Trust Policy

Worcestershire Acute Hospitals NHS Trust

Operational and Admission Policy for the Coronary Care Unit, including Admission into Cardiology Ward

Department / Service:	Coronary Care Unit and Cardiology
Originator:	Kelly Fee
Accountable Director:	Dr J Trevelyan
Approved by:	Divisional Management Board
Date of approval:	23rd April 2025
First Revision Due:	
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Coronary care Unit and Cardiology ward
Target staff categories	Medical doctors Nursing staff Bed managers

Policy Overview:

This document outlines the operational policy for working practices for the Aconbury 2 Coronary Care Unit (CCU) and Aconbury 1 Cardiology Ward at Worcester Royal Hospital. This will include one Coronary Care Bed ring fenced for Primary Percutaneous Coronary Intervention service (PPCI).

Latest Amendments to this policy:

New document

Contents page:

Definitions

- CCU: Coronary Care Unit
- PPCI: Primary Percutaneous Coronary intervention
- CPAP: Continuous Positive Airway Pressure
- IABP: intra-aortic balloon pump
- TPW: Temporary pacing wire
- ACS: Acute Coronary Syndrome

1. Introduction

This document outlines the anticipated working practices for the Aconbury 2 Coronary Care Unit (CCU) and Aconbury 1 cardiology ward within Worcestershire Acute Hospitals NHS Trust. The Aconbury 2 Coronary Care Unit (CCU) is situated in the Aconbury west building on level 2. Aconbury 1 Cardiology ward is located in the same building on level 2 next to Aconbury 2 CCU. Aconbury 2 CCU consists of 10 mixed sex beds nursed in '2-bedded bays' providing level 2 monitored care and Aconbury 1 consists of 20 beds which aims to deliver high quality, safe and effective medical and nursing care to patients in Aconbury 2 CCU and Aconbury 1 Cardiology ward, who meet the criteria set out in this operational policy.

Aconbury 2 CCU beds are designated for patients who have received or require cardiac monitoring and/ or acutely unwell as a result of their cardiac presentation. The purpose of the ring fenced bed is to ensure beds are kept free at all times 24/7 to facilitate the direct admission of patients requiring Primary Percutaneous Coronary Intervention for Acute Myocardial Infarction as per national guidelines.

Aconbury 2 CCU provides high level acute care to both male and female adult patients who requires specialist cardiology medical and nursing input using specialised equipment such as IABP, CPAP and TPW.

1.1 Operation of CCU and Cardiology ward

- Operational period from Monday to Sunday 24 hours
- Ratio of 1:3 registered nurses on Aconbury 2 CCU that must have proven cardiac competencies. Ratio of 1:7 registered nurses on Aconbury 1 Cardiology.
- The Cardiology ward nurses and Consultants will be responsible for the care of all patients admitted into each bed.
- Cardiology Consultant review once daily from the hours of 8am 7 days a week for patients within CCU and Cardiology ward.
- Multidisciplinary assessments/ treatment as required by the patients

- Patients that meet the criteria and have been discussed with the on call Cardiologist if criteria uncertain can be admitted to Aconbury 2 CCU and Cardiology ward

- Patients who are diagnosed with Acute Myocardial Infarction and require PPCI following assessment will be admitted to Aconbury 2 CCU directly from Cardiac catheterisation Lab.

- Bed capacity and decision making with regards to admissions will be the responsibility of the Aconbury 2 CCU Senior Nurse/ co-ordinator on duty who will liaise with the clinical site lead and capacity site managers.

- Once a Cardiologist review has happened and CCU care deemed no longer required, patients will be transferred to the Cardiology Ward for their on-going care or discharged if appropriate

- Once patient is deemed medically stable to transfer from CCU, patients must be transferred to same sex bay within 6 hours in accordance with Trust policy, CCU has mixed sex patients.

- Patients and relatives are included within the discussions regarding treatment and care if appropriate

- Continual close cardiac monitoring systems available to monitor patients' observations on a continuous basis if appropriate within CCU and within 8 cardiac monitored beds on Cardiology Ward

- Allocated pharmacist and technician cover for medicine management and review as appropriate

- Portable telemetry system available for patients requiring cardiac monitor within CCU, Cardiology Ward and other wards within the hospital

1.2 Admission to CCU and Cardiology ward

Admission criteria include

- Assessment, diagnosis and treatment of patients with Acute Myocardial Infarction and other Acute Coronary Syndromes (WAHT-CAR-043)
- Patients with haemodynamically significant brady or tachy arrhythmias (WAHT-CAR-040, WAHT-CAR-039)
- Acute Cardiogenic Pulmonary oedema with haemodynamic compromise who may require CPAP
- Cardiogenic shock
- Patients with Infective Endocarditis
- Patients with ICD or pacemaker issues

- Patients following cardiac procedures (angioplasty, ablations)
- Patients awaiting Cardiac Surgery at local tertiary centres
- Heart Failure due to valvular disease
- Heart Failure patients requiring advanced treatment (eg diuretics infusions, inotropic support, CPAP)
- Type B aortic dissection if antihypertensive control required (shared care with vascular surgery)

1.3 Source of admission

- Direct via email advice and guidance service after consultant review
- WHC
- ED
- AMU
- PPCI
- Elective procedure to remain over night from Cath Lab
- Clinic
- Repatriation from tertiary centres

Same Sex Accommodation

Ward and department managers are responsible for ensuring that no accommodation has mixed sex patients. In the event of a mixed sex incident or patient complaint this should be reported as an adverse incident using the Datix system and escalated to the Divisional Director of Nursing.

Level 2 Intensive Care Units, High Dependency Units, Coronary Care Units and Non-Invasive Ventilation Units can be a mixed sex environment (DH,2010)

Patients in these areas require more detailed observation or intervention in a critical care area to support a single failing organ system, or post- operative care and those ‘stepping down’ form higher levels of care. There is a higher ratio of nursing staff in this area to assist patients to maintain their privacy and dignity. Compliance with DSSA is required within 6 hours of the patient being identified as sufficiently ‘stable’ to be transferred to a level 1 or 0 area within the Trust. This is WAHT local agreement. CCU have 2 bedded bays, if one patient is awaiting a move to a cardiology step down bed and all other patients in the 2 bedded bay is still requiring level 2 care, this would constitute one breach.

Decisions should be based on the needs of the individual patient while in CCU environments and their clinical needs will take priority. Decisions will be made to move patients around and step down to Aconbury 1 Cardiology ward to prevent a breach.

If a patient is ready to leave the Unit but this cannot be implemented there should be clear documentation and a record of actions to be taken to ensure transfer of the patient to appropriate same sex accommodation. WAHT-CG-521

2. Scope of this document

This document outlines the anticipated working practices of the Coronary Care unit and Cardiology ward and guidance criteria for admission into the CCU and Cardiology wards.

Guidelines for the treatment of ACS can be found in document

3. Responsibilities and Duties **Responsibility and Duties**

Matrons and ward managers are responsible for:

- Implementing this policy within clinical areas
- Investigating any incidents related to the use of this policy

The wards will remain open and operational 24 hours every day throughout the year.

When admission to the ward is required we will endeavor to ensure that the length of stay is minimized, whilst delivering safe and effective care. The ward will support the Trust in delivering the organisational objectives relating to Cardiology care services.

All members of staff are responsible for ensuring their practice complies with this policy. The cardiology team is responsible for keeping up-to-date with current research and best practice and disseminating the information.

There is a named clinical lead for Cardiology and a named Cardiology consultant of the week 7 days a week with a named oncall cardiology interventionist on call for the service of PPCI.

- All nurses are responsible to practice within the NMC code of conduct, performance and ethics for nurses and midwives.
- A full nursing assessment will be undertaken and re-evaluated as specified and clearly documented as per Trust Guidelines.
- Escalation to appropriate multidisciplinary team, ie medical doctors, Acute Heart Failure Nurse, Arrhythmia Nurses and Cardiac Rehabilitation Nurses, night practitioners and Critical Care outreach
- Assessment and monitoring of patients physical, emotional and psychological needs
- Establish patient centered goals in collaboration with patient and carers participation including advice and support
- Timely coordinated discharge planning incorporating patients, family and carers

4. Policy detail

Aconbury 2 CCU and Aconbury 1 Cardiology ward will accept patients 17 years of age and over* (16 and over if known to cardiology already) of age presenting with cardiology conditions for assessment, investigation and diagnosis, in relation to the most appropriate plan of care and treatment. Patients will be accepted for acute, chronic and palliative management of cardiology conditions.

(*NB patients that are 16 and 17 years of age will be managed with adherence to the Trust policies on Safeguarding)

Objectives

- Deliver and maintain high quality, safe and effective patient care
- Respect patients' rights to autonomy, privacy and dignity
- Benefit patients and minimise the risk of harm
- Provide fair access to all patients
- Maintain a safe, comfortable and clean environment for all patients and relatives.
- Implement relevant Trust policies and protocols to practice evidence-based medicine
- Operate using a multi-disciplinary team approach to facilitate early safe
- Maintain support for staff, including providing an acceptable working environment and facilities, opportunity for professional development and a supportive team environment
- Maintain staffing at safe and appropriate levels
- Meet educational needs for staff and trainees and for the wider health community
- Reliably collect data about all aspects of care to demonstrate, in a way that would support external review, that we are delivering care to the highest standards.

Benefits

The provision of focused CCU high care within a specialist ward brings with it an opportunity to establish a new way of working. This will particularly reflect the Trust's priorities as below:

- improve patient flow through the hospital system
- reduce length of stay for inpatients
- reduce readmission rates
- provide consistent single sex accommodation for patients, where possible
- provide specialist acute cardiology medical and nursing care
- establish a multidisciplinary team approach to caring for patients in a holistic manner
- maintain training in specialist Cardiology care and competencies of staff working on the ward

a/. Admission Procedure

1/. Transfer of a cardiology case should take priority over any non-cardiac internal medical transfer into Aconbury 2 CCU or Aconbury 1 cardiology Ward. If there are no cardiology outliers and no suitable Cardiology patients in ED we will accept and admit non-cardiac patients to help the flow within ED and the hospital.

2/. An empty PPCI CCU bed will be maintained on Aconbury 2 CCU at all times..

3/. Admission to a CCU bed will only occur after discussion with the appropriate Cardiology consultant, registrar or ward nurse in charge, (whichever is available at the time of transfer).

4/. Transfer from ED, Emergency admissions from Cardiac Catheter Lab and Worcester Heart Centre or cardiology out-patients may also occur during the day following assessments from Cardiology Consultant and Cardiac Specialist nurses. This will be communicated with Capacity to make sure they are aware of admissions.

i. Admission Criteria to Aconbury 2 CCU and Aconbury 1 Cardiology ward beds:

Priority will be given to the following groups of acutely unwell Cardiology patients, requiring Level 0 or 1 specialist cardiology care, from the ED, WHC and other hospital wards or other trusts:

- All patients requiring medical and nursing assessments for Acute Coronary Syndrome
- All patients requiring angiograms must be managed on Aconbury 2 CCU or Aconbury 1 cardiology (high care or non-high care bed depending on patient stability and ward case mix) and receive priority transfer.
- Patients requiring pacemaker insertion
- Patients stepping down from Level 2 critical care (ICU); who do not require the medical or nursing input provided by High Care Unit, but have specialist cardiology nursing requirements
- Patients with any feature of an acute (exacerbation) of heart failure and may require CPAP
- Patients being treated for Endocarditis in which the diagnosis has been confirmed by a Cardiologist
- Patients who require medical and nursing intervention for life threating arrhythmias
- Patients post cardiac arrest who do not require ventilator support
- Any patients in which the cardiology consultant have asked to be transferred to Aconbury 2 CCU as a priority above other patients awaiting transfer due to clinical need not listed here.
- Patients with sever symptomatic aortic stenosis
- Patients with haemodynamically unstable arrhythmias
- Patients with sever Aortic Stenosis

Admissions from other hospitals / trusts: Patients requiring transfer to Aconbury 2 CCU or Aconbury 1 Cardiology ward bed for repatriation following surgery, transfer for pacemaker insertion from Alexandra Hospital should be discussed with and accepted by

the cardiology consultant or registrar and on liaison with ward staff and the bed manager the patient can be transferred when a suitable bed becomes available.

b/. Step down from High Care Unit

Aconbury 2 CCU patients should be “stepped down” when no longer fulfilling the admission criteria. They should be moved into a general cardiology ward bed on the respective cardiology ward. If a suitable cardiology bed is not available, another patient who does not require cardiology care should be transferred to the retrospective cardiology ward (Aconbury 1 Cardiology).

Patients admitted from another specialty ward for acute CCU treatment should be moved back to this ward, if appropriate, for further specialist care.

Patients from Aconbury 2 CCU should not be outlied directly to other wards unless discussed with the Cardiology medical team first.

Patients that are identified to be able to step down from Aconbury 2 CCU should be move out within 6 hours or bed spaces arranged, in order to not cause a mixed sex breach. In the case that this is not possible, it should be escalated to senior nursing and medical team, datix should be submitted and the patient should have a recording on OASIS.

c/. Discharge Process

The ward will comply with Trust policy in that planning for discharge will commence on initial assessment of the patient.

The electronic discharge summary (EDS) will be completed by the medical staff prior to the patient leaving Aconbury 2 CCU and Aconbury 1 Cardiology ward

Should a patient require a follow-up clinic appointment, this must be documented on the EDS and booked through the established channels for each of the sub specialty clinics. Follow up with other teams require direct communication, Ward Clerks liaising with secretaries for follow up on patient discharge.

d/. Infection control and patient isolation

There are general principles to be adhered to within the Trusts Isolation and Bed Management Policy (WHAT-INF-045). If wards are unable to isolate due to clinical need and staffing does not allow to provide the correct level of care for the patient in side room then strict standard infection control or transmission based precautions should be adhered to and that clinical need will outweigh the IPC issues except where a high consequences infectious disease is present eg Viral Haemorrhagic fever. Please contact IPC and matron.

Medical Care

The consultant responsible for the ward patients at any one time is named according to an agreed rota, available both on the ward and via the secretaries in the cardiology department. This will be clearly documented in the electronic patient record and above the bed space.

All patients on Aconbury 2 CCU and Aconbury 1 cardiology ward will be reviewed by a doctor on a daily basis 7 days a week including bank holidays. Those identified as unstable will be seen first and once the most unwell patients have been seen the team will endeavor to support discharges as early in the day as possible.

The medical team, led by the ward consultant, and nurse in charge will conduct a full board round of ward patients before the physical ward round 7 days a week. There will be a trouble shooting board round in the afternoon between at least one doctor and the nurse in charge to expedite discharges and manage emerging clinical and bed allocation issues.

The nursing staff will alert the doctors when patients need to be reviewed outside these times, in accordance with Trust NEWS trigger policy.

In the event of a cardiac arrest or a patient requiring urgent medical assistance, a cardiac arrest call will be placed via switchboard (2222). The medical emergency team will attend the ward in line with the Trust policy.

All new doctors starting with the cardiology team will receive a local induction for orientation to the ward and cardiology team.

ii. Nursing Care

The Ward will be staffed 24 hours a day, 7 days a week.

A dedicated nursing lead, band 6 or above, for Aconbury 2 CCU will be allocated. Each shift will have an overall nurse in charge who will take responsibility for the adequate staffing and smooth running of Aconbury 2 CCU and Aconbury 1 cardiology ward. This nurse will be able to advise on whether a patient meets the admission criteria for Aconbury 2 CCU and Aconbury 1 Cardiology ward. This nurse will also attend to operational demands of each shift and will support the nurse in charge of each individual team to ensure that all aspects of hospital policy are adhered to, e.g. documentation, infection control etc.

These teams will provide a coordinated and appropriate level of cardiology care, with a shared workload, in order to provide equitable care for all patients. All nurses will be expected to assist with other teams in order to deliver safe care.

The senior nurse will ensure ward rounds are undertaken in a timely fashion and inform bed managers daily of specialist beds required and those suitable to step out of Aconbury 2 CCU, to facilitate patient flow and ensure specialist input is received.

There will be a formal nursing handover process from one shift to the next to ensure safe and efficient care for the patients and early discharge planning.

iii. Model of Multidisciplinary Team Approach

A multidisciplinary board round will take place daily to discuss assessments, care plans and to contribute to a safe and efficient discharge process, as part of the SAFER patient flow bundle. Those attending the board round include Consultant, NIC, Registrars (if available), junior doctors, Physician Associates, Physiotherapist, occupational therapist (if available) and ward pharmacist.

Aconbury 2 CCU and Aconbury 1 cardiology ward will use a multi-disciplinary approach to enable the holistic care of patients and to enable early safe discharge whenever possible. This will incorporate the skills of the following services:

- Specialist Cardiology nurses
- Nurse practitioners
- Tier 2 physician's assistants –
- Palliative Care Specialist Nurses
- Physiotherapists
- Occupational Therapists
- Speech and Language Therapists
- Pharmacists
- Social Services
- Onward care team
- Dieticians

Specialist Cardiology Nurses:

The cardiology specialist nurse (CNS) team within the hospital will support patients with discharge.

Physiotherapists:

The physiotherapists based on Aconbury 2 CCU and Aconbury 1 cardiology ward will have a special interest in cardiology physiotherapy, enabling faster recovery from acute illness.

The physiotherapy team will attend the ward daily to review new and known referrals. They will also liaise with other teams to improve patient discharge flows.

For patients with an urgent Cardiology problem requiring physiotherapy out of hours, the on-call physiotherapist is available and can be contacted via Switchboard.

Occupational Therapists (OT):

The occupational therapy team will be directed to patients requiring their input by the nursing, medical or physiotherapy staff, by means of a telephone or electronic referral. They will endeavor to see these patients at their earliest opportunity to enable a safe discharge to the community.

Speech and Language Therapists (SALT)

The Speech and Language Therapy (SLT) are available to assess and manage patients with dysphagia and can be contacted via Switchboard.

Pharmacists:

The ward based pharmacy team will visit daily (Monday to Friday) to: complete patient medicines reconciliation, clinically check medication to ensure safe and appropriate prescribing, provide clinical advice or information as appropriate, and facilitate timely supply of medication to the ward and the dispensing and checking of discharge prescriptions. They will also join the clinical ward rounds wherever possible to integrate into the team approach to patient care.

Social Services/Patient Flow Centre

Social workers will be involved in arranging placements and packages of care to patients being discharged from the ward, and will be contacted by the nursing staff by means of electronic or telephone referral systems.

Support Staff/Admin/Clerks/Housekeepers

Aconbury 2 CCU and Aconbury 1 cardiology ward have a ward administrator, ward clerks and housekeeper Monday to Friday, enabling timely patient admission/discharge and the provision of efficient clerical and reception service.

5. Implementation

5.1 Plan for implementation

The Corporate nursing team will oversee the effective communication of the approved policy to all relevant staff. This includes informing general managers, heads of department, heads of nursing, matrons and ward managers, that the policy is accessible via the policy link on the Trust Intranet.

The policy will be discussed within the cardiology directorate meeting.

5.2 Dissemination

The Policy will be placed on the Trust's Intranet cardiology page and all staff made aware through the use of the Trust Update, Trust-wide e-mail process and in regular Trust briefings.

Line managers are responsible for ensuring that a system is in place for their area of responsibility that keeps staff up to date with new key documents and policy changes.

The key staff identified in this policy will be informed of the policy and any changes to it directly by their line managers and advised that adherence is an essential requirement of their practice.

Staff may print key documents at need but must be aware that these are only valid on the day of printing and must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

Individual members of staff have a responsibility to ensure they are familiar with all key documents that impinge on their work and will ensure that they are working with the current version of a key document. Therefore, the Intranet must be the first place where staff looks for a key document.

Relevant key documents and guidelines will be available on the Trust's Internet.

5.3 Training and awareness

Awareness will be raised by the dissemination of this policy to all staff via the Intranet and through Trust updates. Access to key documents is also included in the Trust's induction programme.

Mandatory Annual Training & Cardiology Competencies:

Clinical staff providing care to patients are expected to complete Annual Mandatory Training. In addition to this, staff will be expected to complete on-going and bespoke training including specific cardiology competencies including CPAP, TPW, IABP, cath lab runner. The Senior Management and Clinical team review Mandatory Annual Training and cardiology Competencies compliance for all staff on an on-going basis.

Risk Register

The risk register will be reviewed any Cardiology risks will be identified and action taken to minimise these risks. The units will review the risk register according to the timescales outlined. Significant risks will be reviewed and actioned at Divisional Quality Assurance meeting.

Adverse Incident Reporting

All staff are encouraged to report adverse incidents and near misses through the Datix system. This reporting mechanism will help to improve standards of care and will minimise risk to patients, staff and visitors. Learning from adverse incidents occurs via team meetings.

6. Monitoring and compliance

Lead clinicians, Matrons, Ward and Department managers are responsible for ensuring staff comply with this policy.

Individual staff members must be aware of the policy and ensure that their clinical practice is in line with its guidance.

Monitoring and compliance against this policy is the responsibility of the Cardiology Medical Directorate Group, as outlined below:

- Audit:
- Patient & Staff Surveys: Annual surveys and review.

- Complaints, incident and Datix review: discussion and review at the Cardiology Directorate clinical governance meetings as required.
- Capacity & Demand: reviewed weekly, actions taken if necessary.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
	Appropriate Patients admitted into CCU and General Cardiology ward beds	Datix monitoring		Cardiology Directorate	Cardiology Directorate Meetings	
	Organisational aspects of care delivery for ACS patinets	MINAP		Cardiology Directorate	Cardiology Directorate Meetings	Every 2-3 yrs.
	Monitor ACS standards	PCI database amd regional ACS dataset	monthly			

7. Policy Review

This policy will be reviewed every 3 years.

8. Background

8.1 Equality requirements

The assessment conducted for this policy reveals no equality issues. The record of the assessment is held in the Clinical Governance Department. (Supporting Document 1)

8.2 Financial risk assessment

A financial risk assessment has been performed and reveals there are no financial implications to this policy. (Supporting Document 2).

8.3 Consultation

Contribution List

This key document has been reviewed in the cardiology Directorate meeting and has been circulated to the following individuals for consultation;

Cardiology Consultants	Dr A Ammar
	Dr M Apostolakis
	Dr F Formisano
	Dr W Foster
	Dr D Goyal
	Dr C Mcaloon
	Dr L Mughal
	Dr D Ramnarase
	Dr H Routledge
	Dr W Roberts
	Dr A Saffy
	Dr O Shaikh
	Dr D Smith
	Dr R Taylor
	Dr J Trevelyan
	Dr D Wilson
Lead nurse cardiology specialist nurse teams	Kerry O'Dowd
Director / heads of Nursing, Matrons	DDN Rebecca Moore
	DDDNJuliet Hawkesford-Barnes
	Matron Kelly fee
Medical Director	
Head of Clinical Governance & Risk Management	Dominique Thorne
Health and Safety Manager	

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Divisional Management Board (pending)

8.4 Approval Process

Divisional Management Board pending

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	Name	Job title	e-mail contact
	Kelly Fee	Matron	Kelly.fee@nhs.net
Date assessment completed	19th May 2025		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: Admission criteria to cardiology ward and CCU			
What is the aim, purpose and/or intended outcomes of this Activity?	Patient in correct speciality bed for treatment			
Who will be affected by the development & implementation of this activity?	❑	Service User x	❑	Staff x
	❑	Patient x	❑	Communities
	❑	Carers	❑	Other _____
	❑	Visitors	❑	

Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	CQC and local policies
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Cardiology physicians and allied health staff
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	Nil	.		
How will you monitor these actions?	N/A			
When will you review this	Policy update and version change			

EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Kelly fee
Date signed	19.05.2025
Comments:	
Signature of person the Leader Person for this activity	Kelly Fee
Date signed	19.05.2025
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	Yes – To establish staffing ratio within high care units.
3.	Does the implementation of this document require additional manpower	Yes, staffing levels for cardiology high care
4.	Does the implementation of this document release any manpower costs through a change in practice	Intended reduced length of stay
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Appendix 1: Levels of Care

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** **• Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly** **• Arterial blood gas analysis - intermittent** **• Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains** **• Severe infection or sepsis**

Level 1b (Multiplier = 1.72*) **Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of the activities of daily living.**	**<u>Care requirements may include the following</u>** **• 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 owing 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 / cardiology support; CPAP** **• Requires a range of therapeutic interventions including:** **• 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** **• Invasive neurological monitoring**

Level 3 (Multiplier = 5.96*) **Patients needing advanced cardiac support and / or therapeutic support of multiple organs.**	**• Monitoring and supportive therapy for compromised / collapse of two or more organ / systems** **• Cardiac compromise requires mechanical / invasive ventilation** **• Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection**