The Royal College of Emergency Medicine

Patron: HRH The Princess Royal
7-9 Bream's Buildings
London
EC4A 1DT

Tel +44 (0)207 404 1999
Fax +44 (0)207 067 1267
www.rcem.ac.uk

RCEM Position statement

Further guidance on helping to support patient safety to manage winter pressures: Reducing variation to resource the ED Red Zone 'Hospital Corridor Wards'

December 2018

Introduction

The College notes the recent publication of Health Education England's position statement – ***Supporting winter pressures safely through managed education[1].*** We understand and appreciate the principles set out. Some aspects require clarification to address variation. We also note the statement by the Academy of Medical Royal Colleges (AoMRC) – ***Running to stand still, managing emergency pressures[2],*** which provides a UK view on the importance of how specialties must work closely together to support patient safety at a time of acute stress for our hospitals and added risk for our patients. The College is pleased to support the AoMRC and indeed it complements our own guidance on ***Improving safety for hospital systems[3]*** that are in the Red or Amber Zone this winter.

There is no doubt that the NHS in the UK faces its biggest challenge in almost two decades as the effects of chronic underfunding for the NHS and Social Care are exacerbated and worsened by the normal acute seasonal stressors of colder weather and winter viral illness on patient care delivery. We look forward next year to the additional funding being provided by the Prime Minister but know that in the meantime, care delivery in emergency settings will be extremely challenging. The resultant cancellation of even more elective work will also sadly impact on many patients as hospitals and Emergency Departments become ever more crowded and need to prioritise emergency work. A proportion of these patients we know will go on to deteriorate and require emergency care as a result of waiting for their elective operation. We also note the guidance issued by the **RCS London[4]** in this regard and support their position statement.

Objectives

This further guidance by this College aims to clarify how hospital Executive Boards, Medical Directors and Clinical Directors of services can best work to support the Clinical Directors of Emergency Departments in the context of the guidance issued by HEE (and equivalent devolved nations) and also the AoMRC for the UK as resources are allocated to best maintain patient safety. We know that good systems have planned well to coordinate care delivery in such tough environments.

We hope this guidance will encourage greater consistency in care delivery especially for those patients who are having to wait for prolonged periods of 4-24 hrs or longer in an Emergency Dept hospital corridor awaiting a hospital bed.

Assessment and management of patients in the Emergency Department

The practice of safe and effective Emergency Medicine requires a wide ranging and well-defined set of competencies that are designed to deliver excellent patient care across a wide spectrum of patients and presentations. These are specialty specific and reflect the variety of patients who present to emergency departments. They are there to ensure quality in care for any and all patients presenting to Emergency Departments. Chief amongst these is the ability to safely assess undifferentiated patients at all levels of acuity.

While other specialties may have some overlapping competencies that are useful in some specific parts of emergency care these are largely condition specific and none of these include assessing undifferentiated presentations. The lack of such skills and training introduces significant clinical risk in an Emergency Department. This College believes that it is inappropriate to transfer junior clinicians into an Emergency Department setting without good induction processes and clarity of roles to ensure they are able to practice safely and be well supported by the Emergency Medicine consultant in charge of the department.

Recommendations for Medical Directors & Clinical Directors of Services

Strategic considerations

1. We recommend that Medical Directors of hospitals & Trusts follow guidance issued by NHS Health Education England (and equivalent bodies in devolved countries) and liaise closely with Postgraduate Deans, Directors of Medical Education & Clinical Directors to have clear escalation plans in place to support managed education balanced with ensuring patient safety this winter.
2. We recommend that the major pressure points within a system are identified by the Executive Boards and prioritised for support. Emergency care systems should link support according to whether their system is in the Red Zone or Amber Zone. Hospital & Trust Executive Boards that are in the ED Red Zone[3] must have strategic focus to give the ED Red Zone as its highest priority on their Risk Register and devise management plans accordingly.
3. In regard to support for the crowded Emergency Department Red Zone we would recommend that the Executive Board & Medical Director work closely with all relevant Clinical Directors with regard to safety and allocation of medical, nursing and allied health professional resources to support the ED staff as they attempt to maintain safety for patients in the ED.
4. Specifically, a major focus must be to implement robust hospital plans to care for patients who are awaiting a hospital bed on a 'hospital corridor ward' area thus allowing ED staff to care for and manage new ED attendances. A Standard Operating Procedure (SOP) with relevant induction materials for

hospital staff working to support the Hospital Corridor Ward should be developed and provided.

5. The Hospital Corridor Ward teams can be de-escalated and stood down once there is capacity within the hospital and there are regularly less than 6 patients waiting a hospital bed in the ED – that is, the ED is no longer in the Red Zone and a safer care environment has been achieved.

Specific recommendations

1. The Clinical Director for the Emergency Department should be supported to have adequate clinical staff to see patients presenting to the Emergency Department.
    a. This will require flexibility in their approach to locum and agency payments in order to absolutely minimise 'rota gaps' that significantly impact on patient safety. Flexibility in terms of rates must be provided to ensure staff are available.
    b. Clinical Directors in Emergency Medicine should already be engaged with their Executive Boards to be planning for the medium term also in order to enhance their junior clinical workforce and move steadily towards RCEM standards for the EM consultant workforce[6]. This will help to significantly reduce the locum and agency spend in EDs of over £400 million in England alone. It will also help to improve the quality of care delivery, enhance ambulatory emergency care strategies and reduce litigation in the long term as recommended levels of trained EM staffing are achieved.

2. In systems that are in the Red or Amber Zone (with significant delays to access a hospital bed) and being managed as a ward patient on the Emergency Department Hospital Corridor, then a specific allocation of staff and allied resource should be provided by the hospital teams to manage such patients – in the ***Red Zone 'Hospital Corridor Ward'***. Clear principles of staffing for the Red Zone Hospital Corridor Ward (HospCW) should be agreed.

    We make recommendations and responsibilities that Medical & Nursing Directors should have within their induction packs for the Hosp CW Team:

    a. **A staffing model** to manage the '**Hospital Corridor Ward**' in an Emergency Department that is in the Red Zone to be:
        i. One qualified nurse from the main hospital, one Clinical Support Worker and one junior doctor from a relevant specialty ideally who has received appropriate induction per 12 patients awaiting a bed in the main hospital
        ii. The junior doctor should be supervised by a relevant in-hospital admitting specialty consultant

iii. The 'HospCW team' must have SOPs provided that clearly describe how they access and link to and supported by senior specialty colleagues.

b. **The 10 main responsibilities** of the Hosp CW team;

i. Maintaining **dignity** of patients in such a tough environment is an absolute priority.

ii. **Therapeutic interventions** such as antibiotics and pain relief are delivered on time. Oxygen tanks on trolleys must be regularly checked.

iii. The patient's **normal medications** are given at the right time.

iv. The patient is given regular **warm fluids** if appropriate especially in cold corridors (tea, coffee, food) and intravenous fluids regularly reviewed.

v. Ensure patients are **kept warm in a 'corridor ward'** environment with enough blankets.

vi. **Patient's relatives** are given somewhere to sit and support them.

vii. Regular structured **documentation** occurs to review status of patient.

viii. The clinician and nursing team link regularly with **relevant specialty teams** responsible for their care to maintain and revise management plans at a minimum of six-hourly intervals.

ix. Regular physiology & observations are recorded to judge any **deterioration and re-priortise** patients as required.

x. Most importantly – **communicate regularly** with the patient and their relatives. Explain how long it might be before they are provided a safer environment in the hospital.

3. If hospital junior clinical staff are being considered to work in the main Emergency Department, all should have been through a short induction, be provided with a detailed induction pack and have clear guidance on line management being to the Emergency Medicine Consultant in charge of the Emergency Department.

4. Senior medical staff from relevant specialties will be working closely with senior Emergency Department colleagues and focused on creating capacity and flow within their own specialty assessment and admission areas as well as managing outliers within the hospital during this time whilst their hospital is in the Red Zone.

   It is also vital that they are involved with and help lead the Hospital Corridor Ward team. Specialty team seniors must regularly communicate with the Emergency Medicine consultant in charge of the ED to judge and mitigate risk.

References

1. https://www.hee.nhs.uk/sites/default/files/documents/HEE%20winter%20pressures%20guidance.pdf
2. http://www.aomrc.org.uk/wp-content/uploads/2018/12/2018-12-14_Running_to_a_stand_still.pdf
3. https://www.rcem.ac.uk/RCEM/Quality_Policy/Policy/Winter_Planning/RCEM/Quality-Policy/Policy/Winter_Planning.aspx?Winter%20Planning
4. https://www.rcseng.ac.uk/news-and-events/news/archive/guidance-to-help-manage-winter-pressures/
5. https://improvement.nhs.uk/documents/3016/EC_workforce_stabilisation_best_practice_guidance_Final.pdf
6. https://www.rcem.ac.uk/docs/Workforce/RCEM%20Workforce%20Recommendations%202018%20-%20Consultant%20Staffing.pdf