Royal College of Emergency Medicine

Best Practice Guideline

College Publications

January 2022

Summary of recommendations

1. RCEM publications must have been subject to the review and approval processes as described within the Terms of Reference of the relevant committee, including peer and lay review.
2. College publications are available on the College website open access platform, therefore must be written with appropriate professional standards of composition. This includes precision in grammar and punctuation, clarity and brevity of message, avoiding potential offense, ensuring patient-centeredness.
3. There is a College style, which should be adhered to, this includes Vancouver referencing and formatting. There are proforma examples of the common RCEM publications.
4. The common RCEM publications are:
    a. Press release, from President's office (not covered by this guidance)
    b. Position statement, a short article on a precise, specific clinical question
    c. Guidelines, longer article describing an aspect of a clinical topic
    d. Toolkit, these consider a large clinical area, and can include a range of tools to implement a clinical service in this area (e.g., clinical guidelines, job descriptions for strategic personnel etc)

Scope

This guideline was produced as a document to advise and assist those clinicians who have been commissioned (or volunteered) to write an article for publication by the College.

Reason for development

This guidance was commissioned by the Quality in Emergency Care committee, in recognition of the need for guidance for those undertaking the writing of articles for consideration of publication by the Royal College of Emergency Medicine.
This is to smooth the processes for review by the relevant committees, and to ensure that submitted articles are of a good standard and have a higher chance of publication.

Introduction

Publications issued by the RCEM ultimately have the aim of improving patient care. There is an established review process within the Terms of Reference of the various committees and sub-committees. Therefore, the articles are reviewed by peers, lay members, and quality controlled by College officers.

There are standard formats for guidelines and position statements, and these are included in the Appendices. These are in Word™, to enable editing.

There is a 'house style' embedded in these documents; font is Century Gothic, 12 point, single spaced, justified (flush left and right margins), Vancouver referencing. References will be denoted by numbers using superscript, sentences will start with 2 spaces prior to capitalisation and main headings will be 14 point.

The document should have readability scores at 'graduate' level and be in the third person.

These documents need to be written considering the fact that they are publications for a professional body for a professional audience; therefore, the standard should be similar to that expected of a peer-review publication. However, these documents are also designed to be useful, quick reference documents; so, clarity and brevity are also essential elements; the inclusion of tables or information boxes can help with this process.

These documents are also available on the RCEM website (with 'open access') when writing these documents this fact should also be considered.

Position statements should be no more than two sides of A4 (less than c.500 words, after formatting and application of styling/branding. These should address the RCEM position on a specific area, and consist of brief introduction, statement of position and clarification of any associated or related issues. Recent examples include Sepsis in the Emergency Department and Cauda Equina Syndrome.

Guidelines cover a broader area, and present a series of best practice points, usually with associated standards. Guidelines are produced when the utility is demonstrated, for example areas of clinical controversy where little robust evidence exists or areas of particular concern or anxiety to Fellows and Members. RCEM guidelines usually exclude areas where unequivocal, accepted guidelines already exist.

With an RCEM guideline, a series of recommendations is made, which forms the front page. These should be clear, precise and actionable (that is, not aspirations, or self-evident statements). The scope and reasons for development are separate sections, as are audit and research suggestions. Authorship should be clear. The body of the text (as with toolkits) is as evidence based as possible, referenced as appropriate. The narrative should be clear; that is the recommendations should relate to explanatory statements in the body of the text. Recent examples include The Patient who Absconds and Management of Suspected Internal Drug Traffickers (SIDT).

Toolkits cover a wider area, and are designed to have a series of resources and tools to enable a service implementation, these tools often include clinical pathways and guidance, job descriptions for key personnel, business plans etc. Authorship should be clear. The body of the text is as evidence based as possible, referenced as appropriate. The narrative should be clear; that is the strategy described should relate to explanatory statements in the body of the text. Recent examples include The Safety Toolkit and Mental Health in the ED.

Authorship

The authorship of articles will be clear, as will any significant contributors. It should be remembered by authors that the editorial process involves review by the Quality in Emergency Care Committee and that RCEM will retain ultimate responsibility for that which is published in its name; submitted drafts may be changed to a greater or lesser extent as part of this process. RCEM may wish to seek endorsements from other professional bodies and this will also be taken into account during the editorial process.

Authors will need to include any relevant declarations of interest e.g. positions of responsibility or financial interests held in relation to the article's content.

Authors

James France, Simon Smith

First published in 2015, Simon Smith

Acknowledgements

QEC Committee

Endorsements

None

Review

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

Declaration of Interests

None

Disclaimers

The College 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

None

Audit standards

None

Key words for search

Guideline

Appendix 1

Examples

Example 1 – Common Errors

"In addition to pain being commonly under-recognised, I also think that it is frequently under-treated and that this treatment may be delayed, often by a considerable time [2,3].

We never should undertreat pain, and we always should attempt to ensure that recognition and alleviation of pain should be a priority when treating the ill, the injured and all patients in our departments. This process should commence at the triage, continue and be monitored throughout patients' time in the ED and finish with ensuring maintenance of adequate analgesia at, and if appropriate and necessary, beyond discharge. There is some evidence that pain relief is related to the important factor of patient satisfaction, and can therefore affect patient satisfaction [4]."

Issues are:
- Split infinitives
- Use of personal pronouns
- Double negative use
- Verbosity
- Repetition and redundancy of statements
- Unreferenced statements
- Grandiose language
- Use of 'wavering' statements

Better written as:

"Pain is commonly under-recognised, under-treated and treatment may be delayed [2,3].

Recognition and alleviation of pain should be a priority when treating the ill and injured. This process should start at the triage, be monitored during their time in the ED and finish with ensuring adequate analgesia at, and if appropriate, beyond discharge. There is some evidence that pain relief is related to patient satisfaction [4]."

Example 2

"**Screening**
There are a number of screening tools such as the Paddington Alcohol Test (PAT) and the Audit C that are considered to be useful in EDs nationally in the UK.

The PAT tool can be found in appendix 1; Prof Touquet's paper on the PAT.

AUDIT-C
This is now more commonly being used in the Emergency Department Setting and is a shortened version (only 3 questions) of the AUDIT tool. It focuses on rapidly and quickly identifying those whose drinking increasing and higher risk drinking as well as dependent drinking. Of particular benefit in the ED setting, the shortened identifies those who are drinking at increasing/higher risk levels before their drinking becomes problematic or dependent. AUDIT can be used with patients of all ages, including problem drinkers who are children legally.

Implementing screening
The people who benefit from Identification and subsequent brief Intervention are the increasing and higher risk drinkers.

An ongoing active education programme to all staff groups needs to include screening to ensure that the correct questions are asked at the appropriate times in the patient's journey through the Emergency Department pathway. The Triage Nurse can enquire as to whether the attendance is alcohol related: and the ED Clinician would be appropriate to perform screening using a Tool described as above.

Barriers to using screening tools
Screening every patient over the age of 18 years can be thought to be too arduous for clinicians in the ED, and a task that is unpleasant; staff may have prejudices about alcoholics . Prof Touquet et al suggested that the 'top 10 conditions' should be screened as these were deemed to be 'high risk' alcohol related conditions. At Southern Hospital we have set up a system that the Symphony IT system 'enquires' about alcohol for every adult patient on entry of the diagnosis. This ensures that the Clinician seeing the patient has to 'think about' alcohol as a secondary diagnosis on every patient. However, the entry is only accurate if the patient has actually been asked about their alcohol consumption. An 'easy' process to initiate screening is that of the Receptionist inserting a PAT/AUDIT-C form into all adult 'CAS' cards/notes to enable the trigger that the form needs completing. The 'Alcohol Champion' (see below) needs to decide on which group of ED staff is the most appropriate to perform the screening in their own ED. "

Issues are: Anecdote use
Use of personal pronouns and trademarks
Not Vancouver referencing style
Not in 'house style'
Grammar and spelling errors
Lack of clarity; heading use
Potential for offense

Better written as:

"2.3 Implementing screening

The people who benefit from identification and subsequent brief intervention are the escalating and higher risk drinkers.

An ongoing active education programme to all staff groups needs to include screening to ensure that the correct questions are asked at the appropriate times in the patient's journey through the Emergency Department pathway. The Triage/Initial Assessment Nurse can enquire as to whether the attendance is alcohol related and the ED Clinician would be appropriate to perform screening using a tool described as above.

Barriers to using screening tools

Screening every patient over the age of 14 years can be thought daunting for clinicians in the ED. Professor Touquet suggested that the 'top 10 conditions' [(9)] should be screened as these were deemed to be 'high risk' alcohol related conditions. Information Technology (IT) can be configured to ensure clinicians 'enquire' about alcohol for every adult patient on entry of the diagnosis. This ensures that the Clinician seeing the patient has to 'think about' alcohol as a secondary diagnosis on every patient. However, the entry is only accurate if the patient has actually been asked about their alcohol consumption. A paper process to initiate screening is that of the Receptionist inserting a PAT/AUDIT-C form into all adult 'CAS' cards/notes to enable the trigger that the form needs completing. The 'Alcohol Champion' (see below) needs to decide on which group of ED staff is the most appropriate to perform the screening in their own ED, and on which patient groups.

It can be difficult to know how a clinician can start a conversation with a patient regarding their drinking but there are ways in which it can be brought up e.g.

'This is a routine set of questions that we ask all patients in the ED'
'During this initial assessment we want to make sure that we can put you in contact with any support you may want/need, so I'm going to ask you about your lifestyle'.

Education also needs to address attitudes of staff to alcohol related attendances. A questionnaire (Appendix 3) is a useful tool to find out about attitudes of staff to this group of patients. Once issues have been addressed (e.g. through education) then a screening process becomes easier to implement within the Emergency Department."

Examples of each publication type can be found on the RCEM website:

https://www.rcem.ac.uk/RCEM/Quality_Policy/Clinical_Standards_Guidance/RCEM_Guidance/RCEM/Quality-Policy/Clinical_Standards_Guidance/RCEM_Guidance.aspx

RCEM
Royal College of Emergency Medicine

The Royal College of Emergency Medicine
54 Ayres Street
London
SE1 1EU

Tel: +44 (0)20 7400 1999
Fax: +44 (0)20 7067 1267

www.rcem.ac.uk

Incorporated by Royal Charter, 2008
Registered Charity number 1122689

Excellence in Emergency Care