Livewell Southwest

Initial Assessment in Minor Injury Units Operational Policy

Version No.1
Review: January 2018

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Clinical Lead**

Asset Number: **944**

Reader Information

Title	Initial Assessment in Minor Injury Units – Operational Policy. V.1
Asset number	944
Rights of access	Public
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Category	Clinical
Document purpose/summary	Patients will be assessed by a suitably qualified member of staff to ensure that they are assessed and treated in a clinically timely manner.
Author	Warren Harper, Clinical Lead
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Job title	Warren Harper, Clinical Lead
Target audience	Staff, Livewell Minor Injury Units
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Consultation process	Consultation with service providers
Equality analysis checklist completed	No
References/sources of information	Mackway-Jones, K (1513) “Emergency Triage: Manchester Triage Group, Third Edition”; Wiley Blackwell, London
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Author contact details	By post: Local Care Centre Mount Gould Hospital, 150 Mount Gould Road, Plymouth, Devon, PL4 7PY. Tel: 0845 155 8085, Fax:01752 272522 (LCC Reception).

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1		28/6/16	Clinical Lead	First draft
0.2	Multiple	29/10/16	Clinical Lead	Second draft following staff consultation
1	Minor amends	January 2017	Community Urgent Care Services Manager	Ratified following PRG meeting 4/1/17

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Initial Assessment Minor Injury Units Operational Policy

1. Introduction

1.1 Livewell Southwest manages three minor injury units, Tavistock, Kingsbridge and in Plymouth at the Cumberland centre. The minor injury units are responsible for in excess of 55000 new episodes per year. Patients attend on an unplanned basis and as such demand varies, leading to delays in assessment and diagnosis by a practitioner. There are occasions when these delays increase beyond that which is suitable for the patient's clinical needs.

1.2 These delays are managed by a process of Initial Contact. This is a clinical prioritisation assessment of patients to maintain safety, to ascertain their immediate clinical needs and thus their safe waiting time.

1.3 This document outlines the operational policy for Initial Contact. It includes the assessment method, standards and competencies required for this process.

2. Purpose

2.1 To standardise the method of clinical prioritisation within the minor injury units.

2.2 To ensure that all staff providing Initial Contact are suitable and assessed as competent to do so.

2.3 To provide a framework for monitoring and audit.

3 Definitions

AP: Assistant Practitioner

Diagnosing Practitioner: Practitioner with competencies to diagnose, treat and discharge (for example, nurse, assistant or emergency care practitioners

ECG: Electrocardiogram

HCA: Health Care Assistant

Manchester Triage: Triage system developed by the Manchester Triage Group as a method of triage in A&E departments.

Widely adopted across the UK

MIU: Minor Injury Units: Livewell Minor Injury Units in Tavistock, Kingsbridge and Plymouth

NP: Nurse Practitioner

PGD: Patient Group Direction

4. Duties & responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

Responsibility of Minor Injury Services Manager to:

- To ensure that the operational policies are adhered to
- Maintain a copy of competencies in the staff member's permanent file to be able to be produced on request
- To ensure that any deficiencies found in the audit process are acted upon

Responsibility of Minor Injury Clinical Lead is to:

- To assess competence of staff
- To promote clinical excellence in the assessment process
- To audit the process and report against standards on a quarterly basis

Responsibility of all **staff** to maintain knowledge and practice to perform initial assessment in a safe and competent fashion.

Responsibility of the **practitioner in charge of the shift** to react appropriately to increase in waiting times and ensure that assessment is provided in a clinically timely manner.

5. Core Standards

Standard 1: The patient will receive an assessment in Initial Contact within 15 minutes of arrival by a competent member of staff.

Standard 2: The patient will receive full clinician assessment within the time allotted by their assessment category.

1	Immediate resuscitation	Immediate response
2	Very Urgent	Within 10 minutes of Initial Contact
3	Urgent	Within 1 hour of Initial Contact
4	Standard	Within 4 hours of Initial Contact
5	Follow Up	As soon as reasonably practicable

Standard 3: All patients will have a pain score completed. They will receive analgesia if required within the time allotted by their triage category.

6. Initial Contact Tool

6.1 The Initial Contact tool is based within the principles of the Manchester Triage System.

6.2 The Manchester Triage System was developed by a team of emergency care experts to provide a consistent approach to triage in Emergency departments. Over the last 15 years it has become the most widely used triage tools in the UK, Europe and Australia.

6.3 Manchester triage is based upon recognition of the presenting complaint and reductive discriminator identification. In simple terms the person performing triage choses one of over fifty flow charts depending upon presenting complaint. They are then guided to the appropriate category via a series of ‘discriminators’; these discriminators could be based upon history, vital signs or presenting condition.

6.4 The Manchester Triage System is designed for use within emergency departments and their wide variety of presenting complaints. The minor injury units have a more limited focus to the delivery of their care and the system is overly complicated for the units.

6.5 A single-sheet flow chart, outlining presentations with red flags has been

produced by LSW MIU staff. Manchester triage discriminators were carefully considered as to whether they added value to the MIU process and whether by dropping them safety would be impeded. Due to the nurse-led nature of the unit and the lack of diagnostic facilities, some of the discriminators have been given a higher priority than the original triage system.

6.6 The tool can be found in appendix 1.

7. Patient Flow to Initial Contact

7.1 Patients attending the MIUs will first be registered by a receptionist (or delegate).

7.2 The reception staff will highlight patients that appear unwell or that they are concerned about to a member of clinical staff.

7.3 Within 15 minutes of arrival Initial Contact will take place. A very brief history will be taken using agreed documentation.

7.4 The triage category will then be allocated and brief documentation be made. Patients presenting as a category 1 will naturally have documentation made retrospectively.

7.5 If first aid (dressing or sling) is required then this will be administered at this point. Equally should analgesia be required then this will be requested from the NP and given to the patient

7.6 If initial treatment (e.g. administering analgesia or controlling the bleed) allays the symptoms then the triage category may be downgraded as appropriate.

7.7 The priority/triage category is recorded on SystmOne (as per Appendix 1).

7.8 Additional information may be sought during Initial Contact, for example basic observations or completion of child safeguarding.

7.9 On occasions, for example, when there are no patients waiting, practitioners are available prior to the patient being assessed in Initial Contact. On these occasions there is no need to perform Initial Contact or prioritise the patient.

8. Escalation

8.1 Patients presenting with a category 1 will be highlighted to the closest practitioner as an emergency. This may require pressing the emergency bell. The practitioner will immediately stop their current activity, without question, and assess the patient.

8.2 Patients presenting as a category 2 will be highlighted to an available practitioner. Should no practitioner be available then the practitioner in charge will be responsible for assessing the patient within 10 minutes, even if this requires them stopping their current activity.

8.3 Patients presenting with a category 3 are recorded on SystmOne. All practitioners have the responsibility to ensure that category 3 patients are seen in a timely manner.

9. Pain Score

All patients presenting with pain will have their pain score assessed using the pain score in each treatment room.

All patients in pain will be offered analgesia. If this declined this should be documented.

The prescribing or administering clinician (under a PGD) will document administration in the treatment section of the SystmOne MIU proforma.

10. Minimum Data Standards

Initial contact will be concise and provide a quick assessment of the patient's clinical needs.

As such full clinical history is not required, only a brief exploration of the patient's symptoms will be made. A full history is taken later when the patient is assessed by a practitioner.

Only relevant observations will be taken at this time. This may include an ECG.

The data standards can be found in Appendix 2

11. Safeguarding

The unit's Child Safeguarding will be completed at Initial contact. It is relevant at this stage as this ensures the maximum compliance and also provides a fall-back should the child not wait to be seen

Should there be safeguarding concerns (adult and child) a more detailed record of the conversation will be made.

12. Training implications

All clinical staff will be able to perform triage.

A training pack is available.

Competency will be assessed by the Clinical Lead or delegate. Assessment will take the form of direct observation, clinical scenarios and a quiz. The competency document will be completed and updated as per competency standard.

13. Monitoring compliance

Initial contact standards will be audited against the defined standards on a quarterly basis.

Standard 1: The patient will receive an assessment in Initial Contact within 15 minutes of arrival by a competent member of staff (SystmOne data analysis, all patients, 90%.

Standard 2: The patient will receive full clinician assessment within the time allotted by their assessment category (SystmOne data analysis, all patients, 90%.

1	Immediate resuscitation	Immediate response
2	Very Urgent	Within 10 minutes of Initial Contact
3	Urgent	Within 1 hour of Initial Contact
4	Standard	Within 4 hours of Initial Contact
5	Follow Up	As soon as reasonably practicable

Standard 3: All patients will have a pain score. They will receive analgesia if required within the time allotted by their triage category (notes audit, sample).

It is the responsibility of the clinical manager and clinical lead to monitor and act on any deficiencies highlighted.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 8th February 2017

Appendix 1: Initial Contact Flow Chart

Initial Contact - Livewell Minor Injury Units

CATEGORY 1 IMMEDIATE	CATEGORY 2 VERY URGENT	CATEGORY 3 URGENT	CATEGORY 4 STANDARD	CATEGORY 5 FOLLOW UP
Airway Compromise Stridor Drooling Inadequate Breathing Signs of Shock Anaphylaxis Floppy Cild Hypoglycemia Altered Conscious Level Fitting FAST Positive Exsanguinating Bleed Chemical Exposure Chemical Eye Injury Active Labour	Severe Pain Very Hot Acutely short of breath Abnormal Pulse Chest Pain Severe Allergic reaction Large burn or inhalation Uncontrollable major bleed Abrupt onset headache Possible sepsis Non Blanching rash Overdose Acute loss of vision Penetrating injury Vascular Compromise Marked Distress High Risk Head Injury Significant Mechanism of Injury Pregnancy Testicular pain	Moderate Pain Uncontrollable minor bleed Feverish child Electrical injury Rapid onset illness Obvious deformity Back pain with loss of sensation Hot joint	All other recent presentations for example: Minor wounds Minor fractures Minor illness FB to skin, ear, nose Minor eye ailments Minor burns ENT Bites Dental pain Sprains/ strains Minor infections	Clinics Dressings Routine Follow Up Booked appointments

CALL FOR HELP

Appendix 2: Minimum Data Standards

Background

Initial contact is performed routinely within the Minor Injuries Unit to ascertain the acuity of a patient's presentation and thus escalate their practitioner assessment as necessary. All patients should be triaged within 15 minutes of their registration.

The process should be quick and dynamic and ideally take no longer than a few minutes. As such in depth questioning, investigations, documentation or observations should be avoided where possible. Treatment should be limited to first aid and analgesia where required. Further information can be added on full practitioner assessment.

This document outlines the minimum required data for Initial contact.

Data Standards

All information will be recorded in the appropriate section on the PCH SystmOne Consultation template.

"Presenting Complaint" and "History of Presenting Complaint" are the only sections that need to be completed for all cases.

Presenting Complaint:

The main complaint that the patient requires consultation for. As a minimum the location of injury/pain should be recorded, e.g.:

- Left leg injury
- Right Elbow Pain
- Chest Pain

History of Presenting Complaint

This should be completed in less than one sentence. It should include a mechanism and time of onset, e.g.:

- 2/7 Injury left leg
- 1/52 Pain right elbow
- 1/24 chest pain at rest

More detailed history can be taken at the practitioner consultation.

Medications

Allergies should be recorded.

Relevant anticoagulant medication should be recorded – i.e. warfarin or equivalent.

Other medications are not required at triage and may be completed later where relevant.

Observations

Observations can be important for deciding a triage category. They are performed in triage to ensure appropriate escalation of patient care not to diagnose the patient.

The following minimum triage observations are advised:

Presenting Complaint	Guideline Observations
Head Injury	**GCS, TPR + BP**
Head Ache, weakness	**FAST, GCS, TPR, BP**
Illness	**GCS, TPR, BP, SPO_2**
Chest Pain	**TPR, BP, SPO_2**
Shortness of Breath	**TPR + SPO_2**
Abdominal Pain/vomiting	**TPR, BP**
Urinary Symptoms	**TPR, BP**
Rashes	**TPR**
Limb Injuries	**Distal perfusion (i.e. colour and warmth)**
Wounds - acute	**Distal perfusion**
Wounds - ?infection	**TPR + BP**

Further observations may be completed during the patient's formal assessment.

Pain Score

All patients require a pain score documented (even if it is zero).

Analgesia should be offered if appropriate.

Safeguarding

Child safeguarding should be completed on all appropriate patients.

Where there is a suspicion of a safeguarding presentation (adult or child) a more complete record of the history should be completed.

Appendix 3:Staff distribution signature sheet for approved & ratified LSW policies and procedural documents

Training requirements must be communicated to staff on dissemination.

Name of Policy:

Policy No:

Statement: I have read the above approved and ratified document and understand its contents. If there are any difficulties regarding implementation or any training needs, I have raised and resolved these with my line manager.

I agree to implement the content of the above approved and ratified document.

Staff Name (please print)	Signature	Date
Diane Oliver		
Warren Harper		
Paul Casey		
Susan Dean		
Andy Dykes		
Sarah Clements		
Alison Tremlett		
Nicola Scholes		
Melanie Hockaday		
Bryan Wright		
Kirstin Buckley		
James Crump		
Penny Toms		

Janet Warner		
Jo Dentley		
Tonya Miles		
Ali Keeler		
Kayleigh Veale		
David Day		
Laura Joseph-Johnson		
Jenny Lane		
Ron Tillson		
Sheila Williams		
Gavin Wollacott		
Lee Parcell		
Michael Mackenzie		
Dawn Hodgkiss		
Tracey Atkin		
Clare Austin		
Jane Hilton		
Tina Wadling		
Sandra Northey		

On completion of this record, this sheet will be kept by the line manager and become part of the training record.

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Appendix 4: Initial Contact Assessment Competency

Title:	Initial Contact Assessment – Minor Injury Units
Version Number:	1.0
Asset Number:	66
Purpose:	*To demonstrate that patients attending the minor injury units are assessed by a competent person to ensure that patients are treated in a timely manner according to their clinical condition*
References:	Mackway-Jones, K, Marsden, J & Winlde, J (Eds) (2013) "Emergency Triage: Manchester Triage Group, Third Edition"; Wiley, London DoH (2011) "The Operating Framework for the NHS 2011/12"; HMSO, London
Author's title **Contact details:**	Name: Warren Harper Role: Clinical Lead Email: warren.harper1@nhs.net Tel: 34930
Applies to:	All clinical staff working on Livewell Minor Injury Units
Ratification date and group:	7th December 2016. Competency Ratification Group
Publication date:	3rd January 2017
Responsibility for implementing:	Diane Oliver/ Warren Harper / Melanie Hockaday
Consultation process:	Implementation to be reviewed at 3, 6 and 12 months
Review date & Frequency of Review:	It is recommended the frequency for review be every three years unless required before
Disposal date:	Date: 7th December 2019

Document Review History				
Version No	**Type of change**	**Date**	**Originator of change**	**Description of change**

All core competencies need to be completed. Evidence should be met by sign off of each individual competency below: **If unregistered staff then formal assessment is required annually.**		**Year 1 Formal Assessment**	**Year 1 Self-Assessment**	**Year 2 Self-Assessment**	**Year 3 Self-Assessment**
1	Demonstrates recording in a person's record accurately, contemporaneously and according to organisational policy (WR)				
2	Can explain the rationale behind Initial Contact and the associated standards (Q&A)				
3	Demonstrate a knowledge and understanding of initial assessment process and applies safely to a range of patients (O, Q&A)				
4	Demonstrate a knowledge of the Initial Contact process and applies to a range of patients (O, Q&A)				
5	Employs age appropriate communication strategies for children reflecting the 'Ten Wishes' campaign (O, Q&A)				
6	Utilises appropriate communication strategies for the individual patient, for example makes adjustments for language or disability (O, Q&A)				
7	Escalates patient's care appropriately to a practitioner depending upon outcome of initial contact assessment (O, Q&A)				
8	Demonstrate a knowledge of A-E assessment in the identification of a unwell person and escalates findings appropriately (Q&A, R)				
9	Identifies normal ranges for observations and escalates findings appropriately (Q&A)				

10	Provides basic first aid control of bleeding, adjunctive measures to alleviate pain (application of sling/support) (O)				
11	Demonstrates an ability to assess pain, identifies when pain control is required and ensures it is administered in a timely fashion (O, Q&A)				
12	Demonstrates a knowledge of risk behaviour in terms of potential for violence and aggression and the actions that should be taken to mitigate this (Q&A, R)				

Evidence used to support claim: Examples of evidence include:		
Observed	**O**	
Questions & Answers	**Q & A**	
Reflection	**R**	
Written records	**WR**	
Witness Statement	**WS**	
Certificate of training/updating	**C**	
Online training	**OT**	
Self-Assessment	**SA**	
Other	**Oth**	
Agreed action plan (if relevant)		

Competency Statement *(Assessor)*
YEAR 1 (Formal assessment)

I confirm this member of staff has achieved the required competency level.

Name: ……..

Designation: ……

Signature: ……..

Date: ……

Competency Statement *(Staff member)*
Year 1 – Self-assessment

Having received appropriate training I am competent in this procedure at this time. I have discussed this role as part of my job description with my manager.

Name: ……..

Designation: ……

Signature: ……

Date: ……

Year 2 – Self-assessment
Competency Statement (staff member)

Having received appropriate training I am competent in this procedure at this time. I have discussed this role as part of my job description with my manager.

Name: ……..

Designation: ……

Signature: ……

Date: ……

Year 3 – Self-assessment

Competency Statement (staff member)

Having received appropriate training I am competent in this procedure at this time. I have discussed this role as part of my job description with my manager.

Name: ……..

Designation: ……

Signature: ……

Date: ……