOP), Clinical Commander and Night Matron Team. | | | | | |
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| Document Control | | | | | | | |
| Version | Date | | Author | | Status | Comments | |
| V1 |  | |  | |  |  | |
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| SOP Objectives | | The aim of this SOP is to standardise the processes by which patients within Calderdale & Huddersfield NHS Trust Emergency Departments, who are acutely unwell or at risk of deterioration are identified and responded to. | | | | | |
| Scope | | This SOP applies to the care of all adult patients who are not receiving end of life care and who are at risk of physical deterioration and may ultimately suffer a respiratory or cardiopulmonary arrest. | | | | | |
| Performance Measures | |  | | | | | |
| Related Documents | | CHFT Adult Physiological Observation Policy - [C-70-2011 - Observation Policy v5.pdf (cht.nhs.uk)](https://documentation.cht.nhs.uk/uploads/710/C-70-2011%20-%20Observation%20Policy%20v5.pdf) | | | | | |

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| **Work Instruction - To ensure the safety of patients at risk of deterioration whilst in the ED usng** | | |
| No. | Action | Responsibility |
| 1 | All adult majors and minors patients requiring admission must have hourly observations using NEWS 2 Scoring System for Adult Patients, or more frequently dependent on the patients clinical condition. This should continue until a Doctor or Advanced Clinical Practitioner documents otherwise. | Nursing Staff |
| 2 | Clinical Response to NEWS -2 Scoring (Track & Trigger)   |  |  |  | | --- | --- | --- | | NEWS-2 Score | Frequency of Monitoring | Clinical Response | | NEWS = 0 | 1 hourly whilst in ED | * Continue 1hrly observations for the first 4 hours . * After 4 hours discuss with Registered Nurse / NIC / ACP / Doctor level of monitoring required whilst in ED (minimum 12 hourly) | | NEWS = 1-4 | 1 hourly whilst in ED | * Inform registered nurse who must assess the patient within the hour * Registered nurse to decide frequency of monitoring and/or escalation of patient care as required. | | 3 in single parameter | Minimum 1 hourly whilst in ED | * Registered nurse to inform the clinician assigned to the patient (if not assigned please inform middle grade or above) * Consider SEPSIS and initiate and complete SEPSIS Bundle on EPR if appropriate. | | Total 5 or more (Urgent Response Threshold) | Minimum 1 hourly whilst in ED | * Registered nurse to inform clinician. * Clinician to review within 30 minutes or middle grade or above if escalation required. * Consider moving to resuscitation area * Consider SEPSIS and initiate and complete SEPSIS Bundle on EPR if appropriate * Consider ceiling of care and resuscitation in liaison with senior physician * Consider informing CCOT / HOOP * CRH CCOT – dial 4924 * HRI CCOT – dial 4206 * CRH HOOP – dial 3655 * HRI HOOP – dial 3358 | | Total 7 or more (Emergency Response Threshold) | Continuous monitoring of vital signs until senior decision maker documents otherwise | * Move patient to resuscitation area * Inform Middle Grade or above * Middle grade or above review immediately * Document escalation plan and ceiling of care in EPR * Referral to CCOT / HOOP * Consider escalation to ICU middle grade or above * Consider transfer to level 2 or 3 care if deemed appropraite | | Registered Nurse / Nurse in Charge / ACP / Junior Doctor / Consultant |

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| |  |  |  | | --- | --- | --- | | **Work Instruction - To ensure patients are appropriately escalated whilst in the ED** | | | | No. | Action | Responsibility | | | |
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| 1. | Escalation is the responsibility of all staff undertaking observations but ensuring action is taken is the responsibility of the registered nurse who is caring for the patient. | All Staff |
| 2. | Escalation and the following actions / decisions must be documented in EPR |  |
| 3. | Escalation in the first instance should be to the registered nurse and or nurse in charge of the clinical area who will then use the above algorithm to ensure timely escalation of patients who are at risk / deteriorated whilst in the ED. |  |
| 4. | Escalations should be communicated using the **S**ituation, **B**ackground, **A**ssessment, **R**ecommendations tool to ensure consistent messages are conveyed. |  |
| 5. | If there is no response to escalations within 15 minutes the concerns should be escalated to the next level. |  |
| 6. | If the patient fails to respond to treatment or deteriorates further discussions regarding ceiling of care must take place and be documented. |  |