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Royal College of Emergency Medicine

2025 Healthcare Quality Improvement Plan

Introduction

The Royal College of Emergency Medicine (RCEM) runs a national Quality Improvement Programme open to all Type 1 UK emergency departments (EDs) to participate and improve the care of patients attending UK EDs.

This programme is run by RCEM's Quality Team and the Quality Assurance and Improvement Committee, a subcommittee of the Quality in Emergency Care Committee.

The programme has the following objectives.

1. Improve the quality of emergency care in UK EDs.
2. Accurately measure and report on the quality of patient care in UK EDs.
3. Educate, support, and empower UK EDs to participate in quality improvement
4. On local and national levels promote evidence-driven dialogue and action concerning improving the quality of UK emergency care.

To achieve these objectives, the programme runs three Quality Improvement Programmes (QIPs) every year, each focusing on a particular patient group or area of emergency care. The focus of each QIP is selected through public competition, allowing emergency medicine professionals to propose focuses relevant to current priorities and issues facing EDs and patients. Each QIP will aim to meet the above objectives in their relevant focus area.

Each QIP is developed for two years by a topic team of healthcare professionals specialising in emergency medicine and/or the QIP focus. It is then run for three years by RCEM and reported on at national and local levels each year. After the third year is complete, RCEM replaces the QIP with a new QIP, however the resources for the QIP are kept available for ongoing local project and reporting independent of RCEM, encouraging sites to further track, analyse, and improve the quality of care in the focus area.

2025 Improvement Goals

In 2024, RCEM is running the following QIPS.

1. Mental Health (Self-Harm) – Year 2
2. Care of Older People – Year 2
3. Time Critical Medication.

Below is a breakdown of the following for each QIP.

1. Focus
    - Including why it is a relevant area of improvement for emergency medicine.

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2. Defined Clinical and Organisational Standards/Targets
    - These standards are the targets that participating EDs should aim for in their practice.
    - Standards are graded as fundamental, developmental, and aspirational, in accordance with their determined importance for quality patient care by the QIP's topic team.
        - Fundamental
            - This is the top priority for your ED to get right. It needs to be met by all those who work and serve in the healthcare system.
            - Practice at all levels of service provision need to be in accordance with at least these fundamental standards. No provider should offer a service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.
        - Developmental
            - This is the second priority for your ED. It is a requirement over and above the fundamental standard.
        - Aspirational
            - This is the third priority for your ED and is about setting longer term goals.
3. Performance Measures and Metrics
    - To track participating ED's performance against the standards and their improvement throughout the QIP
4. Improvement Recommendations and Methods
    - How RCEM suggests sites improve their performance and quality of care within the focus area

Evaluation

The performance of participating EDs against each QIPs standards and overall performance of the QIP to meet its objectives is evaluated through annual reports produced at the end of each year.

Reports for the interim years of the QIP (Years 1-2) evaluate the performance of participating EDs in the given year and advises on how EDs can improve performance in the following year.

The final year report (Year 3) evaluates the performance of participating EDs across the whole three-year cycle, comparing how performance has changed over the period, discussing key trends and potential causation, and finally identifying where performance needs further improvement alongside recommendations to achieve this improvement.

Reports are published on the RCEM website for all UK EDs and other stakeholders to access and implement the given recommendations for improvement.

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Mental Health (Self-Harm)

QIP's Focus

This QIP's focus is to identify and improve the current standard of care for patients attending with self-harm presentations to UK EDs.

Patients presenting to the ED with mental health needs make up around 5% of total attendances. They may have both physical and mental health needs to be met concurrently and some present with high risks of further self-harm and suicide.

In 2018 the Healthcare safety investigation branch (HSIB) published a report on the provision of mental health care to patients presenting at the Emergency Department. A recommendation for RCEM was to improve and standardise the initial assessment of patients. This QIP is part of the ongoing response to this recommendation.

QIP Defined Clinical and Organisational Standards/Targets

For this QIP, the topic team provided the following clinical and organisational standards. EDs should aim for these standards to ensure the highest quality of care for the focused patient group.

The clinical standards set for this QIP are.

Number	Standard	Grading
1	Patients should have a mental health triage by ED nurses/clinician on arrival to briefly gauge their risk of self-harm and/or leaving the department before assessment or treatment is complete.	F
2	Patients at medium or high risk of further self-harm or of leaving before assessment and treatment are complete should be observed closely during the period that they are considered to be high-risk/medium-risk. There should be documented evidence of either continuous observation (1:1) or intermittent checks, interactions, and care delivery (recommended every 15 – 30 minutes)	F
3	When an ED clinician reviews a patient presenting with self-harm, they should record a brief risk assessment of suicide and further self- harm.	F

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The Organisational standards set for this QIP are:

Number	Standard	Grading
1	EDs should have a named Mental Health Lead	F
2	EDs should have a policy in place for assessing and observing patients for those considered to be high or medium risk of self-harm, suicide, or leaving before assessment and treatment are complete.	F
3	EDs should have a policy which clearly states when patients can or cannot be searched. This should be compliant with relevant legislation. Searches which are for the clinical safety of the patient should be conducted by clinical staff rather than security guards.	D
4	ED and mental health teams should have joint pathways which promote parallel assessment of patients with both physical and mental health needs. NICE guidance states that psychosocial assessment should not be delayed until after medical treatment is completed.	F
5	EDs should have an appropriate area available where patients with mental health problem can be observed (i.e., A designated quieter/safer area than a regular cubicle)	A
6	EDs should follow their trust's policy for restrictive intervention and should follow guidance for rapid tranquilisation	F
7	EDs should have a policy for patients under the relevant policing and mental health legislation - including section 297 (Scotland), section 130 (Northern Ireland) or section 136 (England and Wales) to ensure safety, dignity, and timely management.	F
8	EDs should have an appropriate room available for the assessment and assistance of people with mental health needs. These should meet the standards of the Psychiatric Liaison Accreditation Network (PLAN).	F
9	An appropriate programme should be in place to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues.	F

QIP's Performance Measures and Metrics

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For every QIP, participating EDs are asked to submit five eligible patient cases per week and one organisational standards summary per year to the RCEM data entry portal. Their performance against the standards is then available for local analysis through raw data exports and the accompanying chart dashboards available on the portal.

The participating sites are encouraged to analyse their data regularly and initiate PDSA cycles to improve their performance against the clinical standards. Each quarter, the RCEM team reviews data inputted and provides insight to participating EDs on current performance and improvement.

Further detail on the methodology, data analysis, and metrics is provided for all QIPs in the accompanying Information Packs. This is provided to all participating EDs and can be found below.

RCEM - Quality Improvement Programmes

Improvement Recommendations and Methods

As standard RCEM recommends all departments meet the organisational standards set by the QIPs topic team and aims to meet the clinical standards in all instances the given focus presentation/patient group.

From the analysing the results and performance of participating EDs in the QIPs first year, RCEM additionally provided the following recommendations for improvement and higher quality care.

- Local/Departmental Recommendations
    - ED's should focus on the three fundamental standards.
    - Parallel assessment should be encouraged and incorporated into practice.
    - Evidence of compassionate and practical care should be captured better.
    - Capacity assessments should be the responsibility of all involved in care and not the sole responsibility of the triage nurse.
    - Safeguarding / drug and alcohol concerns should be considered and addressed in all cases.
    - Patients leaving prior to ED clinician or APLS review should have a follow up plan arranged and documented.
        - *General Practitioners (GP's) can be an option in some cases. They should not be the default position for all patients. A local process should be in place for follow up of these patients.*
    - EDs should perform accurate and timely data entry.
- Trust/Health Board Recommendations

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- Trust/Health Boards should ensure all policies outlined in the organisational standards are in place at their hospitals.
- Trust/Health Boards should be addressing overcrowding and waiting times to prevent increased stress and prolonged waiting times for this patient group.
- Mental health training for EDs should be reviewed and confirmed as up to date and appropriate for all relevant ED staff.

- Policy/Advocacy Recommendations
  - Further funding should be sourced to improve resourcing and training for all UK EDs treating this patient group.
  - NHS should be addressing overcrowding and waiting times to prevent increased stress and prolonged waiting times for this patient group.

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Care of Older People

QIP's Focus

This QIP's purpose is to identify and improve the current standard of care for patients aged 75 and older attending UK EDs.

Older people account for a large proportion of the attendances to EDs and an even larger proportion of inpatient admissions, but the evidence shows that this cohort of patients frequently do not receive a good standard of care.

The rationale for this QIP is to assess and improve the quality of care given to older and frail patients and to ensure that recommended interventions that can make a meaningful difference to mortality, morbidity and quality of life are implemented where feasible.

QIP Defined Clinical and Organisational Standards/Targets

For this QIP, the topic team provided the following clinical and organisational standards. EDs should aim for these standards to ensure the highest quality of care for the focused patient group.

The clinical standards set for this QIP are.

Number	Standard	Grading
1	Older People (75 years and older) in EDs should be: a) Screened for delirium using 4AT. b) Assessed for falls risk. c) Screened for frailty.	TBC
2	Action is taken based on the findings of screening processes. a) Delirium management plan initiated. b) Post-fall assessment c) Falls mitigation. d) Comprehensive geriatric assessment initiated.	TBC
3	Patients should have their basic care needs met whilst in the ED via a safety round.	TBC

The Organisational standards set for this QIP are:

Number	Standard	Grading
1	EDs should have systems or processes in place to screen for: a) Frailty b) Delirium c) Cognitive impairment	TBC

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	d) Falls risk. e) Elder abuse f) Polypharmacy g) Pressure areas and incontinence. h) Functional status / mobility i) Social support	
2	EDs should have systems in place to record the above information in discharge summaries.	TBC
3	EDs should have a system in place to ensure that patients could be provided with a paper copy if requested, including upon discharge to a care home.	TBC
4	EDs should conduct regular quality assurance of discharge summaries.	TBC
5	The overall design and layout of EDs should consider the needs of frail older patients	TBC
6	EDs should have a dedicated area for people with cognitive impairment	TBC
7	EDs should have timely access to dedicated equipment to support the care of those living with frailty, cognitive and/or sensory impairment	TBC
8	EDs should have timely access to the following services, either within the department, on-site or remotely: a) Real-time language interpreting b) Geriatrician c) Acute Frailty d) Therapies e) Older Adults Mental Health f) Community Admission Avoidance g) Third Sector Support h) Palliative Care i) Pharmacist j) Pastoral / religious support k) Meal provision	TBC
9	EDs should have timely access to previously completed Advance Care Plans	TBC

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10	ED staff should be trained to ask patients routinely about their wishes regarding resuscitation decisions and end of life care.	TBC
11	EDs should have timely access to services or pathways that can support the discharge of people at end of life, to their preferred place of death.	TBC
12	There should be a framework in place whereby feedback from patients and users is sought, analysed and acted-upon in a systematic way, with a focus on older people.	TBC

QIP's Performance Measures and Metrics

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Improvement Recommendations and Methods

As standard RCEM recommends all departments meet the organisational standards set by the QIPs topic team and aims to meet the clinical standards in all instances the given focus presentation/patient group.

From the analysing the results and performance of participating EDs in the QIPs first year, RCEM additionally provided the following recommendations for improvement and higher quality care.

- Local/Departmental Recommendations
    - Delirium
        - EDs should provide training to relevant staff.
            - Demonstrating ease of using the 4AT

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        - On the importance on patient outcomes of early detection of delirium
    - Introduction of delirium care bundles or clinical pathways may motivate staff to screen for delirium.
    - A universal delirium assessment plan should be used in EDs to ensure standardised care. A suggested assessment tool that is evidence based is the 'PINCHME' tool, which acts as an aide-memoire.
    - There should be specific emphasis on improving medication review, urinary retention, and constipation assessment.
- Falls
    - All patients attending an ED over 75 years should be assessed for falls risk to put a falls mitigation pack in place for those at risk.
    - Improve accuracy of data by ensuring that post-fall assessments are not already being done elsewhere in the patient journey e.g., within a 'silver trauma' pathway.
    - Departments should develop and implement falls mitigation policies for all identified at-risk patients.
    - Falls mitigation packs should always be prepared and available in departments. These should always include non-slip footwear.
- CGA
    - Identify barriers to CGA initiation, such as resource constraints, staff training needs, or workflow inefficiencies.
- Safety Rounds
    - Consider alerts / reminders on the EPR to initiate safety rounds for patients once they have reached ED LOS of 6 hours.
    - Implementation of checklist-style safety round care bundles which focus on patient comfort, basic nursing care and regular medications.
    - Involvement of nursing and ancillary staff to lead improvement initiatives in this area

- Trust/Health Board Recommendations
    - Trusts/health boards should ensure that EDs have the resources to provide dedicated areas or cubicles designed to address the specific needs of patients with cognitive impairment.
    - Pharmacy teams in hospitals should be engaged in ED to screen for polypharmacy and support prescribing for older people.

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- Trusts/health boards should ensure a regular audit of the quality of discharge summary information is in place.

- Policy/Advocacy Recommendations
  - Future commissioning should focus on introducing services to improve the patients journey for older people in ED.
    - Examples include third sector support in-hospital or in the community, and acute frailty and therapy services embedded in the ED.
  - As an ever-growing proportion of NHS patients, the needs of older people should be a core consideration by the NHS in the design and refurbishment plans of EDs.

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Time Critical Medications

QIP's Focus

This QIP's focus is to identify and improve the current standard of care for patients who require time critical scheduled medications (TCMs) attending UK EDs.

The Institute for Safe Medication Practices defined TCM as: 'Time Critical scheduled medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy or pharmacological effect'.

TCMs are not seen as a priority in UK EDs and is a concept that is poorly applied and understood in clinical practice. In 2010, the National Patient Safety Agency (NPSA), issued an alert regarding the omission and delayed administration of medicines in hospitals, but despite trusts compiling lists and guidance and regularly auditing this there are still numerous incidents around delayed or omitted doses of TCM.

The rationale for this QIP is to assess and improve the quality of care given to patients who require TCMs, with the additional aim of improving awareness and education around treating this patient group.

QIP Defined Clinical and Organisational Standards/Targets

For this QIP, the topic team provided the following clinical and organisational standards. EDs should aim for these standards to ensure the highest quality of care for the focused patient group.

The clinical standards set for this QIP are.

Number	Standard	Grading
1	Patients on a TCM are identified early within the ED.	F
2	A patient's TCM should be administered according to their usual regime whilst they are in the ED.	F
3	A patient and their carers should be empowered to self-administer their TCM when applicable to do so.	F

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The Organisational standards set for this QIP are:

Number	Standard	Grading
1	TBC	TBC
2	TBC	TBC
3	TBC	TBC
4	TBC	TBC
5	TBC	TBC

QIP's Performance Measures and Metrics

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Once this QIP has completed its first year and the first interim report is released, this plan will be updated with the additional recommendations for improvement from RCEM's analysis of year one.