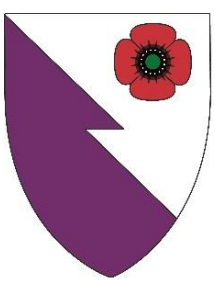
The Royal College of Emergency Medicine

Best Practice Guideline

Giving Information to Patients in the Emergency Department



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Summary of recommendations

1. All patients should be given regular verbal advice during their time in the Emergency Department (e.g. of the interventions that are occurring, and the rationale for these).

2. Discharge advice should be available in a format that is appropriate for the patient, and quality of the writing and production should be high (i.e. printed and legible). All patients should receive discharge advice in both written and verbal formats, and this should be documented in the clinical record.

3. Written advice should be freely available and it is helpful to have standard advice openly accessible to everyone on the organisation's internet site, as well as openly available in printed format within the department.

4. 'Welcome to the Emergency Department' advice should be available that includes

    - A description of the patient journey through the ED
    - Advice about refreshments, and eating and drinking
    - Advice about smoking and mobile phone use in the ED
    - Advice about property and valuables
    - Advice about information governance structures (e.g. informing health visitor of child attendances)
    - Advice about transport home/admission to hospital
    - Advice about how to raise concerns

5. Generic discharge information, made bespoke appropriately, should be given; this should include

    - Advice about pain relief and prescriptions given by the ED
    - Advice about fitness to work and fitness to drive
    - Further appointments and follow-up arrangements
    - Injury or illnesses specific information (often on a separate leaflet)
    - Advice about symptoms or signs that should prompt further assessment
    - Contact information for both the ED and patient advice/liaison service

Scope

This guideline is written to cover the basic requirements for provision of information to patients in Emergency Departments in the United Kingdom. It covers advice that should be available both when the patient attends, during their time in the department, and when they leave the ED.

Reason for development

The guideline was developed to set standards for patient information, as the sub-committee had concerns about variability in practice. It was thought that clarity of guidance would improve patient experience, through emphasis on the need for, content and quality of information provided to patients.

Guidance

It has been long-appreciated that recall of medical information is not complete, and that advice and instructions are more likely to be forgotten than other information [1]. Many elements have an effect on recall, including the communication skills of clinicians [2].

It is also appreciated that provision of written information is effective in increasing patient recall, improving clinical management and patient satisfaction [3]. Consequently, provision of written information is often a key feature of efforts to inform patients, and enhance patient involvement [4].

Given the anxiety for patients presenting to an ED, and the environment of a typical ED, it is perhaps not surprising that these findings have been replicated specifically in the Emergency Department setting[5], especially with regard to post-discharge care and lack of recall [6]. These findings support the use of providing written information in addition to the verbal advice given by clinicians.

The simplest method of providing advice is probably with the provision of patient information leaflets. Many departments have condition specific leaflets for the more common conditions, and these should be offered to all patients with these conditions. The use of alternative formats such as audio and video recordings, while being effective [3], do require a certain amount of resourcing, both for production and distribution.

Patient information leaflets should be produced that are clearly written and 'professionally' presented, and in accordance with the organisation's standards for publication. There is some evidence that leaflets produced may be written in language that lacks clarity and is inappropriate to the target audience, and that this affects information recall [5]. It is good practice to include patient representatives in the writing of these leaflets.

Advantage could be taken for health promotion and health education within these leaflets (e.g. first aid advice in wounds and burns advice leaflets, advice about alcohol and drug misuse), but the key pieces of information suggested by the evidence above are the key treatment points, and follow up advice/plans. In terms of patient safety, advice about symptoms and signs that would require further assessment should also be included. One method could be to have a generic discharge leaflet that the clinician and the patient review and make bespoke at discharge (this also serves as an 'aide memoire' or checklist for both parties.

A proforma leaflet covering the points in the recommendations could be handed at arrival, and amended by the discharging clinician in conjunction with the patient, thus reducing the number of leaflets.

Generic advice that could also be included is: driving advice, advice about fitness to return to work, pain control/prescription advice, and follow up arrangements.

Contact details for the ED and the organisations' patient advice and liaison service should also be included.

It is important to increase availability of patient information. Many organisations publish all the advice sheets on their website, and this may be the most appropriate format for some patients (additionally it has the benefit of reducing printer material). However, these formats are not suitable for all patients, and paper based versions are required. Whilst there is no evidence to support the open access to patient information leaflets in ED, as many such leaflets are available on the internet, it seems that some form of open access for patients to paper based leaflets should be adopted.

The clinician treating the patient has responsibility for the information given to patients; hence the clinician should read and agree with the information leaflets. If using resources that have not been approved by their employing organisation, care should be used. For many less common conditions, it might be appropriate for the organisation to review and 'endorse' information leaflets produced by outside organisations; however there are issues including validity and copyright to be considered. Documentation, within the clinical record, of the provision of advice leaflets is good practice.

When something goes wrong with patient care, a statutory and ethical duty of candour exists; clinicians must explain what has occurred, apologise, the likely effects, the actions that will be taken (both clinically now, and investigations later). Good availability of Patient Advice and Liaison Service (PALS) leaflets is advised.

In summary, standardisation of written information and an emphasis of provision of this information to patients has the effect of improving recall of information about treatment, and has a positive effect on patient satisfaction.

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Acknowledgements

The RCEM QEC Best Practice Subcommittee members.

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None declared.

Disclaimers

RCEM recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

Research into of the utility of Patient Information leaflets from a patient perspective, and the safety benefits. Further study into the environmental costs of, and minimisation of these.

Audit standards

Audit of percentage of patients receiving advice leaflets.

Key words for search

Patient advice, patient information, Emergency Department

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

Appendix 2

Examples of Advice leaflets are available on the Royal College of Emergency Medicine website.

Example of DISCHARGE patient information leaflet usage in a large Emergency Department (c.80,000 attendances p.a., audited by authors)

Information leaflet	Number required per day	Notes
Generic leaflets		
Welcome and discharge	For all patients (c.230)	
Alcohol and drug advice	3	
Domestic violence	Not Known (NK)	
GUM advice	NK	
Driving advice	NK	
Treatment advice: non- condition specific		
Wound care	18	
Analgesia	35	
Sedation	2	
Sling (broad and high)	7	
Walking aids	6	
Neighbour strapping	4	
Plaster advice	15	
VTE prophylaxis	5	
Soft tissue injury	20	
Condition specific advice: trauma		
Ankle sprain	20	
Calf sprain	1	
Post-concussion syndrome	1	
Chest injury	3	
Neck sprain	3	
Head injury	15	
Mallet injury	Sporadic	
Burns	2	
Shoulder injury	3	
Knee injury	3	

Condition specific advice: non-trauma		
Allergy	3	
'Fits, faints, funny turns'	2	
Epistaxis	1	
Febrile convulsion	1	
Fever in children	5	
Palpitation	1	
Early pregnancy problems	1	
Inhaler use	1	
Antibiotic use	5	
TIA	1	
Headache	1	
MAP	Sporadic	
PEPSE	Sporadic	
Needlestick	Sporadic	
Back pain	5	

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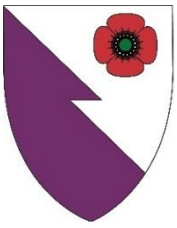

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