Tús Áite do Shábháilteacht Othar
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Health Service Executive

Clinical Strategy and Programmes Division

Office of the Nursing & Midwifery Services Director

EMERGENCY MEDICINE

National Emergency Medicine Programme

Guidance document on staffing for Injury Units (IUs)

INJURY UNIT

Version 3, March 2019

Foreword

This document provides guidance from the National Emergency Medicine Programme (EMP) with regard to the staffing of Injury Units (IUs) to provide safe, high quality patient care. This guidance replaces previous version 2 published September 2013 which was developed at a time when Injury Units were at early stage of development. It is now prudent to revise these guidelines which are informed by operational experience and activity data from established Injury Units across Ireland. The timing of this guideline review also coincides with the Department of Health Taskforce on Staffing and Skill Mix in Nursing; Phase II – Emergency Care Settings. It is anticipated that the pilot of the framework for safe staffing in emergency care settings will include recommendations in relation to nurse staffing for Injury Units based on research and data being collected across four pilot sites nationally including one Injury Unit. It is envisaged that this updated EMP guidance document will align with the outputs and recommendations of this national work

IUs provide limited hours of access for patients with specific presentations within an Emergency Care Network (ECN) framework. This guidance document provides national guidance for minimum staffing requirements for these units. The Department of Health Taskforce on Safe Staffing and Skill Mix Phase II (emergency care settings) is currently in progress and findings from the implementation of this policy will further guide decisions regarding appropriate staffing in Injury Units nationally. In the event that there is any discrepancy between the national work and this guideline, the guideline will be subsequently reviewed and revised if necessary.

IUs vary in attendance volumes and geographical settings therefore the staffing guidance does not preclude the employment of additional staff on the basis of service demand or service characteristics at hospital, network or regional level. This guidance should be used to implement, develop and sustain multidisciplinary teams with appropriate staff compliment and skill-mix to optimise patient safety, quality of care and value in the IU.

The Guide was prepared by the EMP working group and co-ordinated by Ms. Susanna Byrne, Director Nursing and Midwifery Planning and Development Unit, HSE Dublin Mid-Leinster (Palmerstown) and Service Planner for the EMP. The Guide has undergone extensive stakeholder consultation, and the EMP and ONMSD are therefore pleased to endorse the recommendations outlined in this guidance document.

This is version 3 of the document which has been updated taking into account operational experience and data from established IUs.

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Document outline

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1. Purpose

This document provides guidance from the National Emergency Medicine Programme with regard to the staffing of Injury Units (IUs) to provide safe, high quality patient care.

2. Introduction

IUs provide limited hours of access for patients with non-life or non-limb threatening injuries. These units will operate within an Emergency Care Network (ECN) framework under the governance of a Network Coordinator for Emergency Medicine (EM) based at the Lead Emergency Department (ED) for the network. Staff recruitment, rostering and professional development will be managed at network level.

This document represents standardised, national guidance for **minimum** staffing requirements for IUs. **This standardisation does not preclude the employment of additional staff on the basis of service demand or service characteristics at hospital, network or regional level**. IUs will vary in attendance volumes and geographical settings (e.g. urban versus rural and remote) and ECN. EM leads and hospital group/regional management teams should extend this guidance to implement, develop and sustain multidisciplinary teams with appropriate staff compliment and skill-mix to optimise patient safety, quality of care and value in the ECNs for which they are responsible.

Staffing allocations for IUs evolved historically through the transition of EDs to IUs on a limited number of sites, driven by regional reconfiguration. In the intervening period experience has been gained in the establishment of IUs without on-site hospital services as well as the embedding of IUs which are linked to model 4 hospitals. Remote and rural IUs have also become established as has an IU linked to a model 2 hospital in an urban location. On-going IU development is likely to occur in conjunction with the established hospital groups and based on data and experience generated over the last 5 years.

Systems level research and audit of patient outcomes and experience will also inform future IU developments.

3. Baseline assumptions for IU staff modelling

a) Hours of opening: This model has been developed for IUs to be open to the public from 08:00 to 18:00 hours, seven days a week. These units must be staffed for a 12-hour period 08:00 hours to 20:00 hours to allow for 'completion of care' (some patients' treatment may not be complete by 18.00 hours). Any requirement for additional opening hours up to 20:00, with 'completion of care' to 22:00 should be based on demand and may require additional staffing which will have funding implications.

b) Minimum staffing requirements: There is a minimum staffing requirement that must be maintained at any IU site irrespective of annual attendance volume in order to ensure safe provision of care. Additional staffing may be required in some units on the basis of factors such as service need, patterns of demand (activity & acuity), availability of on-site supporting resources, ECN configuration and geography.

c) This staffing recommendation does not include cover for other on-site clinical areas.

d) Inclusion of a time-out factor for nursing staff: This includes all periods of leave that must be factored into staffing models. A time-out of 20% consistent with current recommendations (***Appendix 1***) will be used in this model. This does not include maternity leave and the local maternity leave rates will need to be factored into overall staffing calculations. The Framework for safe Nurse Staffing and Skill Mix phase 1 note that maternity leave rates can vary considerably between organisations, and therefore must be added to the standard 20% time-out calculation. The setting of an absence allowance at organisational level is recommended as organisations will need to increase the allowance to take account of maternity leave rates in their individual organisation. Lack of acuity and case-mix measures pertinent to the IU precludes the development of more refined models for unit staffing. The Department of Health Taskforce on Safe Staffing and Skill Mix Phase II (emergency care settings) is currently in progress and findings from the implementation of this policy will further guide decisions regarding appropriate staffing in Injury Units nationally.

e) ICT systems for the IU should be in place in order to provide accurate data to inform workforce planning. An IT link to the Hub ED should also be developed for established ECNs. Accurate activity and acuity data are essential in order to make a sound recommendation around workforce requirements as these measurements are the key component in determining resource allocation.

f) The model assumes that the appropriate therapy professions, medical social worker, porter, pharmacy, radiography, household and security services are included within the hospital resource but provided to the IU as required. These services are not included in this staffing model.

g) The recommended minimum age of children to be seen and treated in IUs is 5 years of age and specific training requirements for staff in these units are outlined in 7d.

h) Conditions appropriate to IU care are attached in *Appendix 2*.

4. Staff requirements for 12-hours on-site clinical activity 7 days/week

The required hours per year to provide 12 hour cover per day (12 hours shift x 365 days/year) = 4,380 hours/year. The majority of nursing staff will work a standard 12-hour shift to provide for the 'completion of care' period in IUs that are open to the public from 08.00 to 18.00 hours. The minimum staff complement required for an IU is outlined in Table 1. Modifications to minimum staffing according to IU attendance numbers are described in section 6 of this document.

Table 1: Minimum staffing requirements for Injury Units open for 12 hour/ day 7 days/week

- ✓ Reception/administration staff member available to support patient registration and other duties during hours of opening *and*
- ✓ 1 Staff nurse – on duty during all hours of clinical activity *and*
- ✓ 0.5 CNM 2 – to provide leadership and management support to the multidisciplinary team *and*
- ✓ 1 Senior Clinical Decision Maker* on duty during all hours of clinical activity *and*
- ✓ 1 Consultant in Emergency Medicine (EM) – commitment equivalent to 8 hours per week

Notes:

- *A Senior Clinical Decision Maker in an IU is defined as a Registered Advanced Nurse Practitioner (RANP) or a Middle Grade Doctor (Registrar, SpR or Staff Grade/Associate Specialist). Currently, Senior Clinical Decision Maker roles in IUs are fulfilled either by Middle Grade Doctors only or by both doctors and ANPs as all IUs are required to have a Middle Grade doctor present at all times. The potential for IU staffing to migrate to a predominantly ANP-provided service is recognised. The *Guide to Enhance Advanced Nursing Practitioner Service across Emergency Care Networks in Ireland* (EMP 2018) outlines a future vision for ANP led IUs and recommends a minimum of 3 ANPs per unit to provide a 12 hour service 7 days/week. Factors that will influence future senior clinician staffing in IUs will include unit case-mix, demand patterns and availability of Middle Grade doctors and ANPs across the emergency care system.
- There needs to be a continuous Staff Nurse presence during all hours of clinical activity. Arrangements for cover of breaks will depend on factors such as the on-site availability of other nurses with appropriate competencies to cover breaks or whether there is an ANP present. Alternatively, additional nursing resource may be required to ensure staff breaks are adequately covered.
- The IU nursing team will require the support of a CNM 3 or ADON resource within the hospital or network.
- In order to support the requirements of working across a network, senior decision makers will be required to rotate across the sites of the ECN in order to support their CPD.
- **If increased activity is experienced, the professional judgement of relevant clinicians will determine what additional resource is required to safely and effectively deal with this activity.**
- The IU team should link with specialist services on site or within the ECN, including Clinical Nurse Specialists as required.
- Consideration of patient throughput, acuity and patterns in attendances will ultimately influence the skill-mix requirement.

5. Whole time equivalent requirements for each staff grade

Based upon the minimum staffing requirements identified in Table 1, table 2 below describes the WTE to achieve these requirements.
Further details regarding staff availability are outlined in Appendix 1.

Table 2: WTE requirements for each staff group

Grade	Availability (hrs/pa)	Requirement (hours per annum)	WTE required
Consultant	1,728	8 hours/week = 416 hours p.a.	0.24 WTE
Middle grade doctor	1,716	1 Middle grade doctor/shift to cover 4,380 hours p.a.	2.55 WTE
ANP	1,623	1 ANP / shift for 4,380 hours p.a. = 2.7 WTE * plus 0.3WTE to ensure other functions of the role such as education, research & CPD	3.0 WTE
CNM 2	1,623		0.5 WTE
Staff Nurse	1,623	1 Staff Nurse / shift for 4,380 hours p.a.	2.7 WTE
Reception/Admin	1,703	Receptionist on duty all hours of opening 08.00 – 18.00 (10hr)/ day = 3,650 hours p.a.	2.1 WTE (this resource may be shared across clinical areas as appropriate)

*this aligns with the EMP Guide to Enhance Advance Nurse Practitioners across Emergency Care Networks in Ireland

There is emerging data and experience available regarding IU attendances. This experience supports the view that attendance volumes should determine the number and mix of staff present in the unit to effectively and efficiently deliver service. Recommendations based on this experience are outlined in Table 3 below. Flexibility needs to be incorporated when developing rosters and staff/WTEs should be allocated in response to emerging attendance patterns and trends. If a grade resource is not covered by a pool of people, a minimum of 3 WTE will be required to consistently cover the 7 day period each week.

Table 3: Recommended staffing levels on duty by attendance volumes							
IU annual attendances	**Max daily IU attendances**	**No. of senior clinical decision makers <u>on duty</u> in the IU**	**WTE Senior decision makers required** (based on calculation in table 2 & appendix 1)		**No. of staff nurses on duty**	**WTE Staff Nurses** (based on calculation in table 2 & appendix 1)	**No. of admin. staff on duty**
			Middle Grade Dr	ANP			
Up to 7,000	20	1	2.55	3.0	1	2.7	Available
Up to 11,000	30	1.5	3.8	4.5	1	2.7	Available
11,000-14,900	40	1.5	3.8	4.5	1	2.7	Available
15,000-18,000	50	2	5.1	6.0	2	5.4	Available

6. Injury Unit Staff Roles

Advanced Nurse Practitioners: It is anticipated that ANPs will provide the greatest proportion of direct patient care in the IU setting. Current ANP capacity does not support an ANP presence in all IUs. The current figures collected by EMP indicate a total 9 ANPs in post across 8 IUs and a deficit of 24 in terms of recommendations in the EMP's *Report and Strategic Plan to Enhance ANP (Emergency) Nursing Services across Emergency Care Networks*. The ANP role has additional responsibilities such as education of the MDT, research, audit and continuing professional development that are not accounted for in the staff availability calculations. Activities such as clinical supervision, case review and audit should be arranged on a regular basis with the Consultant in Emergency Medicine, while other activities such as research and Continuing Professional Development (CPD) undertaken at the lead ED and at a national level. The role of the staff nurse working with the ANP should also be further considered in the future and may be explored in the Taskforce pilot.

Middle Grade Doctors: The current recommendation from the Department of Health is that a Middle Grade doctor should be present at all times to enable the broadest possible case-mix range to be managed in IUs. This grade includes Registrars, Specialist Registrars and a non-career grade or Emergency Medicine Staff Grade role that has been recommended by the Irish Association of Emergency Medicine (IAEM) and the Irish Committee for Emergency Medicine Training (ICEMT) for the EMP. Increased ANP numbers and expansion of their scope of practice has reduced the requirement for the on-site presence of Middle Grade doctors in these units over time. Depending on unit demand, a single Middle Grade Doctor may cover the 12 hour shift each day or the shift may be split between two doctors.

Consultants in Emergency Medicine: will provide leadership in IU care to the multidisciplinary team and will provide on-site review clinics and direct patient care for limited periods. A minimum Consultant in EM commitment equivalent to two half-day sessions or 8 hours in total for each IU is considered appropriate.

General Practitioners: There is potential for GPs who wish to do so and who have appropriate training and experience in the care of non-life or limb threatening injuries to participate in medical staff rosters for IUs. These roles would be implemented under the governance of Emergency Medicine, within the ECN governance framework.

The staff nurse role: The staff nurse will utilise their skills and competence to support the ANP and Middle Grade Doctors in performing clinical procedures and completing episodes of care. Staff nurses will also be required to support the efficient running of on-site Review Clinics. There is opportunity for staff nurses to gain specific competence and experience in this area of practice under the supervision of the ANP, Middle Grade and Consultant when present.

Nursing Management Support: The EMP recommends that there should be a CNM 2 available on site to provide leadership and nursing management expertise Monday to Friday. This role is particularly important where IUs are geographically distant from the lead network ED. In addition there should be a CNM3 or an ADON resource to supporting each IU within a network and/or at hospital level. The operational remit of CMN 2/ CNM 3/ADON roles should be clearly defined and include, *inter alia*, oversight of the management and support of the IU nursing staff team, IU rostering, ensuring that staff meet mandatory training and continuing professional development requirements.

The Therapy Professions and Medical Social Work: All patients must have equitable access to appropriate therapies and Medical Social Work throughout the ECN. Therefore, IUs must have access to these services, ideally on-site or at the hub ED for more specialised services (e.g. hand therapy). A needs-assessment will indicate whether service demand for physiotherapy, occupational therapy and other services justifies the on-site provision of services. Future expansion in Physiotherapy and Occupational Therapy scope of practice may enable a greater contribution of these professions to IU staffing. Ideally, network or local out-patient therapy clinics should be available to IU patients who require ongoing care or when on-site services are not available. Medical Social Work services must be accessible throughout the hours of IU clinical activity.

Reception/ Administration staff: are required for IUs and for the full duration of opening times to support patient registration among other duties. The resource may also provide administrative support for the on-site MAU.

Roles that may be developed for the IU setting:

Health Care Assistants (HCA): Expansion of the HCA scope of practice may enable this role to contribute to care in the IU setting. Assessment of HCA staffing requirements will necessitate a site-by-site approach with the involvement of the management team of the service. Consideration of patient throughput, acuity and patterns in attendances will ultimately influence the skill-mix requirement. Appropriate preparation and training for the role will be required to ensure their scope of practice matches service requirement.

Paramedic roles: The EMP will work with the National Ambulance Service and the Pre-hospital Emergency Care Council to investigate the potential value of including Paramedic roles in future staffing models for IUs. These roles may be particularly useful in remote and rural areas.

Security: Access to security for all hours the department is open is required.

Other supports: Access to portering and appropriate household/cleaning resources is required.

7. Staff skill-mix and training for IU Nursing Staff

a. A Clinical Facilitator role should be provided at the hub ED to oversee induction, training and ongoing support for IU staff.

b. All nursing staff should meet pre-identified competencies outlined in the Role Profiles for Nursing staff working in Emergency Care settings in Ireland (EMP 2018) or be working towards achieving these competencies. A robust competency assessment process should be in place to measure clinical skills and competencies and should be supported by Clinical Facilitators from the ECN. This activity is important from a quality, safety and succession planning perspective. The expansion of roles and competencies for nursing is outlined at strategic level by the Department of Health (2011, 2017), Office of the Nursing and Midwifery Services Director (ONMSD, HSE (2016) and by The Nursing & Midwifery Board of Ireland (2015) in the context of clinical and regulatory standards.

c. ANPs will have an MSc in advanced practice in emergency care and possess the skills and competence relevant to the specialist area of practice and should include medicinal prescribing and medical ionising radiation (X-ray) prescribing.

d. It is recommended that all nursing staff undertake the Prescribing of Ionising Radiation Programme as experience to date indicates that this skill enhances the patient flow in a IU and makes more efficient use of the senior clinical resource.

e. It is also recommended that nursing staff working in IUs should be Registered Nurse Prescribers, or undertake the programme within an agreed timeframe, to allow for time efficient patient care and throughput and effective use of nursing resource. This requirement may alter somewhat as further operational experience of IUs within ECNs becomes evident.

f. Resuscitation Training: All IU nursing staff and medical staff must have resuscitation training. Dedicated training courses delivered at network level should provide a basic level of resuscitation competency and skills retention. Nursing staff in all IUs where children attend must have training in paediatric resuscitation and the recognition of non-accidental injury.

g. Procedural Analgesia and Anxiolysis: All injury units must be able to provide analgesia and procedural anxiolysis. These should only be provided by members of the clinical team who have completed an approved training programme in conscious procedural analgesia and anxiolysis.

8. Staff turnover and retention

a. Staff Turnover: The turnover of staff from the unit should be monitored on an annual basis so that trends can be identified and factored into the workforce planning process. The age profile of staff should be monitored by network Human Resource Management to identify pending retirements and to make timely arrangements to have these staff replaced.

b. Staff Retention: Every effort should be made to retain experienced staff. This can be done in various ways such as having a robust orientation/induction programme, addressing individuals' CPD needs, undertaking Professional Development Planning (ONMSD 2018) and/or providing opportunities to rotate across sites within the ECN etc. Each IU should develop a retention plan to suit their staff. If experienced staff can be retained, the cost-benefits to the workplace are significant and include the provision of quality care from experience staff as well as avoidance of recruitment costs.

c. Succession planning: A mix of staff is required and ongoing continuing education and professional development of these staff is essential to ensure that senior posts vacated can be filled by staff coming up through the system. Career guidance and personal development planning should take place on an annual basis. This will support the development of career pathways for all nursing roles within the ECN.

d. New working practices: It is essential that IU staff implement national recommendations for new working practices. Service innovation in IUs should be explored, evaluated and shared.

e. Physical working environment (footprint): This must be considered when determining staff requirements.

f. Outcomes Management: Any changes in staffing should be followed by an evaluation of this change. It is important that unit staffing is optimised to ensure efficient and effective practice. The ongoing measurement and evaluation of activity data, key performance indicators (to include nursing metrics), service cost-effectiveness and, most importantly, patient outcome data is the basis on which IU staffing should be evaluated.

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Appendix 1: Staff availability and Time-out factor

It is logical to examine the availability (in hours per annum) of various grades of staff before matching it to the requirement for staff.

The Office of the Nursing and Midwifery Directorate has advocated that a time out of 20% be incorporated into National Clinical Programmes' workforce planning calculations for nursing and midwifery grades. This timeout factor is more recently endorsed in the recent Department of Health Publication Framework for safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland (DOH 2018). Time-out is the collective amount of time staff are away from and therefore unavailable to the clinical area. This time includes study leave, annual leave, paternity leave, adoptive leave, *force majeure* leave and compassionate leave. Timeout factor for maternity leave is not included in this 20% calculation and therefore the local maternity leave rates will need to be factored into overall staffing calculations. The Framework for safe Nurse Staffing and Skill Mix phase 1 note that maternity leave rates can vary considerably between organisations, and therefore must be added to the standard 20% time-out calculation. The setting of an absence allowance at organisational level is recommended as organisations will need to increase the allowance to take account of maternity leave rates in their individual organisation. An accurate calculation of time-out is fundamental to the recommendation of staffing establishments and its exclusion results in significant demands on the service for replacement.

Time-out does not apply to other staff groups and the following table estimates available working hours per year for medical staff groups based on the maximum allowable leave and for reception staff based on usual allowances.

Appendix Table 1: *Staff availability incorporating 20% time-out for nursing staff and estimated annual leave for medical (maximum possible) and administrative staff. Local Maternity Leave will have to be added to this calculation.*

Staff availability incorporating 20% time-out				
Grade	**Working hours/week**	**Working hours/year**	**20% time out/estimated leave**	**Available Working hours/year**
Staff Nurse	39 hours	2,028 hours	405 hours time out	**1,623 hours**
CNM 2	39 hours	2,028 hours	405 hours time out	**1,623 hours**
ANP	39 hours	2,028 hours	405 hours time out	**1,623 hours**
Consultant	39 hours or 37 hours (pre 2008 contracts)	2,028 hours or 1,924 hours	222 hours leave Max 78 hours other leave	**1,728 hours** **or** **1,624 hours**
Middle Grade Doctor	39 hours	2028	234 hours leave Max 78 hours study leave	**1,716 hours**
Reception*	37 hours Or 36 hours (pre 2008 contracts)	1,820 hours Or 1,827 hours	168.75 estimated leave	**1,755 hours** **Or** **1,703 hours**

* NCHDs are required in the Haddington Road agreement to deliver 37 hours of clinical work out of the 39 paid hours, with lunch breaks adjusted accordingly. Reductions in annual leave entitlements are not reflected in these calculations as they are dependent on incremental scales and may be implemented as cash reductions.

Appendix 2: Conditions Suitable and Unsuitable for Care in a Injury Unit

Overview:

Injury Units (IUs) will treat patients with injuries that are not life-threatening and unlikely to result in serious long-term disability. IUs will not treat medical conditions, pregnancy-related or gynaecological problems, injuries to the chest, abdomen or pelvis and serious head and spine injuries. Lists are provided to try to direct patients with single, isolated and uncomplicated injuries to these units. These are not exhaustive lists and patients should be advised to contact the IU or their General Practitioner for guidance if they are uncertain whether or not to attend an IU or Emergency Department.

Notes:

1. These attendance protocols are intended for use in IUs linked to Emergency Departments and operating within the governance of an Emergency Care Network.
2. The protocols are intended as guidance to Lead Consultants in Emergency Medicine for IUs and should be adapted for local use. Clinical governance for IUs rests with the Lead Consultant in EM within the ECN and hospital group governance framework.
3. Patient information leaflets produced on the basis of these protocols should use patient-appropriate language.
4. There should be transfer protocols in place for patients who inadvertently attend IUs when their care needs cannot be met in this clinical environment.
5. The protocols should be supported by ECN and national clinical guidelines. Doctors, ANPs and Nurses working in IUs should have direct access to clinical advice from a Consultant in Emergency Medicine from the lead network ED.
6. The appropriate age for Paediatric IU attendances may be determined by the ECN Lead/Paediatric Emergency Medicine Lead depending on local practice but the EMP recommends that this should not be younger than 5 years.
7. Audit of patient outcomes and monitoring of IU workload will indicate the need for review of these lists, as part of the governance function of the network.

(The National Emergency Medicine Programme report 2012; p362 – 364)

Adult Patients:

Conditions Suitable and Unsuitable for Care in an Injury Unit

What the Injury Unit may treat	What the Injury Unit may NOT treat
✓ Suspected broken bones to legs from knees to toes	✗ Conditions due to medical illness e.g. fever, seizures, headache.
✓ Suspected broken bones to arms from collar bone (clavicle) to finger tips	✗ Suspected serious injury or inability to walk following a fall from a height or a motor vehicle collision. Patients with neck pain or back pain that started on the day of injury should attend an ED rather than a Local Injury Unit.
✓ All sprains and strains	
✓ Minor facial injuries (including oral, dental and nasal injuries)	✗ Injury causing chest pain, abdominal pain or shortness of breath
✓ Minor scalds and burns	✗ Significant Head Injury. Patients taking anticoagulants who have suffered head injury should be brought to an ED
✓ Wounds, bites, cuts, grazes and scalp lacerations	✗ Chest pain
✓ Small abscesses and boils	✗ Respiratory conditions
✓ Splinters and fish hooks	✗ Abdominal pain
✓ Foreign bodies in eyes/ears/nose	✗ Gynaecological problems
✓ Minor head injury (fully conscious patients, who did <u>not</u> experience loss of consciousness or have more than one episode of vomiting after the head injury)	✗ Neck/back pain
	✗ Pregnancy related conditions
	✗ Pelvis or hip fractures
	✗ Injuries due to self-harm

Conditions Suitable and Unsuitable for Care in an Injury Unit

What the Injury Unit may treat	What the Injury Unit may NOT treat
Any child aged 5 years or older with: ✓ Suspected broken bones to legs from knees to toes ✓ Suspected broken bones to arms from collar bone (clavicle) to finger tips ✓ Any sprain or strain ✓ Minor facial injuries (including oral, dental and nasal injuries) ✓ Minor scalds and burns ✓ Wounds, bites, cuts, grazes and scalp lacerations ✓ Splinters and fish hooks ✓ Foreign bodies in eyes/ears/nose ✓ Minor head injury (fully conscious children, who did not experience loss of consciousness or vomit after the head injury)	✗ **Any child of any age with a medical illness e.g. fever, seizures, respiratory symptoms** ✗ **Any child younger than 5 years** ✗ **Any child aged 5 years or older with:** ✗ Non-traumatic limp or non-use of a limb ✗ Injuries following a fall from a height or a motor vehicle collision ✗ Serious head injuries ✗ Abdominal pain ✗ Gynaecological problems ✗ Injuries due to self-harm ✗ Neck pain or back pain

Guidance Document

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