The Royal College of Emergency Medicine

Best Practice Guideline

Measuring the Quality of Patient Care in the Emergency Department

Scope

Emergency Departments should aim to provide a safe, committed, compassionate and caring service. This guideline has been developed to help medical and nursing staff within Emergency Department (EDs) provide better care for their patients.
It has been developed from the *Patient Care in the ED* document; the aim is to define measurable standards for assurance and Quality Improvement.
The importance of Patient Experience Measures and Patient Reported Outcome Measures are highlighted, explained and discussed in the appendices.

Reason for development

The document aims to:

- Define standards for patient care in the ED,
- Identify measurements to enable EDs to assess the quality of care,
- Highlight the importance of patient experience, and measurement of this

Introduction

Patient Care in the ED provides a checklist of care initiatives directed at improving patient experience and the quality of care given to patient, covering the following themes:

- The patient environment
- The Patient pathway through the ED
    - Arrival
    - Early Assessment
    - Assessment and diagnosis
    - Continuing and ongoing care
    - Discharge
- Care for specific patient groups
    - Care of the elderly patient
    - Care of children
    - Care of patients with complex requirements
- Departmental and staff requirements
    - The ED team
    - Education about care
    - Measuring care and leadership

The 'Standards' within *Patient Care in the ED* are graded as either 'Fundamental' or 'Developmental'. These are presented as questions for leaders to consider. Fundamental standards are those which every ED should routinely achieve. Developmental standards are those which departments should be working towards. Achieving these standards requires commitment and support. Emergency Departments are encouraged to regularly analyse their practice using this document, and to regularly audit, to assess compliance with the standards. Where a standard cannot be met, this should be escalated to those who can take appropriate action.

This document should be read in conjunction to these additional linked documents:

Patient Experience in Emergency Departments: A strategic Overview
A Safe Emergency Department: A strategic Overview
Emergency Department Standards: A strategic Overview
RCEM QUALITY IMPROVEMENT GUIDE: A practical guide for clinicians undertaking quality improvement in Emergency Departments

The activity and the role of the Royal College of Emergency Medicine (RCEM) in Quality of Emergency Healthcare is explained in the document:

Royal College of Emergency Medicine Quality Strategy

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Arrival	Welcome and booking in	**Care in Emergency Departments (previously '50 at 50')** Standard 1 All areas of the ED clean and well lit Standard 3 The signage and information for the patients is sufficient to enable easy navigation to, through and from the Emergency Department Standard 4 Clinical areas enable patients to retain dignity and privacy, including facility to register with privacy Standard 7 Relatives and carers catered for: sufficient cubicle seating for patients' relatives and carers, patient and relatives can communicate with staff, bereaved relatives cared for sensitively Standard 8 A message for recumbent patients on the ceiling tiles in the Resus room/cubicle areas Standard 12 Patients, arriving by any means, warmly greeted by a named person **Patient experience in Emergency Departments**	'Mystery shopper' feedback** Evidence of learning from complaints, feedback, incidents Audit of compliance with RCEM standards	Specific Patient experience measures * Including questions regarding: Ease of booking in 'How easy was the process of booking in?' (Likert scale) Warmth of welcome 'How Welcoming and friendly were the staff (at reception)' (Likert scale) Ease of navigation/explanation of processes 'Did the staff explain what was going to happen, at all stages of your care?' 'How easy was it to find your way around the department'' (Likert scale)	**Patient centred**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Staff introductions	**Care in Emergency Departments (previously '50 at 50')** Standard 12 Patients, arriving by any means, warmly greeted by a named person Standard 13a Staff introduce themselves by name, as well as identify their role and position Standard 13b Staff identify the rationale for all interactions with patients	Care and communication skills training attendance Audit of compliance with RCEM standards	Specific Patient experience measures Including questions regarding: 'Did the staff introduce themselves' (sometimes/always/never) 'How well did the staff listen to your concerns' (Likert Scale) Observed metrics	**Patient centred**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Processes explained	**RCEM Advice on Giving Information to Patients** **Care in Emergency Departments (previously '50 at 50')** Standard 14 ED processes, and patient journey explained clearly Standard 15a Patients clearly told how to access staff when they have needs or concerns Standard 15b Access to staff facilitated by the department, to make it as easy as possible	Measurements of signage, advice leaflets presence and use 'Mystery shopper' feedback** Assessments of accessibility	Specific Patient experience measures Including questions regarding: Ease of navigation/explanation of processes (As above) 'How well did the staff explain your care/treatment/medications/follow up' 'How well did the staff answer your questions?' (Likert scale) 'Did the staff tell you how to gain their attention' (yes/no) 'How quickly did the staff come when you called?' (quickly/slowly/not at all)	**Patient centred** **Accessible**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Privacy and dignity maintained	**Care in Emergency Departments (previously '50 at 50')** Standard 4 Clinical areas enable patients to retain dignity and privacy, including facility to register with privacy		Specific Patient experience measures Including questions regarding: 'Did the staff treat you with dignity and respect' (Likert scale) Privacy questions as below Environmental review/audit Incident/complaint reviews	**Patient centred**
Patient Pathway within wider system	Does the patient pathway: Segue with the whole system Minimise 'movement' and re-direction (and handovers) **	Patients should experience a pathway which is as smooth as possible, and co-ordinated Each interaction for elements of system should progress care **Patient experience in Emergency Departments**	'Time and Motion' studies of patient movement and handovers Process mapping of patient journey	Specific Patient experience measures Including questions regarding: Navigation, as above, explanation as above Complaint analysis	**Patient centred** **Effective**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Early Assessment	Establish patient expectations and wishes Of visit Capacity Concerns Specific requirements	**RCEM Advice on Giving Information to Patients** **Patient experience in Emergency Departments** **Care in Emergency Departments (previously '50 at 50')** Standard 15a Patients clearly told how to access staff when they have needs or concerns Standard 15b Access to staff facilitated by the department, to make it as easy as possible Standard 17a Patients routinely given forecasts (every 30 mins), documented in records Standard 17b The process of care clearly explained Standard 24 Patients given regular updates to forecasts (every 30 mins), documented in records	Care and communication skill training attendance Establishing specific patient requirements (including access issues)	Specific Patient experience measures Including questions regarding: 'Did the staff ask you about your concerns/needs?' 'Did staff address your concerns/needs?' (sometimes/always/never) 'Did you have confidence in the staff looking after you?' (Likert scale) Did you have enough time with clinicians?' (Likert scale) Audit of clinical records	**Patient centred** **Equitable**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Early identification of time critical condition: Timely	*e.g. Sepsis, Trauma, fracture NOF, Stroke, MI, end of life* *National guidance e.g. NICE* **Emergency Department Standards** **Safety in Emergency Departments** **Care in Emergency Departments (previously '50 at 50')** Standard 16 Nursing staff at patient entrances have easy and timely access to a senior doctor for treating sick patients as well as prescribing analgesia for severe pain Standard 18 Processes for rapid identification of unwell patient, and escalation of concerns in place, and compliance audited Standard 19 A process for rapid treatment of time critical conditions exists, that is audited for timeliness and effectiveness Standard 44 All young children with vomiting and diarrhoea +/-dehydration to start oral rehydration therapy on arrival	This is helped if nurse at entrance is trained to use PGDs for analgesia/anti-emetic/anaphylaxis and allergy medication /bronchospasm medication/Oxygen etc	Specific elements within: Clinical Review of Standards National audit databases***: e.g. TARN, FFACP, SSNAP, MINAP, NACEL Royal College and specialist society audits	**Timely**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Early identification of time critical condition: Effective	As above		As above and: Specific patient experience measures Patient reported outcome measures*** Including questions regarding: 'Did you get assessment/ treatment of your symptoms quickly (within 30minutes)' 'Did this treatment work?' (yes/no) 'How effective was this treatment at reducing your symptoms?' (Likert Scale) Changes in physiological measures for unwell patients (audit)	**Effective**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Treatment of time critical conditions: Timely	**Care in Emergency Departments (previously '50 at 50')** Standard 16 Nursing staff at patient entrances have easy and timely access to a senior doctor for treating sick patients as well as prescribing analgesia for severe pain Standard 19 A process for rapid treatment of time critical conditions exists, that is audited for timeliness and effectiveness Standard 20 A process for early treatment of symptoms exists, and is audited for timeliness and effectiveness		As above	**Timely**
	Treatment of time critical conditions: Appropriate	As above		As above	**Efficient**
	Treatment of time critical conditions: Effective	As above **Safety in Emergency Departments** **Patient experience in Emergency Departments**		Specific patient experience measures Patient reported outcome measures*** Changes in physiological measures	**Effective**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Early treatment of symptoms: Timely	**RCEM pain guidance** **Patient experience in Emergency Departments** **Care in Emergency Departments (previously '50 at 50')** Standard 20 A process for early treatment of symptoms exists, and is audited for timeliness and effectiveness Standard 44 All young children with vomiting and diarrhoea +/-dehydration to start oral rehydration therapy on arrival	Audit of timing of analgesia	RCEM National QIP programme Specific patient experience measures Patient reported outcome measures*** Including questions regarding: 'Did you get assessment/ treatment of your symptoms quickly (within 30minutes)' 'Did this treatment work?' (yes/no) 'How effective was this treatment at reducing your symptoms?' (Likert Scale)	**Timely**
	Early treatment of symptoms: Appropriate	**Patient experience in Emergency Departments**	Audit of delivery of analgesia against Standards (i.e. appropriate to pain score)	RCEM National QIP programme	**Efficient** **Effective**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Early treatment of symptoms: Effective	**RCEM pain guidance** **Patient experience in Emergency Departments** **Care in Emergency Departments (previously '50 at 50')** Standard 20 A process for early treatment of symptoms exists, and is audited for timeliness and effectiveness	Audit of pain scoring	RCEM National QIP programme Specific patient experience measures Patient reported outcome measures*** Including questions regarding: 'Did staff review your symptoms, and give additional treatment if needed?' (Often/sometimes/never)	**Effective**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Early investigations: Timely	*e.g. ECG, bloods, imaging* **Care in Emergency Departments (previously '50 at 50')** Standard 16 Nursing staff at patient entrances have easy and timely access to a senior doctor for treating sick patients as well as prescribing analgesia for severe pain Standard 22 A process exists for initiation of investigations which is early and appropriate Safety in Emergency Departments	Audit of timing of investigations This requires nursing staff at entrances/assessment to be able to request investigations (including imaging)		**Timely**
	Early investigations: Appropriate	**RCEM guidance on Investigation use in the ED**	Audit of usage of care set, investigation use/appropriateness)		**Efficient** **Effective**
	Early investigations: Reviewed	**Care in Emergency Departments (previously '50 at 50')** Standard 23 Regular, documented reviews of patients, including comfort and clinical needs (within 5 mins for VBG/ECG)	Audit of 'sign off' and accuracy of interpretation Audit of clinical records		**Effective** **Timely** **Efficient**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Forecast/processes explained	**Care in Emergency Departments (previously '50 at 50')** Standard 23 Regular, documented reviews of patients, including comfort and clinical needs (every 30 minutes) Standard 24 Patients given regular updates to forecasts (every 30 mins), documented in records		Specific patient experience measures 'Did staff inform you of what investigations you needed (and why)?' (yes/no) 'Did staff give you the results of your investigations, and explain these to you?' (yes/no)	**Patient centred**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Assessment and diagnosis	Reviews: Planned, actioned documented Including: Comfort Clinical status Symptoms Pathway update (e.g. additional investigations)	**RCEM pain guidance** **Care in Emergency Departments (previously '50 at 50')** Standard 23 Regular, documented reviews of patients, including comfort and clinical needs (every 30 minutes) **Emergency Department Standards** **Patient experience in Emergency Departments**	Comfort round audit Documentation audit Documentation audit, pain audit Documentation audit	Specific patient experience measures Patient reported outcome measures***	**Patient centred** **Effective** **Safe** **Timely** **Efficient**
	Updates Is given Information regarding: Results of tests Medication Treatments Further investigations/follow up	**RCEM Advice on Giving Information to Patients** **Care in Emergency Departments (previously '50 at 50')** Standard 24 Patients given regular updates to forecasts (every 30 mins), documented in records **Patient experience in Emergency Departments**	Comfort round audit	Specific patient experience measures Including questions regarding: 'Did staff give you updates/information on your treatment/investigations/follow up plans?' (Often/sometimes/never) (i.e. 3 questions) Did staff involve you in discussions about care, treatment and follow up? (yes/ no)	Patient centred

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Comfort rounding To include: Food and drink Pressure area care (note may be combined with update and reviews for efficiency)	**Care in Emergency Departments (previously '50 at 50')** Standard 23 Regular, documented reviews of patients, including comfort and clinical needs (every 30 minutes) **Patient experience in Emergency Departments**	Comfort round audit	Specific patient experience measures Including questions regarding: 'Did staff attend to your physical needs (food/comfort/drinks), and give additional support if needed?' (Often/sometimes/never)	**Patient centred**
Continuing care	Observations/review	Populations and requirements defined locally **Safety in Emergency Departments**	Audit of EWS Clinical notes audits (for reviews)		**Patient centred** **Effective** **Safe** **Timely**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Assessments	Falls risk, VTE, AMT etc: Populations and requirements defined locally **Safety in Emergency Departments** **Emergency Department Standards**	Clear policy for required assessments Audit of Compliance with assessments	Incidence data (e.g. for falls)	**Safe** **Patient centred**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Discharge	Information and advice Safety-netting Follow up Medication Social aspects Pragmatic details Communication	'DC checklist' exists and used **RCEM Medication guidance** **Patient experience in Emergency Departments** **Care in Emergency Departments (previously '50 at 50')** Standard 25 Discharge planning includes: A: bespoke written and verbal advice B: check of social and welfare concerns and pragmatic considerations (e.g. how is the patient getting home) C: communication of this to carers, relatives, healthcare providers, custody staff (where appropriate) Standard 26 Follow up arrangement as and medication prescription clear and documented in advice and notes Standard 32 Written information provided for patients, and carers for those returning to care institutions	Compliance with discharge checklist Pharmacy audits Patient information/leaflets audits Specific documentation audits (e.g. Discharge letters given to patients)	Specific patient experience measures Patient reported outcome measures*** Including questions regarding: 'Did staff arrange your discharge medications (incl advice on side effects)/follow up before you left?' (yes/no) (i.e. 3 questions) 'Did staff explain clearly about your medication/follow up/reasons to return?' (yes/no, or Likert scale) (i.e. 3 questions) 'Did you receive information about your visit /treatment and diagnosis? (e.g. a discharge summary/information leaflet' (yes/no) (i.e. three questions) 'Did staff discuss how you would get home?' (yes/no) 'Did staff discuss your needs when at home?' (yes/no) 'Were you given contact details if needing to return/further information (urgent or planned)?' Complaint reviews Incident data	**Patient centred** **Safe** **Equitable**

Patient pathway through the ED	Activity	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
	Results review, including addendums	**RCEM Investigation results management guidance** **RCEM Discharge to General Practice** **RCEM ED patients in Custody** **Care in Emergency Departments (previously '50 at 50')** Standard 27 Processes for communication of results to patient and GP exist	Audit of compliance with advice Audit of 'endorsement' of results, and action Evidence of learning from complaints/incidents		**Safe** **Patient centred** **Effective**
After Discharge	Communication and liaison	**Care in Emergency Departments (previously '50 at 50')** **RCEM Investigation results management guidance** **RCEM Discharge to General Practice** **RCEM ED patients in Custody**	Audit of discharge summaries/GP letters/care home letters/custody letters		**Safe** **Patient centred**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Structure: **Patient environment**	Cleanliness Well maintained Privacy and dignity Signage/process information Waiting areas	**Patient experience in Emergency Departments** **Care in Emergency Departments (previously '50 at 50')** Standard 1 All areas of the ED clean and well lit Standard 2 The physical condition of the ED in good order Standard 3 The signage and information for the patients is sufficient to enable easy navigation to, through and from the Emergency Department Standard 5 All toilet facilities in the ED clearly display a completed daily cleaning log Standard 6 Waiting areas furnished with Refreshments, entertainment, WiFi access, Information regarding process, updated waiting time Standard 8 A message for recumbent patients on the ceiling tiles in the Resus room/cubicle areas Standard 9 A dedicated psychiatric assessment room that conforms to PLAN (4) standards	Cleaning logs Estates/Medical Engineering reporting logs Caldicott Guardian reviews	Specific patient experience measures Including questions regarding: 'How clean and comfortable was the department? (Likert scale) 'Was there enough privacy?' (yes/no) 'Did you feel physically safe in the department?' (yes/no)	**Patient centred** **Safe** **Efficient**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Structure: Clinical estate	Equipped Well maintained	**End of Life Care in the Emergency Department** Care in Emergency Departments (previously '50 at 50') Standard 2 The physical condition of the ED in good order Standard 9 A dedicated psychiatric assessment room that conforms to PLAN (4) standards Standard 10 For dying or recently deceased patient, the relevant clinical area quiet, private, sensitively designed and readily identifiable as such to approaching staff Standard 53 The equipment in the department is easy to locate, clearly organised and labelled, including the use of trollies/packs for frequent activity and procedures Standard An effective process exists to report and respond to problems IT, estates and equipment	Estates/Medical Engineering reporting logs Audit of clinical environment Stock audits		**Safe** **Effective** **Efficient**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Structure: **ED team**	Training and education: In vivo simulation SMT incl Safeguarding Care Safety Induction Supervision Workforce wellbeing	**Care in Emergency Departments (previously '50 at 50')** Standard 11a Patient feedback sought and acted upon Standard 11b Patients' comments (positive and negative) shared with staff Standard 47a Staff feel valued and engaged with organisation Standard 47b Department meets the RCN staffing ratios/ requirements including those for children's nurses Standard 50 Staff able to take breaks Standard 51 Staff from other departments working in the ED supported Standard 52 Staff wellbeing actively managed: a champion exists, communication and support exists, ongoing wellbeing projects, all staff attend resilience training, system to identify burn out in staff, and support Standard 58 Staff aware of how to respond to patients or relatives who wish to complain Locally determined standards National requirements	Audit against local standards Training records audit	Staff surveys GMC NTS survey HEE NETS survey	**Safe** **Effective**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Structure: Quality Management and leadership	Audit and QI processes: effective loops Data collection Departmental Cultural Governance structures Safety	**RCEM Safety toolkit** **Emergency Department Standards** **Patient experience in Emergency Departments** **RCEM QI advice** Standard 60a Measurable improvements in response to their CQC reports, RCEM and local audit, and patient feedback Standard 60b Standards related to patient care improved through audit and quality improvement Standard 60c Engagement with national benchmarking projects to promote service development and excellence	Review of compliance with toolkit Review of QIP and audits and impact Evidence of learning from complaints/incidents Review of CQC, RCEM Nat QIP, GIRFT, etc, and action plans based on these reviews	Incident and complaint data	**Effective**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Process: **Comfort care**		**Care in Emergency Departments (previously '50 at 50')** Standard 55 All staff had training in Customer care and Compassionate care Standard 56 'Care' part of all inductions, and ongoing teaching and handover Standard 58 Staff aware of how to respond to patients or relatives who wish to complain Standard 64a Demonstration that patients are happy with the care provided Standard 64b Demonstration that staff are proud of the care provided	Comfort care round audit	Specific patient experience measures (see above) Staff survey	**Patient centred**
Process: **Communication**		**Care in Emergency Departments (previously '50 at 50')** **RCEM Advice on Giving Information to Patients** Standard 58 Staff aware of how to respond to patients or relatives who wish to complain	Audit against the advice and standards	Specific patient experience measures: See above	**Patient centred**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Process: Handovers		**RCEM Safety toolkit** **Safety in Emergency Departments** **Handover tools (e.g. St Marys ABCDE tool)** Standard 48: A regular joint combined nursing and medical handover exists. Handovers are timetabled and documented	Audit of handover documentation Audit of compliance with RCEM Safety toolkit Evidence of Learning from incidents	Incident data	**Safe**
Process: **Procedural safety**	Checklists Training	**RCEM Invasive procedure checklist** **NATSSIPs** **Safety in Emergency Departments**	Audit of checklist use Audit of presence of checklists and policies Training records audit	Incident data	**Safe**
Process: Infection prevention and Control	Locally determined	**RCEM advice on IPC in COVID** Standard 66 Department follows IPC guidelines	Compliance with local audits on IPC		**Safe**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Process and structure: **Safety**		**RCEM Safety toolkit** **RCEM Safer Care committee activity** **Safety in Emergency Departments** Standard 49 Senior staff approachable and available Standard 57 Staff aware of how to report and escalate concerns Standard 59 Staff aware of duty of candour requirements Standard 65a Policy exists for the care of patients in the ED who are under other teams Standard 65b Policy for handling ambulance delays exists Standard 65c Escalation procedures for crowding/surges exist Standard 65d Safety huddles in place Standard 61 Action on CQC Patient First and RCEM crowding guideline/ toolkit in anticipation and in response to exit block **Emergency Department Standards** **Patient experience in Emergency Departments**	Audit of compliance with RCEM Safety toolkit Audit of compliance with policies Audit of falls and falls prevention activity	Incident data Litigation data Complaint data	**Safe**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Process and structure: **Efficiency**	See RCEM Policy section and Workforce strategy	**RCEM Policy** **Workforce standards** **RCEM CARES**	Audit of compliance with RCEM staffing recommendations Cost improvement and service improvement projects		**Efficient**
Process and structure: **Equity**		Standard 64 The department has an understanding of the population it serves, and tailors its services accordingly. This will include the routine use of translation services (including sign language), and provision of advice sheets in other languages.	Audit of collection of outcome data against protected characteristics Audit of data collection health inequities Presence of Public Health lead Audit of health advocacy (e.g. screening for conditions such as Alcohol screening, HIV testing)	Audit of interventions (after screening) such as referral to services Audit of activity to enable access to services (language services, GP access etc)	**Equitable**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Teaching and training	Remit of: Education Cluster of RCEM Health Education England Education providers Professional regulators				

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Specific patient groups care requirements		**Care in Emergency Departments (previously '50 at 50')** *The older patient:* Standard 35 Dementia awareness training up to date for all staff Standard 36 Dementia care package in place, and compliance audited Standard 37a Skin vulnerability performed on all patients (using validated tool) Standard 37b All those with vulnerable skin managed promptly (at assessment) as per local standards Standard 38 All patients screened for cognitive impairment, *and delirium* Standard 39 All delirious patients offered distraction therapy *Patients under 18:* Standard 42 Demonstrable evidence of the safeguarding of children: all staff are trained to the levels required, staff aware to whom/how to escalate, staff know who the Trust safeguarding lead is Standard 43a Facilities available for distraction of distressed children Standard 43b Facilities meet the RCPCH standards for Emergency Care *Patient with specific requirements:*	Audit against the standards Falls prevention audits		**Patient centred** **Equitable**

Underlying structures and processes	Specific areas	Related Guidance from RCEM (in bold) Related 'Care in ED' Standard (s)	Possible metrics for audit and QI: Process and structure	Possible metrics for audit and QI: Outcomes	Quality Dimension
Specific presentation care requirements		Under development			**Patient centred** **Safe** **Efficient**

* There is a need for development of ED specific PREMs. The current 'Friends and Family tests' are useful, however do not cover all of the elements above.

** Patient experience can be of the system can be that it is labyrinthine, and sometimes Kafka-esque. E.g. A patient can be asked by one element of system to attend another, only to find that they are not expected, and/or that their requirements may not be met. This can also happen within an institution: for example, the patient might be asked by Radiology department to attend ED after Out-patient investigation (unexpected findings or unexpected event), or to go to Pharmacy to collect a prescription etc. Ideally, the better experience for the patient is to move around the hospital/system, as little as possible.

*** There is a need for development of Emergency Care PROMs. These may be as simple as relief of symptoms such as pain, or more subtle and complicated e.g. addressing anxieties and concerns- do the patient 'feel better' following their visit-physically and psychologically?

Notes on the table

This is not designed to be an exhaustive list. This is also not deigned to be a list that replaces innovation in measurement- measurement for QI improvement for example, will often be highly specific and creative in its nature.

Additionally, this is a generic list. The suggested measurements techniques are generic- within these individual elements that will require specific questions/measures, especially when granularity is needed (e.g. when auditing discharge summaries, it may be that the information given to specific groups (e.g. custody officers) is the subject of the audit).

Routine collection of important metrics should be the norm. Increasingly, the use of Information Technology is making easier (with the caveats discussed below).

With large scale, and 'across system' routine measurements (for example Friends and Family test, national audits that are disease specific) there is a lack of granularity and/or lack of specificity to the requirements of patient in the Emergency Department, which may require specific data collection- as described in the table.

Appendix 1: Explanatory notes and caveats

The culture of focusing on national targets and financial balance, whilst neglecting acceptable standards of care was exposed in the 2013 Francis report of the Mid Staffordshire NHS Trust Public Inquiry[1] . The Royal College of Emergency Medicine recognises such occurrences are not isolated to one organisation or one department [2].
The first recommendation of the Francis report is that "*all staff should contribute to a safe, committed, compassionate and caring service*".
The National Advisory Group on the Safety of Patients in England 2013 [3] issued as its first guiding principle: "*place the quality (and safety) of patient care above all other aims for the NHS*".

The definition of Quality in healthcare is subject of much debate, and the measurement of the quality of healthcare also much debated [3].

Caveats and complexities

When measuring quality of care in EDs, it is important to remember:

1: The relationship between: 1. inputs in quality of care (e.g. training, equipment, I.T), 2. processes (i.e. multiple interactions between staff and patients over time), 3: perceptions of quality (both of patients and staff) 4: interplay of organisational management and political factors (e.g. targets distorting care) and 5: health outcomes, is complex. There are also pragmatic issues of measurement; what can be measured and the ease of measurement, together with the differences in measurement for assurance (audit), and measurement for improvement.

2: Emergency Departments are often described as VUCA environments: volatile, uncertain, complex and ambiguous. Hospitals are 'Complex Adaptive Systems', with the potential to hamper the effectiveness of interventions to effect change. This serves to exacerbate the conditions for safety to be compromised. Crowding and a mismatch of demand and supply can affect the achievement of time based measures.

3: Many national audits, and care standards often involve part of the patient journey being delivered within the Emergency Department, and many involve time-based measures. The 'Goodhart' principle holds true when quality measures become targets; what gets measured gets (micro) managed. Working towards achievement of National targets and standards is however, necessary.

The patient experience and perspective

There is a need to develop and define Patient Experience measures that are specific to the care in the Emergency Department, as well as patient reported outcome measures.

Safety, equity and efficient care in the ED

Whilst within the ED the six dimensions of quality underlie all activity. However in terms of ED activity (and measurement) two dimensions can by separated out- to a degree- and these are Safety and Efficiency. This is due to the fact that these are largely due to process and structure (see measurement section below).
Equity in emergency care is important and complex [6]. Leaders within ED need to ensure equity of care (access to and provision of) within the departments. Additionally advocacy is an important role: see RCEM Public Health position statements.

Note Equity, Safety, and Efficiency dimensions have a separate line in the table as per discussion above. However, in terms of ED activity Efficiency is often separated out-cost and service improvements are quality improvements often not *directly* felt by patients.

Therefore, there is a need to develop patient experience metrics and patient reporting outcome measures that are bespoke to Emergency (department) care- this is address in the RCEM quality Strategy and the research recommendations below.

Appendix 2: The patient experience

What is patient experience, and how is it different from patient satisfaction?

The 'Patient Experience' is an individual's experience of their illness/injury (including the way the healthcare system treats them). When concerned with the experience of the health care services it is similar to 'patient satisfaction', but there are slight differences; however there is a link. There are a number of methods of measurement (qualitative, quantitative and mixed methods), and tools collectively known as 'Patient Reported Experience Measures'.

Patient satisfaction (and therefore surveys) is concerned with 'how did we do?' e.g. 'how happy were you with the information given to you', and is usually rated on scales from 'very unhappy' through to 'very happy'. Hence satisfaction is affected by patient expectations, and may be considered a more subjective assessment. Patient experience (and surveys) more commonly asks questions about 'what happened' e.g. 'when you need information, did you get the information you ask for?' and is rated on scales from 'never' through to 'always'.

Why is Patient experience necessary?

Whilst this may seem obvious that patient satisfaction is important, it is worth remembering that there is evidence that better experience and higher satisfaction, is associated with better patient outcomes, decreased health costs, and improved organisational reputation. There are elements of medical care where the patient reported experience is "the best, or only, source of information" [7]. See references and below for further discussion.

What are the elements of patient experience?

The evidence base is limited [8]; however key elements of patient experience appear to be:

- Good communication
- Staff empathy
- Waiting times (including prompt care e.g. rapid pain relief)

Other commonly cited issues in complaints, anecdotally are

- Patient Environment (c.f. 'hotel services')
- Personalised care (making care bespoke, and feel bespoke)

What tools for assessing patient experience?

In the UK, the NHS Friends and Family Test (FFT) is administered by care providers asks patients a single question: "Overall, how was your experience of our service?", ranked from "very good" to "very poor".

The Care Quality Commission (CQC) in the UK has undertaken specific Urgent and Emergency Care Surveys (see https://www.cqc.org.uk/publications/surveys/urgent-emergency-care-survey-2020). These are administered by Picker (see https://picker.org/).
In the USA, the most widely used patient experience measure is the Consumer Assessment of Healthcare Providers and Systems (CHAPS®), which has a specific Emergency Department questionnaire; this has an evidence base (this is discussed on the CMS website (see https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ED)).

What should be in a patient experience measurement tool?

Key areas where questions can be asked:

The CHAPS® survey asks questions regarding:

- Being seen within 30 minutes of arrival
- Whether staff asked about current medications
- Whether staff informed about medications (what for, side effects) both in the ED and on discharge
- Whether staff informed patients about investigations results
- Whether staff treated patients with dignity and respect
- Whether staff listened carefully
- Whether staff 'explained things'
- Whether staff discussed follow up care, and gave information regarding obtaining this
- Whether staff gave 'safety net' advice

The survey also grades care and includes a recommendation question, in a similar way to the FFT.

The CQC survey asks similar questions to above, but also questions regarding:

- How the service was accessed
- Why the service was accessed
- Explanations about process
- Treatment while waiting
- Waiting time (initial greeting, examination, length of stay)
- Information about waiting times
- Wait times for ambulance admission
- Whether time with clinicians sufficient
- Whether staff discussed fears/anxieties
- *Confidence/trust in clinical staff*
- *Whether staff talked 'as if you weren't there'*
- Whether sufficient privacy
- Whether able to get staff attention
- Whether staff explained need for investigations

Whether staff involved patient in discussions about care and treatment
Pain Control
Cleanliness of department
Whether other patients/visitor threatened individuals
Contact details as part of safety-netting
Whether transport arrangements discussed
Additional coronavirus questions are also now asked, including PPE/social distancing etc
Questions in red are those that are patient experience that can only be obtained by asking patients, those in italics not included in table above.

The table in this document suggests the following areas where specific PE questions might be a useful metric, these are:
Booking in: Was the booking in process easy
Staff introductions: Did staff introduce themselves and role to you
Were all processes/pathway through ED explained
Was there clear signage/process information
Whether Privacy and dignity maintained
Does the patient pathway minimise 'movement' and re-direction
Establish patient expectations and wishes (Of visit, Capacity, Concerns, Specific requirements)
Treatment of **time critical** conditions, and symptoms: Effective, timely
Forecast/processes explained
Updates: were these given regularly?
Comfort care: did this occur regularly?
Patient environment: Cleanliness, well maintained, privacy and dignity considered
Information and advice, both during stay and at discharge: Safety-netting, Follow up Medication, investigations (including rationale)

There is need to the development, and validation, of PE questions, suitable for the UK ED setting based on the domains above. Suggetsed questions in the table below.

Area to be assessed	Suggested questions
Booking in: Was the booking in process easy	Ease of booking in 'How easy was the process of booking in?' (Likert scale) Warmth of welcome 'How Welcoming and friendly were the staff (at reception)' (Likert scale) Also: 'How easy was it to find your way around the department'' (Likert scale) below

Staff introductions: Did staff introduce themselves and role to you	'Did the staff introduce themselves' (sometimes/always/never) 'How well did the staff listen to your concerns' (Likert Scale) 'Did the staff tell you how to gain their attention' (yes/no)
Were all processes/pathway through ED explained	Ease of navigation/explanation of processes: 'Did the staff explain what was going to happen, at all stages of your care?' (sometimes/always/never) 'How easy was it to find our way around the department'' (Likert scale) 'How well did the staff explain your care/treatment/medications/follow up' (i.e. four questions) (Likert scale) 'How well did the staff answer your questions?' (Likert scale)
Was there clear signage/process information	'How easy was it to find our way around the department'' (Likert scale) below
Whether Privacy and dignity maintained	'Did the staff treat you with dignity and respect' (Likert scale) 'Did staff involve you in discussions about care, treatment and follow up?' (yes/ no)
Does the patient pathway minimise 'movement' and re-direction	*'How many times did you get moved/redirected?'* *'When you asked a question, was it addressed/resolved?'*
Establish patient expectations and wishes (Of visit, Capacity, Concerns, Specific requirements)	'How quickly did the staff come when you called?' (quickly/slowly/not at all) 'Did the staff ask you about your concerns/needs?' (sometimes/always/never) 'Did staff address your concerns/needs?' (sometimes/always/never) 'Did you have enough time with clinicians?' (Likert scale)
Treatment of time critical conditions, and symptoms: Effective, timely	'Did you get assessment/ treatment of your symptoms quickly (within 30minutes)' (yes/no) 'Did this treatment work?' (yes/no) 'How effective was this treatment at reducing your symptoms?' (Likert Scale) 'Did staff review your symptoms, and give additional treatment if needed?' (Often/sometimes/never)
Forecast/processes explained	'Did staff inform you of what investigations you needed (and why)' (yes/no) 'Did staff give you the results of your investigations, and explain these to you?' (yes/no)
Updates: were these given regularly?	'Did staff give you updates/information on your treatment/investigations/follow up plans?' (Often/sometimes/never) (i.e. three questions)

Comfort care: did this occur regularly?	'Did staff attend to your physical needs (food/comfort/drinks), and give additional support if needed?' (Often/sometimes/never)
Patient environment: Cleanliness, well maintained, privacy and dignity considered	'How clean and comfortable was the department? (Likert scale) 'Was there enough privacy?' (yes/no)
Information and advice, both during stay and at discharge: Safety-netting, Follow up Medication, investigations (including rationale)	Also, as above: 'How well did the staff explain your care/treatment/medications/follow up' (Likert scale) (i.e. four questions) 'How well did the staff answer your questions?' (Likert scale) 'Did staff arrange your discharge medications/follow up before you left?' (yes/no) (i.e. two questions) 'Did staff explain clearly about your medication (incl side effects)/follow up/reasons to return?' (yes/no, or Likert scale) (i.e. three questions) Were you given contact details if needing to return/further information (urgent or planned)? (yes/no) 'Did you receive information about your visit /treatment and diagnosis? (e.g. a discharge summary/information leaflet' (yes/no) 'Did staff discuss how you would get home?' (yes/no) 'Did staff discuss your needs when at home?' (yes/no) (e.g. Fit note, social care needs etc) 'Did you have confidence in the staff looking after you?' (Likert scale) 'Did you feel physically safe in the department?' (yes/no)

Appendix 3: Background-Quality in Emergency Healthcare

What is Quality in Healthcare?

The Institute of Medicine have defined quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' and identified six dimensions [4] (see table).

Quality in health-care The six dimensions* *note IHI have suggested Prevention, Access and Value as additional dimensions					
Safe Avoiding injuries to patients from the care that is intended to help them	**Efficient** Reduce waste	**Effective** Match care to science. Avoid overuse of ineffective care and underuse of effective care	**Patient-centered** Respect the individual and their choices	**Timely** Reduce waiting for both patients and those who give care	**Equitable** Close gaps in health status between different patient groups

These elements underpin the quality of patient care, however It is difficult to separate activity aiming to maintain and improve quality into these dimensions. The same is true of the patient perspective and experience of healthcare- this is discussed further below.
The RCEM strategic overviews and Quality Strategy describe the work of RCEM across these domains.

What is Quality in Emergency Care?

The table below identifies, as a form of 'process map', the essential elements of quality in the ED, by considering both:

- the essential elements of the patient journey through the Emergency Department
- the structures and processes essential to this

The table also then identifies

- which quality domain (s) these link to
- Suggests some overarching measures that can be used.

The rationale for this is that the main 'control' and influence of ED to affect quality is the time the patient spends in the ED. However, as discussed below, many aspects outside of the ED affect quality of care (and the patient experience), and many aspects of the patient journey (which includes time in ED) are beyond the control of the ED. Additionally, EDs sit within a wider healthcare system, which will have requirements (e.g. staff training, safeguarding expectations), and also constraints (financial, contractual) that effect how care is delivered within the ED.

Measuring Quality of Healthcare

How to assess the quality of healthcare is the subject of much debate. A common framework is to divide the information into three linked categories [5]:

- **Structure** (environment in which care is delivered: e.g. buildings, staff (including training), financial structures)
- **Process** (the activity making up healthcare)
- **Outcomes** (effects of healthcare)

Measurement can be for quality assurance, or quality improvement. The difference is how the data is used, and the amount of data used- often the measurements themselves are the same.
Commonly measurements of quality are separated into:

- **Outcome measures** are 'the voice of the patient', that is, what actually happens to the patient. Patient satisfaction is an example, as are outcomes such as symptom improvement, morbidity and mortality.

- **Process measures** are 'the voice of the system', that is measures of processes with the system (e.g. waiting times, reviewing and endorsement of investigations). Structural elements of the model may also be audited here within both domains (e.g. the patient environment may affect patient experience)

Standards and quality measures

Clinical standards are statements (relating to a specific condition) of the necessary steps in patient care. The function of these is to improve patient outcomes, reduce waste and improve efficiency. Quality standards define the quality of clinical care, and to identify areas for improvement.

Quality measures are often limited to one domain (as above) or one part of the patient journey (e.g. within the ED). These metrics are often derived from available (administrative) data sources, and may be measures of process rather than outcomes. Recently there has been a move to 'PROMs' (patient reported outcome measures).

Measuring Quality in Emergency Care

Using the model of described above, a suite of related metrics has been identified. This is not an exhaustive list, and further discussion on the development and use of quality measures can be found in '*RCEM QUALITY IMPROVEMENT GUIDE: A practical guide for clinicians undertaking quality improvement in Emergency Departments*'.
These are listed in the table above, and separated into outcome and process measures.

Measures of the structural element of the Donabedian model are included where appropriate (e.g. regarding patient environment), however many of these relate to training, staffing and cost-effectiveness activity. Whilst these are important, and underpin delivery of good quality care, these are often not directly 'felt' by patients, and therefore separated in this model (and within RCEM activity; see Strategy documents listed above).

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Review

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

Conflicts of Interest

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

There is a need to develop and test ED specific Patient Experience Measures and Patient Reported Outcomes.

Audit standards

See table in text.

Key words for search

Patient care, Emergency Department/Medicine, Standards, Quality

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