The Royal College of Emergency Medicine

Clinical Audits

EXCELLENCE IN EMERGENCY MEDICINE

Consultant Sign-off
Clinical Audit Information 2016/2017

Background

Emergency Medicine (EM) is a rapidly developing specialty. Over the past 40 years the Emergency Department (ED) has become the "front door" of the acute hospital, responsible for the management of 15 million patients every year in England alone. Some of the sickest patients in the hospital will be found in the ED, and the level of clinical risk is very high because ED clinicians are required to make critical decisions under conditions of considerable uncertainty with limited information, limited resources and limited time. Published research indicates that consultant-delivered care reduces waiting times and length of stay, improves clinical outcomes and ensures that patients are only admitted to hospital if there is no reasonable alternative (Wyatt et al, 1999; Thornton & Hazell, 2008; Geelhoed et al, 2008; White et al, 2010).

The ED is an excellent training area for junior doctors, because they are required to see a large number of acutely ill and injured patients and make important clinical decisions. This provides effective training, but it also has the effect of matching inexperienced staff with very sick patients, creating high levels of clinical risk. In addition, nurse practitioners increasingly work within EDs, as do professional groups not fully trained in EM (e.g. General Practitioners). In response, EM consultants have put in place systems to support their teams and manage risk. Not all EDs have enough EM consultants to provide a consistent 24/7 presence. Despite this there is an increasing expectation that care will be delivered and supervised by fully-trained consultant medical staff.

The Royal College of Emergency Medicine advocates progressive EM consultant expansion in order to improve the quality and timeliness of care, and enhance the support provided to junior doctors and other practitioners working within the ED. The College believes that it is appropriate to specify particular high-risk patient groups who should be reviewed by a consultant in EM before they are discharged from the ED.

This topic was previously audited in 2011/12. Following a subsequent data-based review in 2016, the relevant patient groups for the 2016/17 audit have been revised. These patient groups have been selected on the basis that they are important ED presentations with a risk of life-threatening disease that may not be immediately appreciated by less experienced staff.

It is accepted that some EDs, particularly those with lower numbers of EM consultants, will find it challenging to adopt this standard. However its purpose is to promote improved risk management by reducing the possibility of catastrophic clinical error, whilst at the same time supporting the case for an expansion in EM

consultant numbers. Where it is not feasible to immediately implement this standard the College recommends that EDs have in place a plan to both address the clinical risk and work towards achievement of the standard, through an increase in EM consultant numbers.

Review by a senior trainee or similarly experienced doctor is considered an interim measure pending a move towards extended EM consultant shop floor presence. EDs are encouraged to work towards this standard in association with their employing Trust.

Aims and objectives
The purpose of the audit is:
1. To benchmark current performance in EDs against the standards
2. To allow comparison nationally and between peers
3. To identify areas in need of improvement

The standard
The following four high-risk patient groups should be reviewed by a consultant in EM prior to discharge from the ED (includes patients who die in the ED).

1. Atraumatic chest pain in patients aged 30 years and over
2. Fever in children under 1 year of age
3. Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge
4. Abdominal pain in patients aged 70 years and over

If, due to insufficient numbers of consultant staff, an EM consultant in not immediately available on the "shop floor" of the ED, then review may be carried out by a senior trainee in EM (ST4 or above), or by a staff grade or similar substantive career grade doctor with sufficient ED experience to be designated to undertake this role by the EM consultant medical staff.

Junior doctors should have formulated a clear diagnosis or differential diagnosis and documented their proposed action plan prior to seeking EM consultant sign-off. The consultant review should be recorded in the patient's clinical notes, and should normally include the patient being seen and reviewed in person by the EM consultant. If the consultant is unable to make a contemporaneous note in the patient's ED record they should countersign the notes at the next opportunity, making a record of the date and time that this occurs.

Inclusion criteria
General:
- Patients in the four high-risk patient groups presenting to the ED should be included in the audit if discharged home
- Include patients who die in the ED.

Patient groups
This audit includes the following four high-risk patient groups:
1. Atraumatic chest pain in patients aged 30 years and over
2. Fever in children under 1 year of age

3. Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge
4. Abdominal pain in patients aged 70 years and over

Exclusion criteria

- Patients admitted to an inpatient ward outside of the ED
- Patients leaving the ED before being seen
- Patients directly referred to other specialities from primary care

Sample size

RCEM recommends auditing a different number of cases depending on the number of patients *in each patient group* that you expect to see within the data collection period. The recommended minimum is 10 cases for each patient group.

If this is an area of concern in your ED, you are able to submit data for more cases for an in depth look at your ED's performance.

Basing the audit sample size on the number of cases in this way increases the reliability of your ED's audit results.

Audited cases should be consecutive during the data collection period (1 January 2016 to 31 December 2016).

Expected number of cases	**Recommended audit sample**
< 50	All eligible cases
50-250	50 consecutive cases
>250	100 consecutive cases

Data collection period

From 1 January 2016 to 31 December 2016.
Note: You can start the audit at any point during the data collection period, as long as you submit the data by 31 January 2017.

Data submission period

Data can be submitted online at the link below between 1 August 2016 to 31 January 2017: https://rcem.l2s2.com

Data Sources

ED patient records (paper, electronic or both).

Standards

STANDARD	**GRADE**
The following high-risk patient groups should be reviewed by a consultant in EM prior to discharge from the ED:	
1. Atraumatic chest pain in patients aged 30 years and over	D
2. Fever in children under 1 year of age	D
3. Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge	F
4. Abdominal pain in patients aged 70 years and over	D

Grade

F - Fundamental: need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels and service provision need to be in accordance with at least these fundamental standards. No provider should provide any service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

D - Developmental: set requirements over and above the fundamental standards.

A - Aspirational: setting longer term goals.

Standards definitions

Standard	Term	Definition
All	Discharge	Discharge home (or to the patient's usual place of residence) from the ED. Do not include patients discharged from another specialty. Include patients who die in the ED.
2	Fever	Temperature of ≥38˚C at triage/ED arrival, not prior to arrival or subsequently.
3	Unscheduled return	Do not include patients who leave before being seen and then re-attend within 72 hours
3	Unscheduled return	Do not include patients who return within 72 hours and then leave before being seen

Organisational audit – about your ED					
Q1a-e: Only one response per ED is required Q1a-e: Only non-English EDs should complete this section. English EDs should instead complete the Census run by HEE					
Q1a	How many patients attend main Emergency Department per year? *(To nearest thousand per annum)*	Leave blank if unknown			
Q1b	What is the casemix of your ED?	Adults only			
		Children only			
		Both adults and children			
Q1c	On a **weekday**, assuming all shifts are filled, how many staff would **usually** be on each **clinical** shift? *(RCEM recommends using July 2016 as the census month)*		Morning shift	Afternoon/ evening shift	Night shift
		Consultant	Leave blank if unknown	Leave blank if unknown	Leave blank if unknown
		Tier 4 (ST4+, senior clincial fellows, SaS)			
		Tier 3 (CT3, clinical fellows, some GPs, junior SaS)			
		Tier 2 (F2, CT1,2 some GPs)			
		Tier 1 (FY1)			
		Non-medical practitioner (e.g. nurse)			
Q1d	On a **weekend**, assuming all shifts are filled, how many staff would **usually** be on each **clinical** shift? *(RCEM recommends using July 2016 as the census month)*		Morning shift	Afternoon/ evening shift	Night shift
		Consultant	Leave blank if unknown	Leave blank if unknown	Leave blank if unknown
		Tier 4 (ST4+, senior clincial fellows, SaS)			
		Tier 3 (CT3, clinical fellows, some GPs, junior SaS)			
		Tier 2 (F2, CT1,2 some GPs)			
		Tier 1 (FY1)			
		Non-medical practitioner (e.g. nurse)			
Q1e	How many **vacant posts** do you currently have? *(RCEM recommends using July 2016 as the census month)*	Consultant	Leave blank if unknown		
		Tier 4 (ST4+, senior clincial fellows, SaS)			
		Tier 3 (CT3, clinical fellows, some GPs, junior SaS)			
		Tier 2 (F2, CT1,2 some GPs)			
		Tier 1 (FY1)			

		Non-medical practitioner (e.g. nurse)	
Organisational audit – about consultant sign-off			
Q1f-h: Only one response per ED is required Q1f-h: All EDs should complete this section			
Q1f	How easy is it to collect data about Consultant sign-off in your ED?	Fully automated	
		Straightforward	
		Problematic	
		Difficult	
Q1g	In your opinion, does the existence of the consultant sign-off standard have an effect on the clinical management of patients? If so, what are the effects?	Yes	
		No	
Q1h	In your opinion, does the existence of the consultant sign-off standard have an effect on the decision to admit or discharge patients? If so, what are the effects?	Yes	
		No	

Patient audit			
All EDs should complete this section			
Q2	Patient reference		
Q3	Date of arrival (dd/mm/yyyy)	dd/mm/yyyy	
Q4	Time of arrival (Use 24 hour clock e.g. 11.23pm = 23:23)	HH:MM	
Q5	Patient group	Atraumatic chest pain in patients aged 30 years and over	
		Fever in children under 1 year of age	
		Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge	
		Abdominal pain in patients aged 70 years and over	
Q6	Patient outcome	Discharged from the ED	
		Patient died	
		Not recorded	
Q7a	Grade of most senior ED doctor to actually see and assess the patient in person	Consultant	
		Associate specialist	
		Staff grade/specialty doctor	
		Senior clinical fellow (registrar or equivalent)	

		Junior clinical fellow (SHO or equivalent)	
		ST4-7	
		ST3	
		ST1-2	
		FY1-2	
		Non-medical practitioner (e.g. nurse)	
Q7b	Was this doctor a locum?	Yes	
		No	
		N/A	
Q8a	Grade of most senior ED doctor with whom the patient was discussed during their visit to the ED	Consultant	
		Associate specialist	
		Staff grade/specialty doctor	
		Senior clinical fellow (registrar or equivalent)	
		Junior clinical fellow (SHO or equivalent)	
		ST4-7	
		ST3	
		ST1-2	
		FY1-2	
		Non-medical practitioner (e.g. nurse)	
Q8b	Was this doctor a locum?	Yes	
		No	
		N/A	
Q9a	Grade of most senior ED doctor to retrospectively review the patient's case following their visit to the ED	Consultant	
		Associate specialist	
		Staff grade/specialty doctor	
		Senior clinical fellow (registrar or equivalent)	
		Junior clinical fellow (SHO or equivalent)	
		ST4-7	
		ST3	
		ST1-2	
		FY1-2	
		Non-medical practitioner (e.g. nurse)	
		Not reviewed	
Q9b	Was this doctor a locum?	Yes	
		No	
		N/A	

Notes

Question and answer definitions

Question	Definition
Q1c-d	Do not include shifts by staff working pre-hospital unless this is part of this trust Do not include non-clinical activity in the clinical shifts e.g. management, teaching (even if on the floor)

References

1. Geelhoed GC, Geelhoed EA. Positive impact of increased number of emergency consultants. Arch Dis Child 2008;93:62-64.

2. Thornton V, Hazell W. Junior doctor strike model of care: Reduced access block and predominant Fellow of the Australasian College for Emergency Medicine staffing improve emergency department performance. Emergency Medicine Australasia 2008;20:425-30.

3. White AL, Armstrong PAR, Thakore S. Impact of senior clinical review on patient disposition from the emergency department. Emerg Med J 2010;27:262-265.

4. Wyatt JP, Henry J, Beard D. The association between seniority of Accident and Emergency doctor and outcome following trauma. Injury 1999;30(3):165-168.