Local Involvement Network

Joint Working Group

‘Enter and View’ Visits

To

Emergency Departments of

Acute Hospitals in the

Great Western Ambulance Service

Trust Area

1. Background Information

Local Involvement Networks (LINks) were set up in April 2008 as part of the legislation in the Local Government and Public Involvement in Health Act 2007. One of the primary functions of LINks is to collect views from patients, carers and the public about health and social care services in their local authority area. These views are passed on to the Commissioners, Providers and Regulators of the services, to help improve or change these services. The Joint Working Group (JWG) was formed by members of the seven LINks in the GWAS area to work together to look at ambulance services.

Sir Ian Carruthers OBE, Chief Executive of the South West Strategic Health Authority stated that 'patient delays and ambulance handover waits have the potential to impact on patient care as well as wasting valuable NHS resources. Throughout the year, delays can be experienced by both patients and ambulance crews but historically, these delays increase during the winter months as pressure builds in acute settings *(NHS South West: Ensuring timely handover of patient care – ambulance to hospital October 2009, Foreword by Sir Ian Carruthers OBE)*. Sir Ian also pointed out that it is vital for NHS organisations to work together to develop systems and processes that manages patient care in an effective systematic way to ensure timely handovers thereby reducing unnecessary waits across the system.

New A&E Clinical Quality Indicators were introduced in April 2011 by the Department of Health (Gateway Ref 15322). Quality Indicator [6] refers to '*time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs), for all patient arriving by emergency ambulance'*.

For patients conveyed by the ambulance service to an Emergency Department as a result of a 999 call, the 'arrival time' is the time the ambulance crew enters the Emergency Department and confirms arrival using the Emergency Department ambulance arrival screen. A hospital representative is required to corroborate this time on the ambulance patient care record.

The 'handover clock' begins when the ambulance clinician confirms arrival within the Emergency Department. The recommended standard is that clinical handover i.e. responsibility for the patient, should happen within 15 minutes of the arrival time.

Following arrival in the Emergency Department, a hospital representative is provided with a brief summary of the patient's condition. Using this information the hospital representative directs the ambulance crew to an appropriate care location (Emergency Department trolley). The ambulance crew transfers the patient to the designated hospital trolley and provides a comprehensive clinical report to the nurse responsible for that trolley. Responsibility for the

patient has now transferred to the hospital. This is deemed as 'handover time' and is confirmed using the Emergency Department ambulance arrival screen and corroborated by the nurse receiving the patient.

The ambulance 'wrap up period' begins once handover has been confirmed. The recommended standard is that ambulance wrap up should be completed within 15 minutes of handover time.

Following handover, the ambulance clinicians are required to complete any outstanding documentation, replenish used equipment and carry out any infection control procedures. An exclusion to the 15 minutes wrap up time may be claimed in exceptional circumstances e.g. incident debrief.

Once wrap up requirements have been completed the ambulance clinician enters 'clear' to their vehicle screen. The time between 'handover' and 'clear' is recorded as the wrap up period.

The Arrival Screens (Capacity Management System) were introduced in all eight hospitals in the GWAS area following a period of working together of the acute trusts who had agreed they needed more information concerning in-bound ambulances and their expected time of arrival. The screens were installed during August 2011 following a trial in May 2011 at Weston General Hospital, Gloucester Royal Hospital and the Royal United Hospital, Bath. Each Acute Trust provided its own screen, with GWAS taking responsibility for providing the software and ensuring that the screens were compatible with their existing CAD system. The screens enable real-time monitoring of the pressure experienced by acute hospitals, both in terms of their overall bed pressure, and by the individual access points related to that hospital. The main benefit of the screens is that waiting times are reduced which results in better patient care and better performance for hospitals.

2. Purpose of the Visits

For some considerable time, the members of the LINks Joint Working Group (JWG) have been concerned about the ambulance turnaround times for patients at hospitals in the Great Western Ambulance Service (GWAS) area. Figures for the period 2009 to 2011 for the total number of ambulances arriving at the Emergency Department and the percentage of ambulances with a handover period of greater than 15 minutes are illustrated in the following tables. Average attendances by GWAS greater than 15 minutes were 34.8% in December 2009, 18.5% in June 2010, 22.6% in June 2011 and 26.6% in December 2011.

Total number of Ambulances arriving at Emergency Departments

	Bristol Royal Infirmary	Cheltenham General Hospital	Frenchay Hospital	Gloucester Royal Hospital	Great Western Hospital	Royal United Hospital	Salisbury Hospital	Weston General Hospital	TOTAL
June 2009	1865	821	1583	1402	1467	1860	811	762	10571
December 2009	1843	1158	1562	1804	1669	1995	814	873	11718
June 2010	1593	1007	1414	1597	1531	1706	709	861	10418
July 2011	1858	1223	1745	1744	1494	1779	820	830	11593
October 2011	1949	1251	1791	2072	1673	1942	820	941	12439
November 2011	1779	1168	1639	1941	1540	1806	812	845	11530
December 2011	1960	1253	1758	2025	1714	1886	841	895	12332
Number of cubicles at time of visit	11	10	8	9	16	18	10	18	

Percentage of Ambulances with a Handover Period of Greater than 15 minutes

	Bristol Royal Infirmary	Cheltenham General Hospital	Frenchay Hospital	Gloucester Royal Hospital	Great Western Hospital	Royal United Hospital	Salisbury Hospital	Weston General Hospital	
June 2009	30.8	36.1	44.2	31.1	19.3	20.3	13.9	40.1	
December 2009	37.5	47.1	42.3	53.7	26.6	6.7	11.7	61.2	
June 2010	27.1	22.1	38.4	31.9	14.9	5.2	5.8	10.5	
July 2011	28.8	29.0	42.0	16.9	7.7	4.8	6.1	22.8	
October 2011	38.3	31.4	50.4	29.1	14.5	4.6	7.1	25.3	
November 2011	32.6	28.3	48.4	29.3	12.9	7.1	6.0	17.8	
December 2011	37.9	20.4	63.4	24.4	14.3	8.4	5.4	25.3	
Number of cubicles at time of visit	11	10	8	9	16	18	10	18	

The members of the JWG were aware that a number of processes had been implemented to improve the turnaround times, in particular the installation of new Arrival Screens in the Emergency departments in the eight hospitals in the GWAS area.

Following a presentation on September 12th 2011 to the JWG by Marija Kontic, Project Manager Great Western Ambulance Services (GWAS), highlighting the use of the newly installed 'Arrival Screens', it was agreed that the each LINk should make an 'Enter and View' visit to the Emergency department of its local Acute Hospital(s) to observe handover processes associated with the Arrival Screens and assess the benefits to patients. It was agreed that the Authorised Representatives may talk to hospital and ambulance staff about their experiences in using the Arrival Screens at the Acute hospitals in the GWAS area.

The visits took place between October 2011 and March 2012 and were carried out by LINk members who were Authorised 'Enter and View' Representatives of the relevant LINk. Each hospital was advised of the proposed visit and that it would be undertaken by two named LINk Authorised Representatives *(see appendix One).*

3. Results of the Visits

An agreed list of questions was used for each visit *(see Appendix Two).*

3.1 The first part of the questionnaire contained questions about the Emergency Departments, the staffing levels and any additional rooms within the department. The results are shown in the table below.

	Bristol Royal Infirmary	**Cheltenham General Hospital**	**Frenchay Hospital**	**Gloucester Royal Hospital**	**Great Western Hospital**	**Royal United Hospital**	**Salisbury Hospital**	**Weston General Hospital**	
A&E Open 24/7	yes	yes	yes	yes	yes	yes	yes	yes	
Number of cubicles	11	10	8	9	16	18	10	18	
Additional waiting area for ambulance patients	Yes Long corridor	No	Yes	No	Yes 4-5 patients		No	No	
Is there a separate children's area?	N/A	Yes	Yes	Yes	No	Yes	Yes	Yes	
Is there a resuscitation area	Yes 6	Yes	Yes 7	Yes 4 beds	Yes 4	Yes 4	Yes 3	Yes 5	
Number of Doctors on duty per day	varied	5/6	5	2	7	2	2	3	
Is this throughout a 24 hour period?	No 8am – 10pm	Yes	Yes	Yes	No 8am – 7pm	No	No 8.30am - midnight	No	
Number of ED Consultants on duty	2	1	2	2	2 1 w/ends	3	1	No 8am – 10pm	
Number of Nurses on duty	11	12	8	7	varies	23	6	8	
Number of nurse practitioners	16	1	0	1	6 minimum	4	1	1	
Average number of patients per day arriving in ambulances (Dec 2011) **	63	41	56	65	55	61	27	29	
Ratio of number of patients per day (Dec 2011) per cubicle	5.7	4.1	7	7.2	3.4	3.4	2.7	1.6	

** Based on an assumption of one patient per ambulance

3.2 The second part of the Questionnaire concentrated on the use of Arrival Screens in Emergency Departments, and other observations from the LINk members

For all of the hospitals visited, the patient journey to the Emergency Department was recorded on the Arrival Screens in the following way:

- At the start of the patient journey in a GWAS ambulance, information regarding the patient is automatically logged into the system by the staff. This gives the receiving hospital an estimated time of arrival and clinical information.

- At a predetermined point as the ambulance approached the hospital, the tracking system automatically registers the imminent arrival of the ambulance onto the Arrival Screen. It shows the priority of the patient as advised by the ambulance crew. It also shows the Ambulance Call Sign, Job Number, notes about the patient, Estimated Time of Arrival at the Emergency Department and Handover Time.

Out of area ambulances do not show on the Arrival Screens and require a manual handover. Two hospitals had a second Arrival Screen, which are linked to another ambulance service.

The questions asked at all sites were:

- What is the procedure for use of the Arrival Screen?
- Is the Arrival Screen the responsibility of a particular member of staff? If so, who?
- Who meets the patient on their arrival?

The answers to these questions and relevant observations are shown in the following sections. The full reports can be seen in *appendix three*

Bristol Royal Infirmary (BRI)

Ambulance staff pass the screen on way into the department and check the patient in.

There is no particular staff member assigned to the screen. It is anyone on duty at the time. At the time of the visit, a staff member from GWAS was helping to use the screen on a part time basis.

A shift coordinator (Band 6/7) meets the stretcher/patient.

The LINk members noted that although all GWAS vehicles are shown on the Arrival Screens, ambulance cars arriving at BRI are not booked in with arrival and departure times. This also applied to patients taken direct to the wards e.g., heart conditions and some GP admissions.

The screens arrived in the department without any prior notice or training. The matron considers that all staff, including some GWAS staff need considerable training on the use and benefits of the arrival ~Screen. The suggestion was that the department does not have enough staff to have a dedicated person watching the screen.

The agreed handover time is that as soon as the BRI staff relieve the GWAS of their patient they should enter the time on the screen but they do not always do this until their paperwork has been completed. This causes a time lag and shows up against the fifteen minute requirement.

Cheltenham General Hospital

Ambulances arriving at the department entrance take patients to the trolley space which is close to the nurses' station with the Arrival Screen. One crew member remains with the patient, whilst the other one goes to the nurses' station to book the patient in.

There is a Dedicated Nurse Coordinator assigned to look at the Arrival Screen who remains at her post.

Dedicated Triage Nurse meets the patient

Ambulances from outside the GWAS area are not able to access the Arrival Screen so manually report to the nurses' station. At the time of the visit, an ambulance arrived from West Midlands Ambulance area and the ambulance crew waited five minutes to be booked in. The ED staff did not notice the crew was there until it was pointed out by the Authorised Representatives.

Frenchay Hospital

On arrival in the Emergency Department, one of the ambulance crew will 'tick' the Emergency Department IPT box on the Arrival Screen.

Great Western Ambulance personnel take the responsibility for 'ticking' the boxes on the Arrival Screen. North Bristol Trust Frenchay Emergency Department would like it to be a joint responsibility. The arrival screens were supplied by GWAS and solely their responsibility at this moment in time.

At present, the Charge Nurse meets the patient on arrival. In future, it will be the Initial Assessment Nurse (IAN).

It was observed that it took 4 minutes for one patient to be brought in following the time arrival on the screen. It was also noted that the ambulance crew did not ring the door alarm bell before entering, according to procedure, in order to warn the Charge Nurse that a patient was being brought through. This could have led to a further delay if the Charge Nurse was occupied elsewhere. The care of the patient was immediately handed over to the IAN but the box on the arrival screen was not ticked indicating handover was still in progress.

Validation of the handover times at present cannot be taken as accurate. There is a gap between recorded handover in the ED and actuality, It is believed that ambulance crews, once at Frenchay, can grab a hot drink and clean the ambulance before going back to operational duties.

Gloucester Royal Hospital

At the time of the visit the ambulance staff had to walk past the Nurses Station and Arrival Screen and go to the main Reception area to book the patient in. As the reception can be and often are in discussion with 'walk-in' patients, the crew had to wait until they are free before the patient can be booked in. This procedure has been now been altered and the ambulance staff now book the patient in at the nurses station

The nurse in charge is responsible for the Arrival Screens but at the time of the visit, did not remain at post the whole time but left the screens unattended to do other things in the department.

Any nurse, who is available, will meet the patient.

Great Western Hospital Swindon

.An example of the information on the screen was '89 year old male with shortness of breath, arrival time 6 minutes. The arrival screen has been received positively by the staff as it helps with the more efficient organisation of ED They are shortly to install a second screen that will provide easier access for the ambulance crew, who also have to signal their arrival on the screen.

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The nurse in charge takes responsibility to ensure a cubicle or resuscitation room is ready for the patient. The aim of the Emergency Department is always to keep one area free.

The nurse in charge does the initial assessment

At the time of the visit, the Authorised Representatives were advised that the ED will have, in the next two weeks, a new electronic 'capacity management system' installed for 999 re-routing. This will record pressures on ED every two hours. It will mainly support ambulances in outlying areas, where an alternative hospital may be more convenient. It is recognized that the priority should be to admit a patient to their local hospital wherever possible. A patient in a hospital out of area creates a number of administrative and social difficulties.

There is a separate ambulance holding area where the patients are cared for by ambulance staff. This area is used at least once a day when the ED reaches its capacity. There is room for 4-5 patients in this area.

Royal United Hospital Bath (RUH)

Ambulance crews log-on to screen on arrival with patient in department (1 screen for each ambulance service). The crews log onto the screen when the patient is handed over to a nurse.

The RUH Co-ordinator and ambulance crew take the patient to a cubicle. The Co-ordinator meets the patient

Historically there have been discrepancies between hospitals' recording of ambulance turn-around time and the times recorded on the ambulance service's IT systems. Both sets of records are still generated but the turn-around times recorded were moderated jointly by the hospital and ambulance Trust at regular meetings to ensure a single and agreed set of records for official performance

Salisbury District Hospital

As soon as the patient arrives, a crew member immediately acknowledges this on the screen so there is a record of arrival time. When the crews leave, they chart the departure time.

Great Western Ambulance Service is responsible for the screens input. The patient is usually met by a band 6 nurse or Sister.

Salisbury Hospital Emergency Department has recently been refurbished. The horizontal 'white board' in the centre console of Majors as it means staff has access to patient

information that the public cannot see. It was noted at the time of the visit that none of the cubicles had their curtains drawn, so patients could be seen by everyone passing by. At one point, a lady in an open backed gown wandered up the central area looking lost.

Weston General Hospital

Dispatch send the information to the screens, then GWAS staff update when arrive at the hospital.
Hospital staff do not have anything to do with the system at all. They do not look at the screen, they do not have time, the screen is not in the main working area.

GWAS personnel are responsible for the screens

Reception and triage nurse meet the patient

The Arrival Screen is located near the entrance corridor for ambulance patients and some yards from the control area. The sister in charge admitted they rarely have time to look at it the screen as it was too far from their work area and lacked details. It was clear that it would not be possible to have another screen in the control area as ambulance staff would need to come in and use it. Paramedics told members the details of any patients needing immediate treatment were phoned through to the Emergency Department. Both the GWAS staff and hospital staff were satisfied with how the system was working.

Comparative Information for December 2009 and December 2011

December 2009	Bristol Royal Infirmary	Cheltenham General Hospital	Frenchay Hospital	Gloucester Royal Hospital	Great Western Hospital	Royal United Hospital	Salisbury Hospital	Weston General Hospital	
Number of cubicles at time of visit	11	10	8	9	16	18	10	18	
Average number of patients per day arriving in ambulances	59	37	50	58	54	64	26	28	
Percentage of ambulances with a handover time of greater than 15 mins	37.5	47.1	42.3	53.7	26.6	6.7	11.7	61.2	
Ratio of number of patients per cubicle per day	5.3	3.7	6.2	6.4	3.4	3.5	2.6	1.5	

DECEMBER 2011	Bristol Royal Infirmary	Cheltenham General Hospital	Frenchay Hospital	Gloucester Royal Hospital	Great Western Hospital	Royal United Hospital	Salisbury Hospital	Weston General Hospital	
Number of cubicles at time of visit	11	10	8	9	16	18	10	18	
Average number of patients per day arriving in ambulances	63	41	56	65	55	61	27	29	
Percentage of ambulances with a handover time of greater than 15 mins	37.9	20.4	63.4	24.4	14.3	8.4	5.4	25.3	
Ratio of number of patients per cubicle per day	5.7	4.1	7	7.2	3.4	3.4	2.7	1.6	

4. Findings

1. There was clear evidence of good relations and close working together between the GWAS staff and all the hospital staff in the Emergency departments

2. There is a variance across the GWAS area in the way the arrival screens are used

3. The use of the arrival screens has improved the patient journey in several of the hospitals but not in others.

4. In several hospitals effective use of the arrival screens does not seem to have been promoted by the hospital trusts

5. The advantages of using the arrival screens does not seem to have been fully appreciated by the hospital staff

6. All the hospitals except Great Western Hospital have a separate area for children.

7. The number of cubicles available in the Emergency Departments in comparison with the average number of ambulances arriving each day is variable across the GWAS area and may well contributes to the difficulties in meeting the ambulance turnaround targets in some places

8. Bristol Royal Infirmary staff appear to have little interest in the screens, although it is thought this is due to lack of knowledge and training

9. LINk members reported that, at Bristol Royal Infirmary the Rapid Response vehicles and Emergency Care Practitioners attract handover breaches because their vehicles are automatically registered on the Arrival Screens but do not appear to be cleared on departure

10. In both Cheltenham General Hospital and Gloucester Royal Hospital there has been a considerable improvement in the turnaround times in spite of increased attendances at the Emergency departments. The use of the arrival screens appears to have contributed to this improvement

11. Frenchay Hospital the screens are the sole responsibility of the GWAS staff although it appears the North Bristol Trust would like a different arrangement

12. Since the visit to the Great Western Hospital, a Capacity Management System has been installed, allowing for ambulances to be rerouted to another hospital if their patient capacity has been reached

13. The screen is sited in the wrong place at Great Western Hospital. The area is cramped resulting in not enough room for staff to use it. It is understood a second screen is being considered

14. Weston Hospital staff are not using the Arrival Screens possibly because they are sited in the wrong place

5. Recommendations

The members of the JWG would recommend that:

1. A full audit of the use of the arrival screens should be carried out by the GWAS and hospital trust staff.

2. The siting of the screens is important and consideration should be given to re-siting the screens in some of the Emergency Departments.

3. The advantages of the arrival screens should be promoted to the staff in the hospitals where they are only being used by the GWAS staff

4. Additional training should be available for staff in the hospitals who are not using the screens correctly.

5. All the emergency departments should use the arrival screens to full capacity as they Improve the patient journey and the ambulance turnaround times

6. Where the ratio of number of patients to number of cubicles is high, e.g., Frenchay Hospital, consideration should be given to increasing the number of cubicles available

6. References/Bibliography

Dept of Health: A&E Clinical Quality indicators Gateway Reference 15321NHS South West: Ensuring timely handover of patient care – ambulance to hospital October 2008

Dept of Health: A&E Clinical Quality Indicators Implementation Guidance Gateway Reference 15321 Publication Date 17 Dec 2010

Dept of Health: A&E Clinical Quality Indicators Data Definitions Gateway Reference 15322 Publication Date 17 Dec 2010

Appendices

The rest of the appendices are to be added!

Appendix One

The LINks Authorised 'Enter and View' Representatives

Bristol Royal Infirmary
Margaret Adams
South Gloucestershire Local Involvement Network
Gill Maw
Bristol Local Involvement Network

Cheltenham General Hospital
Judy Gazzard and Albert Weager
Gloucestershire Local Involvement Network

Frenchay Hospital
Mike Garett and Wei Song
South Gloucestershire Local Involvement Network
Gill Maw
Bristol Local Involvement Network

Gloucester Royal Hospital
Judy Gazzard and Albert Weager
Gloucestershire Local Involvement Network

Great Western Hospital Swindon
Keith Smith, Val Vaughan and John Green
Swindon Local Involvement Network

Royal United Hospital Bath
Jill Tompkins and Veronica Parker
Accompanied by Mike Vousden, Scout Enterprises (Host)
Bath and North East Somerset Local Involvement Network

Salisbury District Hospital
Phil Matthews and Anne Keat
Wiltshire Local Involvement Network

Weston General Hospital
Nikki Edwards and Tony Hawkings
North Somerset Local Involvement Network

Appendix Two

Local Involvement Networks (LINk) Joint Working Group (JWG)
ENTER AND VIEW VISIT TO EMERGENCY DEPARTMENT 2011/12

Venue:	**Date and Time of Visit:**

Further questions to be answered	
What is the layout of the Emergency Department	Draw diagram if possible
How many cubicles are there?	
Is there a waiting area for ambulance patients in addition to the cubicles?	
Is there a separate children's area?	
Is there a resuscitation area?	
How many doctors are on duty today?	
Is this throughout a 24 hour period?	
If not, when does it change	
How many ED consultants are on duty?	
How many nurses are on duty today?	
How many are nurse practitioners with extra ED training?	

Questions about the Arrival Screens	
What is the procedure for use of the Arrival Screens?	
Is the Arrival Screens the responsibility of a particular member of staff? If so, who?	
Who meets the patient on their arrival?	

Appendix Three

Enter and View to Emergency Department
Bristol Royal Infirmary
Monday 5th March 2012

LINk Personnel – M Adams (South Glos LINk) and G Maw (Bristol LINk)

Matron in Charge – Bernie Greenland

We were greeted by Matron who took us to her office and answered all our questions with courtesy and general helpfulness.

Although she had been told about the Screens which we were there to view they had arrived in her department without prior notice nor any training. She now had Alex Finlay from GWAS on a part time basis but is of the opinion that all her staff need considerable training – and it would appear that so to do some of the GWAS Employees. Perhaps this further training would help the staff to appreciate the clinical benefit of the screen.

When we viewed the screen we found that ALL GWAS VEHICLES are listed for arrival but CARS do not enter arrival and departure times and vehicles going direct to wards do not go through A & E e.g., Heart Attacks go directly to Heart Department and some GP admissions go directly to wards. This means that these vehicles show 'Uncleared' on Arrival Screens but do NOT go through A & E. Whilst we were there the screen showed three outstanding cases that were not A & E responsibility. There was an ambulance crew attending a patient and the male crew member came and corrected the screen but there were ten breaches shown against hospital records and this was totally wrong. There needs to be an up-date of the system or the records will never agree.

The agreed handover timing is that at soon as BRI staff relieve GWAS of their patient they should then enter that time on screen but they don't always do this until their paperwork has been completed and this causes a time-lag and shows up against the hospital requirement of fifteen minutes.

Matron suggested that noting how many vehicles were on the way and the condition of the patient was helpful BUT does not have a dedicated person watching the screen. The suggestion was that they do not have enough staff for it in this very busy department.

As well as the full Emergency Department they have an MIU where they have eight static trolleys as well as an Observation Ward mainly used for patients prior to discharge to make sure they are fit to go home. This has eight spaces.

The Department is due for a complete up-date in June and we have been invited back to view just prior to it being opened.

Local Involvement Networks (LINk) Joint Working Group (JWG)

ENTER AND VIEW VISIT TO EMERGENCY DEPARTMENT 2011/12

Venue: Bristol Royal Infirmary	**Date and Time of Visit: 5th March 2012 1.00pm – 2-30pm**

Further questions to be answered	
What is the layout of the Emergency Department	Draw diagram if possible
How many cubicles are there?	11
Is there a waiting area for ambulance patients in addition to the cubicles? *There is a long L-shaped corridor capable of taking many GWAS trolleys – They do have need sometimes to use GWAS staff to*	
~~Is there a separate children's area?~~ *Send the patients to release ambulances*	
Is there a resuscitation area? *It is large and has in situ x-ray for help of patients*	Yes 6 spaces
How many doctors are on duty today? *Plus housemen*	2 Consultants 1 Registrar
Is this throughout a 24 hour period? *Consultants work 8am to 4pm and 4pm to 10pm*	No
If not, when does it change Consultant off department but on call after 10pm	After 10pm
How many ED consultants are on duty?	See above
How many nurses are on duty today?	
How many are nurse practitioners with extra ED training? *Daytime 11 Reg and 1 assistant. Night duty 10 Reg and 1 assistant*	11/10

Questions about the Arrival Screens
What is the procedure for use of the Arrival Screens? *Ambulance staff pass the screen on way in*
Is the Arrival Screens the responsibility of a particular member of staff? If so, who? *No particular person – anyone on duty*
Who meets the patient on their arrival? *Whichever member of staff they are taken to but there is a shift co-ordinator (Band 6/9) who meets the stretcher*

Gloucestershire Local Involvement Network (LINk)

Visit to Cheltenham General Hospital Emergency Departments

To look at the impact of the new Arrival Screens on Ambulance Handover times

The Visits

The visits were carried out by two Gloucestershire LINk Authorised Representatives, Albert Weager, Chair of the JWG, and Judy Gazzard, a member of the Gloucestershire LINk Stewardship Board, to the Emergency Departments at Cheltenham General Hospital on Wednesday afternoon 26th October

Questions about the Layout of the Emergency Department?

What is the Layout of the Emergency Department? There are ten cubicles, divided into a four and a six in two separate areas plus a resuscitation room and a resuscitation triage room
Is there a waiting area for ambulance patients in addition to the cubicles? Ambulances arrive at the department entrance and take patients to the trolley space which is close to the nurses station/Arrival Screen. One crew member remains with the patient, whilst the other one goes to the nurses station to book the patient in
Is there a separate children's area? Yes
Is there a resuscitation area? There is a resuscitation room as well as a resuscitation triage room immediately on the right just inside the front door
How many doctors are on duty today? The variation for doctors was from two during the midnight-3.00am time, and then gradually increasing throughout the day so that by 4.00pm there are seven doctors on duty
How many consultants are on duty? There was one consultant on call throughout the 24 hour period

How many nurses are on duty today and how many are nurse practitioners with extra ED training? There were twelve nurses and one nurse practitioner on duty at the time of the visit

Questions about Arrival Screens

What is the procedure for use of the Arrival Screens? Information appears on the screen when the ambulance collects a patient, advising the estimated time of arrival. This only applies if the patient is from the GWAS area. Patients arriving from areas outside of the GWAS area do not show on the screen. The screen informs the Emergency Department of the condition of the patient which enables the emergency Department of the condition of the patient which enables the necessary preparation to be made eg resuscitation.
Who takes responsibility? There is a dedicated nurse coordinator assigned to look at the Arrival Screen at CGH. She remained at her post even when all staff were responding to a crisis. A member of the ambulance crew went straight to the Nurses Station to be booked in.
Who meets the patient on their arrival? The duty staff nurse meets the patient after he or she has been booked in
Additional Information The handover process was very smooth and slick

Conclusion

It is clear that the use of Arrival Screens has contributed to a considerable improvement in the patient pathway and the ambulance turnaround time. This was because patients are usually handed over promptly to the clinical staff rather than remaining in the care of the ambulance staff. The Arrival Screen also gave the clinical staff prior information on the nature of the 'emergency'. This was particularly evident in Cheltenham where a 'crash' team had been assembled before the ambulance arrived.

Bristol and South Glos Local Involvement Network

Visited North Bristol NHS Trust to view the Emergency Department (ED) Frenchay Hospital, Bristol on Monday 13th February 2012 at 1.00pm

Visitors: Gill Maw Bristol LINk, Wei Song SouthGlos LINk, Mike Garett SouthGlos LINk

Introduction

We met with Juliette Hughes, Matron and Lizanne Hartland, South Glos PCT and had a discussion on how the Emergency Department [ED] works at Frenchay Hospital

Interview Questions

What is the Layout of ED?

When a patient is brought in to the ED they are seen immediately by the Charge Nurse who makes the decision as to which area they are to be taken, Resuc, Major or See and Treat [the walking wounded]

The Charge Nurse's office has oversight of most of the ED. Apart from the Resuc., Major, See and Treat areas there is an 11 bed Observation area where patients can be kept in for a specified time, overnight if necessary, before being discharged. Close by is the X Ray department and a fracture / plastering unit.

Patients that are brought in by non GWAS ambulances, such as St John's or from outside the GWAS area are not notified in advance to the ED. They have to be ready for such emergencies.

Is there a waiting area for ambulance patients in addition to the cubicles?

The ED has 15 cubicles – 7 for Resuc. And 8 for Majors. If patients arrive and these are full, arrangements are made for these patients to be found a space. When patients are queued up they are held within eyesight and easy reach of those responsible. To be left in a corridor is a very last resort

Is there a separate children's area?

In the main reception area there is a designated childrens zone. There is a resuc. Area which can be used for children, this area doubles up for adults should the need arise. Many children are brought in to the ED by parents who do not want to have to wait for an ambulance to arrive.

Is there a resuscitation area?

There are 4 major high dependency beds allocated

How many doctors are on duty today?

It will depend on demand, normally there are 2 consultants [A&E specialists], 1 registrar and 4 junior doctors.

How many consultants are on duty?

Again this depends on demand, generally during the 24 hour period there are 2 during the day and 1 at night

How many nurses are on duty today and how many are nurse practitioners with extra ED training?

There are 8 nurses on duty [Mon 13th Feb]. For the future Frenchay ED is aiming to get an IAN [Initial Assessment Nurse]. An acting-up IAN was on duty on the day of the visit.
We understood that there were no nurse practitioners at Frenchay. There are two at Southmead in Minors – this grade was not funded at Frenchay. Frenchay had 2 Band 7s trained to EMP and all Band 6s and other Band 7s had Advanced Skills – other Bands have extra training.

Questions about Arrival Screens

What is the procedure for use of the Arrival Screens?

The Arrival Screens indicate the expected arrival of a patient by ambulance. It will show the priority of the patient as advised by the ambulance crew. It will also show the Ambulance Call Sign, Job No, Notes about the patient, Estimated Time of Arrival at the ED and Handover Time.
On arrival in the ED one of the ambulance crew will "tick" the ED IPT box.

Who takes responsibility?

It is GWAS personnel who take the responsibility for "ticking" the boxes on the Arrival Screen. NBT Frenchay ED would like it to be a joint responsibility. The Arrival Screens are supplied by GWAS and solely their responsibility at this moment in time.

Who meets the patient on their arrival?

At present it is the Charge Nurse, in future it will be the IAN [Initial Assessment Nurse] as well.

Additional information

We were informed that Frenchay ED receives on average 70 ambulances per day.
Handover times, nationally, are expected to be within 15 minutes from arrival, at Frenchay it is said to be more like 20 – 25 minutes. Validation of handover times at present cannot be taken as accurate. There is a gap between recorded handover of patients at ED and actuality, it is felt, because ambulance crews once at Frenchay can grab a hot drink and clean the ambulance out before getting back in to full operational duties again.

On the day of the visit, we noted that four ambulances were on their way. The first one arrived during our visit and it was observed that the time of arrival had clicked up on the screen, but it was approximately 4 minutes before the patient was brought in. It was also noted that the crew did not ring the door alarm bell before entering, according to procedure, in order to warn the Charge Nurse that a patient was being brought through. This could have led to a further delay if the Charge Nurse was occupied elsewhere. The care of this patient was handed over immediately to the acting-up IAN who began assessment but the ambulance crew did not tick the appropriate box on the screen to signify handover was complete. Therefore during our observation, it appeared therefore that the handover was still in progress. We felt this was misleading and an unfair representation of the situation.

It was noted that there was a 10% reduction in handover times at the RUH in Bath with the introduction of Pathways.
An Intensive Support Team when inspecting Frenchay ED, for the length of stay of patients, said that apart from some recommendations the ED is “fabulous”

Conclusion

We were impressed by the efficiency of the staff and by the cleanliness of the Emergency Department. With the possibility of the introduction of Pathways the ED could become as efficient at handover times as the RUH Bath

Completed by : Mike Garett [SouthGlos LINk] & Gill Maw [Bristol LINk]
Date: 29/02/2012

Gloucestershire Local Involvement Network (LINk)
Visit to Gloucester Royal Hospital Emergency Departments
To look at the impact of the new Arrival Screens on Ambulance Handover times

The Visits

The visit was carried out by two Gloucestershire LINk Authorised Representatives, Albert Weager, Chair of the JWG, and Judy Gazzard, a member of the Gloucestershire LINk Stewardship Board, to the Emergency Departments at Gloucester Royal Hospital on Monday morning 28th October.

Questions about the Layout of the Emergency Department?

What is the Layout of the Emergency Department? There are eight cubicles, three resuscitation cubicles and one major incident room. They are all in one place with a staff base in the middle of the area
Is there a waiting area for ambulance patients in addition to the cubicles? Ambulances arrive at the entrance to the emergency department and take the patient into the trolley bay. One member of the crew stays with the patient whilst the other member of the crew reports to reception
Is there a separate children's area? Yes
Is there a resuscitation area? The resuscitation area is immediately on the left just inside the front door and contains three cubicles
How many doctors are on duty today? The number of doctors on duty varied throughout the 24 hour period. There were two doctors on duty at the time of the visit but it was clear that there were more that could be call upon quickly if needed
How many consultants are on duty? There were two consultants on duty at the time of the visit and one on duty throughout the 24 hour period
How many nurses are on duty today and how many are nurse practitioners with extra ED training? There were seven nurses and one nurse practitioner on duty at the time of the visit

Questions about Arrival Screens

What is the procedure for use of the Arrival Screens? Information appears on the screen when the ambulance collects a patient, advising the estimated time of arrival. This only applies if the patient is from the GWAS area. Patients arriving from areas outside of the GWAS area do not show on the screen. The screen informs the Emergency Department of the condition of the patient which enables the emergency Department of the condition of the patient which enables the necessary preparation to be made eg resuscitation.
Who takes responsibility? The nurse in charge was responsible for the Arrival Screen however at the time of the visit, did not remain at post the whole time but left the screens unattended to do other things in the department
Who meets the patient on their arrival? The patient is met by whichever nurse is available
Additional Information Because a member of the ambulance crew has to report to reception, there is the potential to build in a delay in handing over the patient

Conclusion

It is clear that the use of Arrival Screens has contributed to a considerable improvement in the patient pathway and the ambulance turnaround time. This was because patients are usually handed over promptly to the clinical staff rather than remaining in the care of the ambulance staff. The Arrival Screen also gave the clinical staff prior information on the nature of the 'emergency'.

Swindon LINk

Swindon Local Involvement Network

Invited visit to the Emergency Department (ED) Great Western Hospital (GWH), Swindon on Wednesday 23rd November 2011 at 9.30am

Visitors: Keith Smith, Val Vaughan, John Green

Introduction

The visitors were welcomed by Liz Daly of Head of Patient Experience, Great Western Hospitals NHS Foundation Trust and introduced to Leighton Day, Deputy General Manager of ED. The visitors explained the main purpose of the visit was to view the Ambulance Arrival Screens. Also they had some questions about the organisation of the ED.

Leighton introduced the visit by informing us that between 170 and 200 people attended ED every day. This included between 40 – 50 ambulance arrivals, 90% of which were Great Western Ambulance Service (GWAS) ambulances. The busiest days of the week were Monday, Friday and Saturday.

Interview Questions

What is the Layout of ED?

The ED is divided into 2 main areas, Minor Area and Major Area.

The Minor department deals with mainly walk-in patients, such as patients with broken arms, bad cuts, dislocations. The patient is assessed, treated and discharged.

The Major Area is for patients who usually need to lie down, need treatment and are likely to remain in hospital. Ambulances mostly transport patients with major needs.

The ED is set out in such a way that all cubicles can be viewed from a central nurses' station. There are 16 cubicles in Major area.

Is there a waiting area for ambulance patients in addition to the cubicles?

There is a separate ambulance holding area. ED is reluctant to use it, but every day at some point the department reaches capacity. The ambulance waiting area is staffed by ambulance personnel. There is room for 4-5 additional patients in this area. GWH recognises the need for rapid turn-around of ambulances. There is an agreement that should there be more than one ambulance team in the holding area then one crew will supervise all the patients, thus allowing ambulances to get back on the road quickly.

The ED reports there are very few long delays, those described as more than 30 minutes. ED reports that it knows its ambulance crews well which has led to good relationships between the services. If ED becomes full up with patients waiting there is an escalation programme, which involves other sections of the hospital working with ED to admit patients onto the ward. ED will not move patients until they are stabilised. Always, their first priority is to the patient.

Is there a separate children's area?

No. ED plans to create one next year. In the meantime the needs of children are prioritised. Those children that need to be admitted are stabilised and moved as quickly as possible to the Paedriatric ward. ED staff have extended CP training.

Is there a resuscitation area?

Yes. There are 4 resuscitation areas in the Major section. One resuscitation room is always ready.

How many doctors are on duty today?

There are 4 junior doctors and 3 middle doctors. The number on duty varies according to need. Their shift times are staggered. ED knows when peak times are likely to be.

The Minors department is staffed by emergency nurse practitioners with a doctor on back-up from 8am to 8pm.

How many consultants are on duty?

There are two consultants on duty in the day time and one consultant at the week-end between 8am and 7pm. The consultants are supplemented with speciality doctors, including 2 specialists in chest pain and a senior cardiology specialist as well as a paediatrician.

How many nurses are on duty today and how many are nurse practitioners with extra ED training?

The number of nurses on duty varies according to need. There are never fewer than 6 specially trained nurse practitioners on duty.

Questions about Arrival Screens

What is the procedure for use of the Arrival Screens?

Who takes responsibility?

The ambulance crew sends details of the patient to control. Control inform ED of the new job, detailing which crew is on its way, how long it will take to arrive, from what the patient is suffering. For example on the screen that we saw was: **'89 year old male with shortness of breath, arrival time 6 minutes.'** The nurse-in-charge takes responsibility to ensure a cubicle or resuscitation room is ready for the patient. The aim of the ED is always to keep one area free.

Who meets the patient on their arrival?

The nurse-in-charge does the initial assessment.

Additional information

The Arrival Screen has been received positively by the staff as it helps with the more efficient organisation of ED. They are shortly to install a second screen that will provide easier access for the ambulance crew, who also have to signal their arrival on the touch screen.

In the next two weeks ED will have a new electronic *'capacity management system'* installed, for 999 re-routing. This will record pressures on ED every two hours. This is mainly to support ambulances in outlying areas, where an alternative hospital may be more convenient. GWH and the ED recognise that the priority should be to admit a patient to their local hospital wherever possible. A patient in a hospital out of area creates a number of administrative and social difficulties.

Most patients, even if they require a specialist centre, will usually be brought to GWH first to be stabilised.

Occasionally patients who self - present with a major problem will take priority over an ambulance. The ED has to be prepared for any eventuality.

Conclusion

The visitors were given a detailed and very open opportunity to see the ED in action. All questions were answered fully and frankly. The Deputy Manager agreed that they were not yet reaching the national targets of 15 minutes consistently. Their average is around 18 minutes. However, they are not complacent and are working hard to achieve better times. To have an ambulance sitting waiting outside ED when someone is in urgent and desperate need is not acceptable. The needs of the patient are paramount.

Completed by Swindon LINk participant Keith Smith
on behalf of Val Vaughan and John Green for Swindon Local Involvement Network

Bath and North East Somerset

Local Involvement Network

LINk Visit to A&E Department at the Royal United Hospital, Bath

16 January 2012

Members of the Bath & North East Somerset Local Involvement Network carried out an informal visit to the A&E Department of the Royal United Hospital Bath on 16 January 2012 at 1.30pm.

The LINk Members taking part in the visit were Jill Tompkins and Veronica Parker, and they were accompanied by Mike Vousden, the Manager of the "Host" organisation that provides support to the LINk. Although the LINk has a statutory power to Enter and View premises in which NHS care is provided, it had decided not to invoke this power on this occasion, but rather to make this an informal visit by agreement with the Trust.

Three members of staff of the Department met LINk Members for the visit:

Fiona Bird (Specialty Manager);
John Sexton (Clinical Practice Facilitator);
Heidi Cox (Administration & IT Manager).

As agreed with the Joint LINks Group covering the Great Western Ambulance area, the visiting team concentrated mainly on the pro-forma questionnaire agreed for use by all the LINk teams visiting A&E Departments. The information thus gathered is shown in the following table.

The team also sought information on a number of related issues –

1. In the past, there have been discrepancies between hospitals' recording of ambulance turn-around time and the times recorded on the ambulance service's IT systems. It was explained to the LINk visitors that both sets of records were still generated, but that the turn-around times recorded were moderated jointly by the hospital and ambulance Trust at regular meetings to ensure a single and agreed set of records for official performance monitoring purposes.
2. Information was sought on the provision made in the A&E Department for patients with mental illness who needed care. It was explained that close liaison and monthly meetings occurred between the hospital and the Avon & Wiltshire Mental Health Partnership Trust. During normal working hours, two mental health nurses were available on the Department, and outside those hours the Mental Health Crisis Team were available to help.

Questionnaire	
What is the layout of the Emergency Department?	See attached plan
How many cubicles are there?	"Majors" – 18 "High Care" – 6 "Resusc." – 4 "Minors" - 13
Is there a waiting area for ambulance patients in addition to the cubicles?	No, only corridor nearly all patients are taken directly from A&E entrance to cubicles.
Is there a separate children's area?	Yes
Is there a resuscitation area?	Yes – 4 bays
How many doctors are on duty today?	Total across day: 3 x Consultants 2 x Registrars + SHO's
Is this throughout a 24 hour period?	No, varies with time of day
If not, when does it change	8.00am, 2.00pm, 6.00pm, 12.00pm, with overlapping shift pattern.
How many ED consultants are on duty?	*see above*

How many nurses are on duty today?	23 (across 3 shifts)
How many are nurse practitioners with extra ED training?	4 (across 3 shifts)

Questions about the Arrival Screens	
What is the procedure for use of the Arrival Screens?	Ambulance crews log-on to screen on arrival with patient in Dept.(1 Screen for each ambulance service). Met by Co-0rdinator and crew take patient to cubicle, and when patient handed-over to nurse, crews log this on screen.
Is the Arrival Screens the responsibility of a particular member of staff? If so, who?	RUH Co-ordinator and Ambulance Crew
Who meets the patient on their arrival?	Co-ordinator

WILTSHIRE INVOLVEMENT NETWORK

ENTER AND VIEW VISIT TO EMERGENCY DEPARTMENT

Venue: Salisbury Hospital	**Date and Time of Visit: 6th February 2012 10.30**

Questions to be answered	
What is the layout of the Emergency Department Recently refurbished, the department consists of a central Majors area, with Minors, a resuscitation area, a good waiting area and a short stay emergency unit, allowing for patients to spend longer recovering and then to be discharged.	Draw diagram if possible
How many cubicles are there? There are 10 cubicles in Majors, 6 in Minors, 3 in Resus and 8 in SSEU	A total of 27
Is there a waiting area for ambulance patients in addition to the cubicles?	No
Is there a separate children's area?	Yes
Is there a resuscitation area? There are 3 resus cubicles.	Yes
How many doctors are on duty today? There were 2 doctors on duty and consultant cover from 8.30 to midnight.	3
Is this throughout a 24 hour period? There can be 4 doctors during busy periods.	2-4

If not, when does it change	This depends on the needs of the department
How many ED consultants are on duty? Normally 1 consultant with 1 for SSEU	1+1
How many nurses are on duty today? 5 trained staff and 1 health care assistant.	6
How many are nurse practitioners with extra ED training? In minors	1

Questions about the Arrival Screens	
What is the procedure for use of the Arrival Screens? Ambulance control put details on line which show on the screen in the department so that A&E knows there is a patient on the way, giving details of the patient's condition. As soon as the patient arrives, a crew member immediately acknowledges this on the screen so there is a record of arrival time, and when the crew leave they chart the departure time.	
Is the Arrival Screens the responsibility of a particular member of staff? If so, who? Great Western Ambulance Service is responsible for the screens input.	
Who meets the patient on their arrival? The patient is usually met by a band 6 nurse or sister.	

Additional comments:

A&E in Salisbury is a pleasant well laid out department with several aspects which, on our 'enter and view' visit, we felt deserved mentioning:

- Access for ambulances bringing patients in is good, which must surely make things easier for crews to off load stretchers with injured patients.

- The bereavement room is an excellent idea and a very important asset for a busy A&E department
- We like the 'private room' concept as too often in busy units this tends to get forgotten, and grieving could feel in the way.
- The 'white board' situated, horizontally, in the centre console of Majors is excellent, as it means only staff have sight of it, whereas too often everyone sees all the names and details, of patients being treated.
- There is very little in Salisbury A&E that one could fault, but it was noted that several patients, in their cubicles, had no curtains drawn, so could be seen by everyone passing by. At one point a lady in an open backed gown wandered up the central area looking a little lost. This is more an observation than a criticism because it is appreciated that things move quickly in a busy department. All in all an enjoyable visit.

North Somerset LINk

Enter & View Visit to Weston General
on 13th January 2012
Report – Tony Hawkings

Nikki Edwards and I met Nick wood, Chief Operating Officer who showed us around the new Emergency Department. Patients who arrived by ambulance had a separate entrance and were taken direct to the triage area. From there they would be placed in a cubicle for major cases or moved to the minor case area or even to the adjacent GP Unit. The Department was not very busy when we were there but there was an air of efficiency and staff were also happy in their jobs.

The main purpose of the visit was to see if the new handover screens were working. The screen was situated near the entrance corridor for ambulance patients and was some yards from the control area. A GWAS paramedic showed us how the screen worked and it was obvious that the timing of activity was clearly recorded. However, the sister in charge admitted that they rarely had time to look at the screen as it was too far from their work station and lacked detail. It was clear that it would not be possible to have another screen in the control area when ambulance staff would need to come and operate it. The paramedics said that if it was vital for a patient to receive immediate treatment they would phone in and provide full details. Both the paramedics and sister were satisfied with the way the system was working.

Weston also had a similar screen set up by South West Ambulance. This was better in that it provided more detail about the patient but was still not used regularly by Hospital staff.

The Emergency Department had 18 cubicles, and some other waiting area increasing this to 25. An Emergency Department Consultant was available from 9am-10pm and on call at other times. Several doctors were available and there are 8 nurses at all times. The corridor's where ambulance patients would wait was separate from the walk-in patients.

There was a problem for ambulances as they would have to wait at busy times. The main reason was several shortages of beds so patients could not be moved onto a ward. Also, Weston seemed to have far more older patients who needed to be kept under observation for a few hours or who could not be released so quickly. Nick Wood has recently arrived from Truro hospital which has over 600 beds but their A&E through put is only half of Weston where there are 230 beds. If there is a major emergency there were special plans prepared to ensure that the injured could be quickly dealt with. In the recent M5 crash, Weston was prepared to receive extra cases but they were all dealt with at Taunton.