

Guidelines for the Provision of Emergency Medical Services

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Foreword

Our Emergency Departments are extraordinary places. They are staffed by people with very broad clinical skills and commendable pragmatism. In many ways, Emergency Departments have become victims of their own success. By committing to provide high quality care round the clock, this has created a safety net for system-wide lack of capacity. The Emergency Department exists to provide a safety net for patients at a time of their greatest need.

This document defines the expectations of Emergency Medicine Services, our services have frequently evolved organically to fill needs of other parts of the healthcare system. While this helpfulness is commendable, it has meant that our departments are often so busy that we are unable to deliver our primary purpose of the initial assessment and stabilisation of undifferentiated emergency patients. Furthermore, the evolution of our services has not been uniform. This document shares best practice, define standards and makes pragmatic, patient centred recommendations. I am grateful to all of the authors who have contributed to this guide. There have been lively discussions and agreeable disagreements, all conducted with grace and good humour.

I commend the Guidelines for Provision of Emergency Medicine Services to you all.



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Introduction

Emergency medicine services overlap but are distinct from Emergency Departments. The core emergency medicine service should deliver prompt initial assessment, rapid identification of serious illness and injury and stabilisation of undifferentiated patients. Emergency medicine staff should not routinely be providing care to people with predictable complications of treatment, especially as this causes delay and harm for patients who have not yet seen a clinician. Over years, capacity constraints in the UK have meant that many patients with known diagnoses are directed to the Emergency Department as the only way into an acute hospital, when of course Emergency Departments are intended to provide care for most patients with emergency care needs, and for some of those with urgent care needs.

Emergency, Urgent and Non-Urgent Care

- Patients who require emergency care may need care immediately for a life-threatening condition, or within minutes to preserve life or limb for a serious condition.
- Patients who require urgent care may need assessment and management within hours to treat or prevent deterioration of their condition, or to rule out a condition requiring urgent intervention.
- Patients with non-urgent conditions do not meet the above criteria.

The emergency medicine service is a pivotal interface between the community and the in-hospital setting. Patients may arrive on their own, via ambulance or other emergency services, or occasionally internally from other parts of the hospital. They may be suitable for discharge with or without follow up, require admission, or be transferred to more specialist facilities. Emergency Departments must be able to respond to patients of any age, gender, and from any cultural and socio-economic background. They must be able to provide timely and effective clinical care for a wide range of physical and mental health conditions and, in addition, provide specific responses that match the needs of their local populations. They are an important training environment for clinicians from many backgrounds, and should also be able to recruit participants for research. To undertake this function services must have the right capability and capacity. This means their role must be well defined, along with the role of other places and clinical resources within a system. Emergency Departments do not possess infinite resource. There is an opportunity cost associated with trying to do too much for too many, and this is carried by patients, staff, and the wider health system.

Some patient groups require specific consideration. These include children, pregnant women, patients with mental health problems, and older people. In addition, there is good evidence to support the development of specific pathways of care for patients with identified conditions such as major trauma, ST elevation myocardial infarction, and stroke. Provision of facilities to deal with highly specialised conditions such as oncological emergencies, or ophthalmological emergencies, is highly desirable, as are arrangements to deal with problems that may present more commonly in a specific local population.

Emergency medicine clinicians are trained to run Emergency Departments along with nursing and other colleagues, and to provide care for some, but not all, patients, who meet these criteria.

There are some important considerations to place this work in its rightful place. It does not define the skills of an emergency medicine clinician, as these are defined by our curricula. It also does not define standards for training, as these are described by Promoting Excellence in Emergency Medicine Training. The standards and recommendations are generally applicable across the four nations of the United Kingdom.

This guide follows a structured format: Standards are defined as an expectation that must be met, while recommendations are more aspirational.

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The Emergency Medicine Workforce

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Introduction

The Emergency Medicine workforce consists of highly skilled doctors, nurses, other health professionals, porters, administrative and hotel staff who work together in a pressured, team-based environment. This workforce forms the basis for high quality emergency care. The nature of the workforce is changing, with a drive towards the increased availability of senior decision makers, evolution of training pathways for all staff, sub-specialised practice, enhanced practice in nursing and other health care professionals, and with the changing nature of the speciality itself.

Standards

1. Nurse staffing levels must be in line with Royal College of Emergency Medicine (RCEM) / Royal College of Nursing (RCN) guidance.
2. Doctor and practitioner staffing levels must be matched to demand, casemix, and be designed in line with sustainable working patterns and practice as set out in RCEM guidance.
3. There must be at least one whole time equivalent (WTE) consultant for every 4000 annual attendances.
 - a. The minimum number of WTE consultants for a small department is 12, rising to 18-25 in medium department, up to 48 in the largest EDs.
4. There must be a consultant in Emergency Medicine available on call at all times for every Emergency Department.
5. There must be a senior decision maker (tier 4) on the shop floor 24/7/365.

Recommendations

1. RCEM supports the development of a balanced multiprofessional workforce to provide emergency care
 - a. RCEM supports the development of the ACP workforce within EM along the lines of the RCEM curriculum and the ACP credentialing framework
 - b. RCEM does not currently support the development of the Physician Associate workforce within Emergency Medicine
2. RCEM guidance for overall staffing, and regarding individual professional groups, should be used as the basis for workforce planning at departmental, system, and national level (across 4 nations). Staffing levels should aim to provide
 - a. The right capacity
 - b. The right capability
 - c. Working patterns that are realistic and sustainable
3. Retention, along with recruitment of staff, will be improved through the adoption of sustainable working practices. Working practices for all staff, and job planning for senior medical staff, should be
 - a. Legal
 - b. Sustainable
 - c. Designed to enhance recruitment and retention
4. The terms and conditions, including for senior doctors' job plans, play an important part in recruitment and retention. Employment practice should follow RCEM guidance.
5. Investing in the basic working environment of Emergency Medicine teams is an investment in both patients and staff
6. Staffing levels based on permanent staff are safer and more cost effective than those relying on temporary or locum staff
7. Emergency Department crowding should be regarded as a critical issue in terms of recruitment and retention to EM, along with its negative impact on patient experience and safety

Background

The Emergency Medicine workforce consists of highly skilled professionals from a variety of backgrounds, working within a complex system. Along with ED crowding, our ability to recruit enough staff with the right skills, and then keep them in EM, is the single biggest threat to the effective provision of emergency care in the UK.

Working out the national picture with respect to medical staff and ACPs in emergency medicine services for each of the 4 nations is complex. At the time of writing RCEM has undertaken census' for England, Scotland and Wales, and is using that to inform policy discussions.

RCEM has produced professional guidance with respect to the numbers of medical and nursing staff, and at what level, that are required to provide effective emergency care within individual services. However, numbers provide only one piece of the jigsaw. Attention to sustainable working and careers, and to wellbeing of staff, is critical.

Capacity

As far as local demand-capacity planning is concerned matching the workforce to expected demand is a basic operational requirement. The fundamentals are

1. Understanding demand. Demand for emergency care is relatively predictable within certain limits. It is important to map casemix and acuity, expected variation, how demand is segmented into streams, how this relates to the physical layout of the department, and what work is expected to be undertaken.
2. Deciding upon a capacity strategy to meet the demand. This will usually be a mixture of "level" strategies aiming to provide a baseline minimum level of cover based on physical layout / demand / resilience / personal safety etc, and then a "chase" strategy based on predicted variation in demand.
3. Understanding the capacity of different groups within the workforce, of the workforce as a whole unit, and of the processes that they undertake and interface with.
4. Working out how to ensure that demand and capacity are matched, and that the workforce has the right skill mix available, within sustainable and legal working patterns, 24/7/365
 - a. Appropriate adjustments should be made for training, expected levels of sickness and maternity, and to allow for flexible working patterns and LTFT working.

Workforce productivity is complex. Simply demanding that ED staff work harder or faster will not achieve optimal productivity. Productivity is a combination of individual factors, and of workplace factors. The latter includes crowding and having enough of the right staff available. Effective informatics systems, simplified processes, and access to clinical spaces and equipment are all important. The need to dedicate senior staff to actively managing a department, and the different areas of a department, is another key factor, along with the capability, supervision and training needs of clinicians working in different areas, and the casemix they are dealing with. There is also an increasing tendency for downstream services to front-load work into the Emergency Department. Whilst this may carry benefits for both patients and for downstream efficiency, it further reduces productivity at the front door. Organisations must decide where they want work to happen, and then ensure that the resources match the requirements. RCEM workforce guidance explicitly addresses productivity, and how to account for it when undertaking workforce planning.

Capability

RCEM describes the EM medical and practitioner workforce according to the following tiers

Tier	What it means
1	Require complete supervision, with all patients being reviewed by a more senior clinician Require direct supervision, and will usually have a reduced, but developing, scope of practice
2	Progression of increasing responsibility and experience as per RCEM curriculum More senior / experienced clinicians, requiring access to on-site supervision but able to see some patients independently within an agreed scope of practice
3	Progression of increasing responsibility and experience as per RCEM curriculum Senior doctors able to lead a department with remote support. Possess some extended skills that can be practiced independently. Full scope of practice
4	Progression of increasing responsibility and experience as per RCEM curriculum Senior doctors with a full set of extended skills and who have demonstrated their ability to take independent clinical responsibility for an ED. Most doctors in this tier will have an advanced postgraduate qualification in EM
5	Reference point: RCEM curriculum

Training and professional development for EM staff is challenging and requires particular attention. This applies to all professional groups working in the ED. It should be recognised that the nature of EM requires a high level of preparedness to deal with rare but critical conditions, the ability to respond effectively to common emergencies but within teams that are constantly changing, and the need to be able to know what to do across a huge range of clinical conditions in all ages. Mandatory training requirements, along with regulatory demands, mean that the burden of compulsory courses and updates is high. Staff turnover is expected to be higher than in many other services. All this needs to be factored into workforce thinking.

Sustainable working and careers

The need to consider sustainable working for staff working in Emergency Departments cannot be overstated. Effective leadership is critical here.

It has become increasingly apparent that sustainable working, and sustainable careers, are a key concern for emergency department staff. Rates of exhaustion, moral distress, moral injury, burnout, and exhaustion are unacceptably high. Crowding and understaffing are key drivers for this, as are poor attention to the basics of looking after staff, and unsustainable working patterns in high intensity environments.

For clinical staff RCEM has produced extensive guidance key relating to sustainable working and wellbeing through progressive employment practices and attention to working conditions. See the sections on job planning and wellbeing. Meeting the professional and career development needs of all staff groups is another key building block.

Organisational culture should explicitly address civility and respect, since they contribute to a positive working environment, as well as to patient outcomes. In addition, a workplace culture that empowers staff to engage with and enact change, and to speak freely where they have concerns about patient safety or about behaviours they witness or experience, is essential.

Violence and aggression towards ED staff from patients or accompanying persons is a significant concern. Where they are within the control of the organisation, root causes should be tackled (the most common issue is long waits). Conflict Resolution Training can only achieve so much, and security arrangements need to be responsive and robust, around the clock.

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Job planning for substantive senior Emergency Physicians

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Introduction

Job planning for emergency physicians needs to reflect the nature of the role, its intensity, and adhere to the principles of sustainable working. There is a balance between the needs of the NHS, individual organisations, and individuals. Approaches which ensure that patients benefit from the expertise of senior emergency physicians, whilst those clinicians can enjoy full careers, personal and professional development, and empowerment to run and improve their services, are most likely to prove successful.

Standards

1. Job plans must reflect the needs of a modern Emergency Medicine service by aiming to both deliver clinical care, and all the leadership and quality orientated activities which go into delivering a service
2. Direct Clinical Care schedules must be designed in a manner consistent with sustainable working
3. For consultants all scheduled time premium time working is by negotiation and must not be imposed without agreement. RCEM recommends that 2 hours per PA after 1900, and 1.5 hours per PA after midnight, are acceptable rates to support sustainable working
4. The role of the on-call Emergency Physician must fit with published RCEM guidance
5. SPA time must adequately reflect
 - a. The activity required to run an Emergency Department and to develop the service (see below for examples)
 - b. The activity required to train clinicians in Emergency Medicine (see below for detail)
 - c. The continuing professional development needs of Emergency Physicians
6. Emergency Physicians must be supported to undertake additional roles within their organisations and systems, wider NHS roles, and external roles

Recommendations

RCEM recommends that job plans conform with

1. BMA Job Planning guidance
2. RCEM medical staffing guidance
3. RCEM sustainable working good practice

Organisations should support flexible working in all its guises, flexible job planning, and the development of portfolio careers.

1. Job plans should usually not exceed 12 PAs
2. Consultant Job Plans should contain a minimum of 2.5 SPAs. A minimum 3 SPAs is considered best practice as in Wales
3. Job plans should be annualised, ideally supported by self-rostering
4. Arrangements for sabbaticals should be agreed within organisations
5. Weekend frequency should be considered in workforce planning
 - a. For Consultants: Baseline maximum weekend working frequency of 1:8 is considered ideal if only one person is on duty every weekend day. A maximum weekend frequency of 1:6 should be considered if there are two or more consultants on duty each day.
 - b. For SAS doctors: weekend frequency should be no more than 1:4.
6. Out of hours working for SAS doctors should be no more than 40% of contracted hours.
7. Consideration of the older consultant should be included in job planning (e.g.)
 - a. The proportion of Supporting Professional Activities (SPA) to Direct Clinical Care (DCC) should increase with advancing age
 - b. Late night or overnight working, and participation in on call rotas, should reduce or discontinue from age 55. This requires proactive recruitment planning

The high intensity nature of ED working, combined with the shift working pattern, places emergency physicians at high risk of exhaustion and burnout. ED crowding and understaffing are additional risk factors. Moral distress and injury are also thought to be on the rise as a result of ED crowding and demand-capacity mismatch. RCEM has produced extensive recommendations around sustainable working.

Emergency Medicine Services require a significant amount of non-clinical time in order to function effectively. This usually means that emergency physicians are working a lower DCC: SPA ratio than colleagues in many other specialities. This is a mark of good practice rather than inefficiency. This may be particularly noticeable in smaller departments.

Direct Clinical Care includes

- All shop floor time, including CDU rounds and any clinic work undertaken
- All clinical administrative time, whether undertaken as a team or individual. This includes handling complaints
- Multidisciplinary and other meetings about individual patient care
- Undertaking shop floor education where trainees are directly supervised or observed on the shop floor

Supporting Professional Activity Includes

- CPD
- Appraisal (own)
- Handling regular emails
- Departmental meetings
- Engagement with job planning
- All teaching and training activity except shop floor educator shifts as above
- All audit and local governance work
- Service management, and quality improvement work
- Research

It is recommended that as a minimum the following roles are established in each ED, and that they should attract dedicated time

- Clinical Service Lead (+/- deputy)
- Workforce and Recruitment Lead
 - Wellbeing Lead
- Informatics Lead
- Design and Estates
- Equipment Lead
- Clinical Governance Lead (+/- deputy)
 - May require specific leads for safety, complaints, mortality
- Quality Improvement, Audit and / or Clinical Effectiveness Leads
- Research Lead
- Paediatric Emergency Medicine Lead
 - Safeguarding in Children Lead

- Lead for Emergency Preparedness, Resilience and Response
- Inclusion and Civility Champion
- Environmental / GreenED lead
- Education and Training Leads for
 - Emergency Medicine training (College Tutor)
 - Other postgraduate medical trainees and fellows
 - ACPs
 - Undergraduates
 - International Medical Graduates
 - SAS doctors
 - Portfolio Pathway (was CESR) program
 - Ultrasound
 - Simulation
- Leads for specific areas: resus, ambulatory care, minor injuries, frailty, mental health, major trauma, sedation, safeguarding in adults

Educational supervision is a significant requirement in Emergency Departments. Training capacity is defined by the ability to provide workplace, clinical and educational supervision for specialty trainees. RCEM recognises that there is also a significant training workload and need for quality standards when supporting the wider EM multi-disciplinary team

- **Speciality Trainees:** Trainers should have 0.25 PA per trainee in their job plans to ensure they can deliver high quality training
- **Advanced Clinical Practitioner (ACP) trainees:** There should be at least one consultant per trainee and one RCEM trainer who has completed ACP credentialing training for every two trainees, with 0.25 PA allocated in the job plan per trainee. Please refer to current RCEM ACP curriculum for ES/ACP credentialing trainer requirements
- **Portfolio Pathway Trainees:** There should be at least one consultant per trainee and an accredited consultant trainer with 0.25 PA allocated in their job plan per trainee

Life Support courses rely heavily on emergency physicians because of the skill set. Life Support Teaching should be regarded as additional SPA and not simply part of the role of an Emergency Physician

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Pharmacists & Pharmacy Services in the Emergency Department

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Introduction

Patients presenting to the ED are increasingly complex with multiple co-morbidities and significant polypharmacy. Pharmacy services are uniquely qualified to ensure safe and effective use of medicines, improving quality of care and reducing unnecessary cost and treatment delays.

Pharmacists optimise medication use in the acutely unwell patient, improving prescribing quality and safety, factoring in instability and complexity of medicines used in this patient group, using evidence-based recommendations and collaborating with medical and nursing teams. In comparative studies proactive reconciliation and optimisation of both acute and chronic medicines by pharmacy teams in patients presenting to the Emergency Department has been shown to reduce medication errors and improve outcomes for patients.^[1] Evidence supporting the use of ward-based pharmacy services, from admission to discharge in emergency and acute care, shows clinical and economic benefits with significant cost savings.^[2] NICE recommends inclusion of pharmacists in the multi-disciplinary care of patients requiring emergency admission to the hospital.^[3]

Pharmacy Technicians and Assistant Technical Officers (ATO) provide invaluable expertise in medicines management, expenditure reporting and practical medication advice. Their supporting and direct patient-facing roles allow pharmacists more time to undertake medicines optimisation.

RCEM recommends the use of dedicated ED pharmacists and pharmacy services to work as part of the multidisciplinary team to help support the safe and efficient delivery of care to patients in the Emergency Department as well as in Clinical Decision Units / Observation wards.

Standards

1. All Emergency Departments must have a dedicated pharmacist. For clinical cover, RCEM recommends 0.1 WTE pharmacist per resus bed plus 0.05 WTE pharmacist per majors/high acuity bed.
2. All Emergency Departments must have a dedicated Pharmacy Technician. RCEM recommends 1 WTE as a minimum however there must be sufficient allocated Pharmacy Technician and ATO time to provide supporting roles and assist in medicines management relative to size and complexity of the ED.
3. Co-located observation wards / Clinical Decision Units must have a dedicated pharmacist supplementing the dedicated ED pharmacist to cover the area. This resource must be sufficient to ensure medicines reconciliation occurs within 24 hours of patient arrival to ED and ensure efficient and coordinated discharge.
4. The Emergency Department pharmacy service must be present seven days per week. As a minimum the service must be available five days per week and plans in place to increase to seven days per week.^[4]
5. The ED pharmacist must have a clear role description and support to allow sufficient time to be dedicated to all aspects of the role. There must be sufficient pharmacy team resource available to support non-patient facing activities as part of the ED management team.
6. ED pharmacists must be working towards or have achieved accreditation on the RPS Advanced Specialist Curriculum, Advanced Pharmacy Framework, or equivalent. Other pharmacists working in ED must be engaging with a relevant curriculum, have appropriate skills and experience and have access to the ED pharmacist for clinical support. ^[5,6]
7. RCEM does not support the use of pharmacists without additional training to see ED patients independently except for issues directly pertaining to usage of medicines.

Recommendations

1. Sufficient resource should be provided to ensure that periods of annual, sickness and educational leave are covered to ensure continuity of service to ED patients. This may be best achieved via use of a pharmacy team than individual practitioners.
2. In times of escalation and reduced patient flow from ED, additional pharmacy service resource (pharmacist or pharmacy technician) should be made available to reduce risk of patient harm.^[7] RCEM recommends where required an additional 0.05 WTE pharmacist or pharmacy technician per occupied corridor/overflow bed OR 0.05 WTE per patient waiting 12 hours or greater in the ED.
3. If not already resourced, the ED pharmacist should also provide clinical and operational support to any Emergency Department operated separate Urgent Treatment Centre.
4. Emergency Department pharmacists should be supported and encouraged to become active independent prescribers in emergency medicine and maintain appropriate Consultant/SAS clinical supervision.
5. Pharmacy Technicians should be experienced in working with acutely unwell patients and appropriately certified to take histories and reconcile medicines.

Background

The following are examples of core duties of the Emergency Department pharmacy service and should be considered when designing and implementing team structures

Medicines reconciliation and treatment optimisation

ensuring an accurate drug list is available and acute/chronic treatments optimised as soon as a decision to admit has been made, aiming to reduce length of hospital stay.

Focus on high-risk patient groups

Patients who are elderly (STOPP/START Tool; a medication review tool), have renal failure, or a disease requiring time-critical medication to manage to help ensure these patients do not deteriorate whilst in the Emergency Department or if subsequently admitted; as well as considering drug interactions. The promotion and monitoring of safe prescribing in children.

'Ward based' activity

Anecdotally pharmacy cover has been scanty for Clinical Decision Units / Observation Wards; the rapid turnover often complex patients (e.g. older patients after a fall, awaiting therapy or social input) may result in issues with drug prescription and administration, as described above.

As part of the ED management team

Drug budget analysis, safe management of controlled drugs, development of guidelines / drug monographs, prescription charging, liaison role with the rest of hospital regarding medicines policies and impact upon the Emergency Department, electronic prescribing and 'automated' dispensing.

Liaison with primary care

To provide feedback to general practitioners regarding their patients who have attended the Emergency Department and who may be on less than optimum drug therapy (too many, too few, wrong ones) irrespective of presenting complaint and to coordinate complex changes at the point of discharge.

Patient safety

Embedded in clinical governance as part of the ED management team, prevention and reporting of drug errors, drug safety alerts, review and advice regarding high-risk medicines such as warfarin, insulin and anti-cancer agents, promotion of safe prescribing. Ensuring time critical medications are prescribed and administered correctly, providing alternative plans for those patients.

Clinical decision support

For Emergency Department professionals encompassing safe prescribing, drug location and drug administration. Specific issues for the Emergency Department include antidote availability, compliance with national guidance relating to pharmaceuticals (e.g. recalls). Pharmacists have a key role in staff education of use of medicines.

Dispensing of prescriptions

Rapid access to palliative care discharges, fast tracking of prescriptions for patients waiting to be discharged, to avoid breach emergency access standard ('4-hour target'), particularly if the hospital pharmacy is located some distance from the Emergency Department.

Patient education

New drug prescriptions, inhaler technique, use of injector pens.

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Staff Wellbeing

Authors

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Introduction

This section defines the expectations of individuals, departments, and organisations to maximise the wellbeing of ED staff.

Standards

1. Organisations must promote rest for ED staff while on shift, including the facility to sleep post-nights and take power naps during the shifts.
2. All staff working in emergency departments must have 24/7 access to basic food provision and healthy hot food and provide clearly rostered breaks that comply with rest/break entitlements.
3. When designing rotas, explicitly consider published guidance such as the RCEM EM-POWER guideline¹ and the Good Rostering Guide².
4. The ED must always have adequate staffing numbers and should adhere to the relevant RCEM workforce recommendations^{3,4}.
5. Every ED must have a dedicated Wellbeing Lead (supported by a team) who should be accessible and proactive.
6. ED clinicians must have access to an effective mentoring programme run within their organisation.

Recommendations

1. All staff should look after their own wellbeing including ensuring adequate sleep, exercise, nutrition, hydration, taking breaks/leave, setting boundaries, and engaging in enriching activities and that bring joy and purpose.
2. All staff should acknowledge the benefits of civility and show compassion towards colleagues, patients, relatives, and others they may contact within and beyond the ED.
3. EDs and organisations should support a work environment that is open, inclusive, and accessible for all, including those with disabilities and chronic illness.
4. EDs and organisations should promote positive feedback/praise as part of a normal culture; finding innovative ways to give meaningful positive feedback outside of (but including) formal processes.
5. EDs should organise regular team activities and training to foster a supportive environment, empathy and compassion towards the other team members and promote team development and cohesion.

Background

Wellbeing encompasses physical, mental, emotional and cultural health. It also includes the cultivation of healthy relationships at personal and professional levels based on appreciation, kindness, gratitude and compassion.

The wellbeing of clinicians is vital because there is abundant evidence that workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health. A number of studies have found that doctors with high levels of burnout had higher odds of making a major medical error⁶. Two thirds of UK doctors in training are at high or moderate risk of burnout⁷ and almost half of hospital employees in England are considering leaving the organisations in which they work⁸. Optimising staff wellbeing should therefore be a priority for everyone

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Emergency Department Estate Standards

Authors

Adrian Boyle | Susan Robinson

Introduction

This section defines the physical structure of an Emergency Department.

Standards

- 1.** The building of new emergency departments must, at a minimum, comply with the Health Building Note 15-01: Accident and Emergency departments planning and design guidance ⁽¹⁾.
- 2.** Areas where children are cared for must comply with the standards described in Facing the Future: Standards for children in emergency care settings ⁽²⁾. Children must have separate waiting rooms and assessment areas from the main department.
 - a.** Ideally there must be a separate entrance to the paediatric emergency department.
- 3.** Every Emergency Department must have at least one Psychiatric Liaison Accreditation Network (PLAN) compliant room for people presenting with mental illness ⁽³⁾.
 - a.** Furthermore, there must be a similar room for children and young people who present in mental health crisis.
- 4.** Every Emergency Department that cares for adults must have an environment that is suitable for older persons and those who are living with frailty ⁽⁴⁾.
- 5.** Every department must be able to provide equity of access to all areas for people with disabilities, both patients and members of staff.

Standards

6. Emergency Departments that treat women presenting with gynaecological symptoms must have a private clinical examination space that affords an appropriate level of privacy to allow necessary examinations to take place with a chaperone. This would include a room that has a securable door and is visually separated from the remainder of the clinical space. ⁽⁵⁾.
7. Every Emergency Department must have the ability to isolate patients who are potentially infectious on arrival to reduce the risk of nosocomial infection of staff and other patients.
8. Every Emergency Department must have a room that can provide a suitable environment to break bad news. This should provide a quiet and controlled environment.
9. Every Emergency Department must have an area where staff handovers can be conducted without breaching patient confidentiality.
10. There must be dedicated space within the ED able to provide critical care interventions to the level of mechanical ventilation and invasive haemodynamic monitoring. The equipment used for critical care interventions in Emergency Departments must be standardised across a hospital.
11. All staff must have access to a break room of an adequate size with sufficient facilities for the number of staff within the ED where staff can prepare hot food, eat and rest. Staff must also have access to appropriate changing facilities.
12. Post Graduate Doctors in Training and trainee Advanced Care Practitioners must have access to a separate non-clinical space. This allows important non-clinical work to be conducted, such as research, quality improvement and management ⁽⁶⁾.
13. Senior staff and departmental administrative staff need appropriate non-clinical space. Some of this needs to allow confidential discussions, for example between a Post Graduate Doctor in Training and their educational supervisor.
14. Departments without in-situ 'hot labs' must have access to automated, rapid and reliable transport systems (eg. Pods) for pathology specimens.

Recommendations

1. Patients should not be cared for in corridors.
2. Every Emergency Department should consider how they care for bariatric patients.
3. Departments should have a separate, dedicated areas for the preparation of intravenous medications and infusions, ideally a room(s). This reduces the risk of drug errors.
4. Larger departments should consider developing a separate area for adolescents.

Background

Many departments have developed as the result of creative use of space. Whilst pragmatism is commendable, this has resulted in departments whose design does not support efficient use of staff, optimal flow, high quality of infection prevention and control and a good patient and staff experience. There are some useful guiding principles that should be followed when considering how space is used in an Emergency Department.

1. Linear design. A series of assessment spaces using a linear design, rather than a pod or circular layout, evens out workload across staff and is more efficient.
2. Flexibility, being able to adapt assessment spaces for different acuity and patient needs promotes good patient flow.
3. Dignity and privacy. There has been an unwelcome trend to care for emergency patients in small, poorly adapted spaces as departments have become increasingly crowded. Patients should be able to provide their history and discuss their care without being overheard. Patients must be able to be examined in privacy. Individual rooms should be the normal.
4. An assessment and treatment space must have visual and auditory privacy, have access to oxygen, suction and a way of contacting staff quickly. A space that does not meet these requirements should not be counted as an assessment space.
5. The number of assessment spaces is dependent on the number of attendances, the case mix and acuity, and their length of stay. Calculations about the number of assessment spaces should be made on the 80th centile of activity, rather than the average number of attendances.
6. Non-clinical areas in departments provide a necessary function, both for senior permanent staff and for Post Graduate Doctors in Training. These must be designed in such a way that they cannot be turned into clinical spaces to mitigate short term operational pressures.
7. Multidisciplinary in situ training within the ED provides a high-quality educational experience and contributes to safer care. These facilities (such as meeting spaces, seminar rooms or simulation suite) need to be provided close to the ED or ideally, within it.
8. Staff need to be able to take breaks in an area that signals respect for their contribution to the department. Adequate staff facilities that include sufficient toilets, space for changing, expressing breast milk and the safe storage of personal effects are crucial. These should have adequate electrical and IT points.

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Observation Units as part of the Emergency Department

Author

Ed Smith

Introduction

Emergency Department Observation Units were first recognised in the UK in 1960 by the Nuffield review of casualty services. They have existed alongside Emergency Departments since then and are identified by various names, including clinical decision units, observation wards and assessment units/wards.

The main objective of these units is to manage a cohort of patients that originally present to the ED with specific identifiable characteristics. These patients have either

- Limited medical needs (e.g. alcohol intoxication or minor head injury)
- A need for short term observation (e.g. overdose with no specific medical intervention required, or
- A short-term treatment need (e.g. comparatively simple medical intervention such as rate control in atrial fibrillation).

Evidence from historical systematic reviews of observations units suggest that they have a benefit in terms of concentrating medical expertise and resources in a single defined area and enable early senior review of the patient. In addition, they improve patient satisfaction, are safe and decrease overall length of stay in appropriate patient groups. They may also deliver overall cost savings related to reduction in length of stay.

Observation units can consist of beds, chairs or combination of both.

Standards

1. Observation units run by Emergency Physicians are short stay facilities. A 48-hour cut off for length of stay is a reasonable standard, however most patients will stay in the observation unit for a shorter length of time (24 hours maximum).
2. Patient cohorts selected for Observation Units are locally agreed. However, they should be patients with limited medical needs, with a need for short term observation, or with a short-term treatment need, only.
3. Observation units must not be used as a performance management tool to manage nationally imposed performance standards. They are for suitable patient cohorts only and must not accommodate the 'next patient in the bed queue' or be used to avoid a breach in an undifferentiated patient.

Recommendations

1. It is recommended that there is clarity about which clinician sees which patient in each clinical setting. In recent years there has been an emergence (particularly in England) of a push to manage lower acuity patients through Same Day Emergency Care (SDEC) facilities. There are a lot of similarities between SDEC units and observation units, to the point where they may have become the same entity in some hospitals.
2. Historically observation units have evolved physically from space adjacent to the ED. They have often not been purpose-built but have been established in a response to an identified need. This limits the standardisation of design features in such units. When designing a new or refurbished unit it is recommended that consideration is given to reducing the chance of the unit being converted into a ward which then evolves into a long stay ward in a crowded hospital system: e.g. not using a conventional ward layout with large bed spaces/curtains etc. This is a difficult balance as it needs to be recognised that patient experience and privacy and dignity issues should be taken into consideration.
3. If the observation unit is set up to take patients with a medical presentation it is recommended that support from the general medical team is agreed from the outset. One risk of an observation unit is that it is seen by specialty teams as a 'soft' admission route, avoiding their input and thus reducing workload. This should be resisted.
4. If it becomes apparent after the patient has been admitted to the observation unit that a patient needs a non-EM specialist then that specialist team should look after the patient in the observation unit until an appropriate space becomes available.
5. For an observation unit to be effective, establishing a flow out of the unit is critical. Even if unit entry criteria are robust, there will be patients in whom longer inpatient stays are required. These patients should be prioritised for admission once it is identified that longer stay admission to hospital is required.

Background

Observation units have been in existence for as long as Emergency Department care has been delivered. The original driver was the need to observe and/or treat certain cohorts of patients for longer than the typical length of stay of a patient in the ED. It was also the case that continuity of care (by remaining under the care of an emergency physician, rather than onward referral to an inpatient team) would be of benefit to the patient. The number of beds required to deliver this function effectively varied from unit to unit depending on local needs and service delivery, however the British Association of Accident and Emergency Medicine recommended that this should be one short stay bed for every 5000 attendances.

Over time the function of observation units has evolved to reflect local need depending on case-mix. There has also been a degree of variability of delivery that probably reflects local preference and/or the expertise of the clinician team overseeing the service. The advent of the four-hour Emergency Care Standard in the early 2000s probably led to a perceived opportunity to use observation units as ways of housing patients waiting inpatient beds in a 'ward' setting and therefore ensuring that they were not counted as breaches of the standard (at times of bed pressures, exit block etc).

In the last few years, the role of the observation unit has changed again in some locations as there is a national push to encourage the management of patients through non-admitted care pathways. This is referred to as Same Day Emergency Care and there is a degree of crossover between the functionality of SDEC units and observation units – they are 'off the clock' areas that focus on the lower acuity patients with a specific diagnostic or observational need, with an expectation of a less than 24-hour turnaround time.

It is likely that the local architecture of SDEC and observation units will continue to vary between hospitals. This will be driven by the local expertise and interests within the services (and the relative input of emergency physicians and acute physicians etc) as well as case-mix and physical estate restraints. Despite this there will always be a need for observation of a proportion of our patients beyond a standard four-hour ED stay, and the value of emergency physician input into managing certain groups of these patients, such as on a local ED observation unit, is significant.

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Same Day Emergency Care and the Emergency Department

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Introduction

The purpose of Same Day Emergency Care (SDEC) is to provide urgent clinical care without admission. From an ED perspective this will provide alternative pathways of care with improved security in discharge and may reduce crowding.

SDEC services may be provided for patients with medical, surgical, paediatric, gynaecological, orthopaedic, frailty, urological, oncology and mental health conditions. This may be in a stand-alone unit or a shared space. The workforce can be single speciality or mixed/ multi-skilled. Emergency medicine consultants and other clinicians may choose to work in this area, in addition to the ED.

Standards

1. All hospitals with a type 1 ED must provide an SDEC service. Minimum opening times must be 12 hours a day 7 days a week. **NHS Long Term Plan**
2. Care delivered in a SDEC unit must be geographically distinct from the main Emergency Department.
3. SDEC must provide a service for patients with a medical issue which can be investigated and treated without the need for an overnight stay either on the day or patients can be brought to the service for management the next day.
NHS England » Same day emergency care
4. Patients in SDEC must require urgent treatment; planned care is provided for in a planned care unit not SDEC.
5. Patients must not be moved to SDEC to avoid a breach when their care is best be completed in ED or where admission is obviously required.
6. Access must be maintained at times of pressure and the physical space must not be bedded.
7. There must be capacity to accept referrals from ED, 111, ambulance services, secondary care, primary care and community teams. **NHS England » Same day emergency care**
8. Investigation timeframes must have the same turnaround times as ED and are conducive to same day working.
Joint Statement RCEM and SAM regarding Same Day Emergency Care (SDEC) | RCEM
9. Activity must be recorded using ECDS data sets. **NHS Long Term Plan**

Recommendations

Exclusions to SDEC

1. Planned Care /Medical Day Unit procedures (e.g., biopsies, planned infusions, transfusions and intravenous treatments, blood tests after ward discharge and dressings).
2. Patients who clearly require inpatient admission at the point of referral.
3. Red flag conditions-needing urgent interventions e.g., resus patients- to be confirmed at local level.
4. Fractures (requiring surgical intervention).

Access to the service

The following principles should be followed when considering how patients are referred into the service

- Referrals accepted from all appropriately trained healthcare profession (for example-doctor, nurse, ANP, DN, Paramedic, CNS).
- Patients are referred into the service by telephone, email or digital tool.
- Times of referral into the service reflect opening times and the ability to allow treatment completion.
- Identification of patients suitable for SDEC may include scoring systems, pathway specifics and clinical conversation.
- Patients will be asked to attend immediately or given a time to attend (which may be the next day).
- Patient is triaged promptly on arrival (suggested KPI 15mins) if not completed-unless trusted assessment taken.
- POCT may be used if it supports the service.
- The patient is assessed and managed within an appropriate time frame (suggested KPI 6 hours).
- Discharge to appropriate place including home, GP, virtual service, community service.
- Letter electronic to GP.

Key Performance Indicators

- Patient should be transferred to SDEC within 60 minutes of arrival to an ED or UTC.
- Triage within 15 minutes of arrival (if no trusted assessment).
- Patients should be assessed by an appropriate clinician within 60 minutes of arrival to SDEC.
- Turnaround times for pathology results 2 hours.
- Turnaround times for request to imaging 2 hours.
- Percentage admissions from SDEC benchmarked against local and national standards and 10%.
- Number of SDEC patients as a proportion of all UEC activity on the site- (KPI 30% as zero LOS).
- Number of attendances from all the referring services (ED, UTC, community).
- Unplanned returns to service within 7 days <5%.
- Patient should stay in SDEC no more than 8 hours.
- Total time from arrival to discharge home or admission.
- Letter sent to GP on the day the episode completed.
- Disposal data- home, admission, hot clinic etc.

Other measures

- Unplanned returns to hospital 28 days
- SIs and complaints
- Patient Feedback
- Staff feedback
- Capacity issues per week workforce or space

Workforce

The substantive workforce is a multi-disciplinary team of professionals who as well as delivering excellent care can effectively use the rich case mix to train others.

Joint Statement RCEM and SAM regarding Same Day Emergency Care (SDEC) | RCEM.

Specific speciality SDEC

There are some specific recommendations for SDEC relating to certain specialities. Trusts may choose to combine SDEC facilities eg medicine and frailty or have separate units. There are benefits to joint models of care including flexible use of space and utilisation of expertise.

Specialty Specific Guidance

➤ Frailty : [SDEC_guide_frailty_May_2019_update.pdf \(england.nhs.uk\)](#).

➤ **Includes specifically:**

- Trusts with a type 1 ED should provide 70 hours of frailty service a week for a MDT assessment
- Clinical Frailty assessment within 30 minutes of arrival

Paediatrics: [NHS England » Paediatric same day emergency care](#).

Includes specifically:

- An appropriate environment for babies and children [Recommendations | Babies, children and young people's experience of healthcare | Guidance | NICE](#)
- Safeguarding procedures are in place
- Surgery and orthopaedics: [Ambulatory Care Services - Surgical AEC Programme \(ambulatoryemergencycare.org.uk\)](#)
- Gynaecology and pregnancy: [The Association of Early Pregnancy Units \(aepu.org.uk\)](#)
- Patients with early pregnancy issues are seen in a suitable unit
- Oncology: [Acute Oncology and New Models of Same Day Emergency Care \(SDEC\) :: UK Acute Oncology Society-A less well established but developing area.](#)

Background

Early work in this field focused on ED based Clinical Decision Units. The concept of Ambulatory Emergency Care (AEC) also emerged, initially focused on ‘medical’ conditions, although many specialities have been developing ambulatory models of care without it being recognised as such. The concept of SDEC draws these ideas together. It allows specialists to care for patients on the same day of arrival as an alternative to hospital admission. The benefits include reducing unwarranted variation, better patient and staff satisfaction, reduced admission rates and enhanced flow in the Urgent and Emergency Care (UEC) pathway. **Joint Statement RCEM and SAM regarding Same Day Emergency Care (SDEC) | RCEM.**

There are a lot of similarities between SDEC units and ED observation units, to the point where they may have become the same entity in some hospitals. Many EDs no longer have CDUs following the pandemic. Where SDEC is occurring in multiple environments care should be taken to clarify clinical pathways, ensure that criteria are inclusive rather than exclusive, and that there is clarity over responsibility for care.

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Psychiatric Assessment Rooms

Author

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Introduction

This section describes the built environment that an emergency department should have to look after patients who present in mental health crisis.

Standards

Facilities must meet the following requirements

1. Be located within the main Emergency Department.
2. Have at least two doors which open outwards and are not lockable from the inside.
3. Have an observation panel or window which allows staff from outside the room to check on the patient or staff member, but which still provides a sufficient degree of privacy.
4. Have a panic button or alarm system (unless staff carry alarms at all times).
5. Only include furniture, fittings and equipment which are unlikely to be used to cause harm or injury to the patient or staff member. For example, sinks, sharp edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used to cause harm or as a missile are not permitted.
6. Have a ceiling which has been risk assessed.
7. Not have any ligature points.
8. Sharp corners, such as at the corners of protruding walls are covered to reduce the risk of harm. If there is a bed within the room, this should be weighted with no ligature risks.
9. There must be a process in place to ensure the patient is monitored whilst in the room.

Recommendations

1. Be appropriately decorated to provide a sense of calmness.
2. There should be a process in place to ensure patients are supported to access ligature free toilet facilities or at minimum toilets with thumb turn locks.

Background

Patients who present to Emergency Departments with a mental health crisis need a different environment to be safely assessed in. They are asked sensitive information, may be frightened or agitated and may be a risk to themselves or others. Our standards and recommendations are entirely based on the Royal College of Psychiatrist's Psychiatric Liaison Network's (PLAN) standards.

Clinical Information Systems

Author

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Introduction

The choice of clinical information system (or Electronic Patient Record) can have huge impact on the quality of life at work in an Emergency Department. Multiple login requests, excessive clicks required for a simple action and unnecessary alerts leech time, bandwidth and enthusiasm from all exposed to them. Research by members of the RCEM Informatics Committee has demonstrated the poor useability of the majority of systems in use in 2019¹.

Emergency Department Information Systems (EDIS) rarely operate or are procured in isolation so Emergency Physicians have limited scope to control or influence decisions around them. However, this chapter will provide a brief introduction to the underlying standards and principles.

Standards immediately applicable to Emergency Departments

ECDS Information standards notice: this specifies the information which must be submitted by all Emergency Departments (including from 2024 Same Day Emergency Care). It is regularly updated and the current version can be found at

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds>.

Emergency Care Discharge Standard: this was developed by the Professional Record Standards Body (PRSB) in conjunction with RCEM, RCGP and RCP amongst others. It details the information which should be included in communications with the GP when a patient is discharged from Emergency Care. The current version is at

<https://theprsb.org/standards/emergencycaredischarge/>.

Recommendations

The RCEM informatics committee has prepared advice for clinicians involved in IT system procurement
<https://rcem.ac.uk/advice-for-clinicians-involved-in-ed-it-procurement/>

A clinical information system has a number of functions relevant to Emergency Care

1. Core functions

- Recording an ED attendance, including for a patient who arrives unconscious;
- Merging records when patient identity becomes known;
- Admitting to a ward;
- Making and attending an ED follow-up appointment;
- Record attendance or non-attendance from a 111 contact;
- Major incident functions including multiple unknown patients.

2. Core functions

- Access to relevant records including hospital, GP, mental health and CPIS;
- Documentation of acuity assessment including triage and streaming;
- Documentation of clinical records;
- Requesting and reporting of investigations including imaging;
- Documentation and communication of referral and transfer to specialty teams and areas (including specialties at a different centre);
- Providing an overview of all emergency care areas (the “whiteboard” function).

3. Core functions

- Retrieval and incorporation of medication history from other sources;
- Allergy checking and documentation;
- Prescribing and administration of drugs, including retrospective documentation of drugs given in an emergency scenario;
- Fluid and blood product prescribing and tracking;
- Integration of Patient Group Directives and Non-Medical Prescribing function.

4. Core functions

- Extraction and reporting of Core Data Sets (ECDS);
- Live identification and alerts for patient deterioration;
- Report building eg to support business cases or for QI/research.

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High Intensity User and Frequent Attender Services

Authors

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Introduction

There are a number of patients who frequently and disproportionately attend emergency departments. They frequently have poor patient experience and may undergo unnecessary treatment and potentially harmful investigations. The Royal College has previously described optimal care in our guideline here

[Frequent_Attendance_in_the_Emergency_Department_v1.pdf \(rcem.ac.uk\)](#)

Standards

- 1.** A senior decision making clinician must have funded time to improve care for this patient group. This can be used for developing bespoke case management plans, liaising with relevant inpatient specialties and ensuring plans are kept up to date. This improves patient and staff experience, reduces unnecessary investigations and treatments.
- 2.** Information about bespoke case management plans must be held securely to maintain patient confidentiality but also be easily accessible to treating clinicians. Electronic patient record (EPR) systems should highlight when a patient has a specific management plan.
- 3.** Emergency departments should have systems that can identify high intensity users (HIU). These are likely to include a combination of information technology based reporting as well as less formal 'shop-floor' feedback.
- 4.** Relevant information must be shared across the care team, including the patient's General Practitioner.
- 5.** Patients whose frequent attendances are primarily related to mental ill health should have management plans developed in conjunction with liaison psychiatry teams.

Recommendations

1. Individual EDs should define what they consider to be a HIU reflecting local differences in patient demographics, commissioning, and wider service engagement. RCEM have previously cited 5 or more attendances in a year as reflecting HIU.
2. External organisations, such as charities, can provide useful additional services for high intensity services.
3. Staff should receive regular training in how to compassionately and professionally support high intensity users.
4. Larger organisations should consider developing specialist High Intensity User Clinics.

Background

The number of patients frequently attending EDs as a result of unmet health and care needs, or with underlying vulnerabilities is rising. An ED visit is not always beneficial for these patients and may increase health care anxiety. Frequent attendance to the ED is often a reflection of a system wide deficiency of care for the most vulnerable members of society and this patient group has often been marginalised in the ED and other healthcare settings.

'Frequent attendance' to EDs is associated with frequent attendance of other health and social care facilities. This cohort tends to be of higher acuity, have greater rates of admission, and a greater burden of chronic disease, when compared to matched groups. Patients with multiple vulnerabilities (e.g. chronic mental health problems combined with social problems and alcohol/substance misuse) are more likely to have the highest intensity of ED use and may struggle to access other services. Mortality rates are markedly higher among patients with HIU relative to those with less frequent use, partially reflecting a higher risk of death due to violent means and suicide.

HIU services are crucial in supporting vulnerable patients with complex physical and mental health needs. By developing links with physical, psychological, social support, and the third sector, these services can also benefit patients who attend less frequently. Individual EDs should decide on a feasible HIU definition with sufficient flexibility to include patients who may benefit from MDT intervention even if they do not fulfil a generic definition. EDs should consider including patients who; attend very frequently over a short period of time, escalate their frequency of attendance, or who present complex clinical challenges (even if they do not attend very frequently).

Metrics in Emergency Medicine

Authors

Ian Higginson | James France

Introduction

Metrics are a key building block in making sure that we deliver the right standards of care for our patients, and care for our staff in the right way. They must be carefully derived and carefully used within leadership and management paradigms that appreciate the complexity of healthcare delivery, and the application of improvement science in complex environments. ⁽¹⁾

Metrics will never tell the whole story about care in the Emergency Department (ED). The axiom “not everything that can be counted counts, and not everything that counts can be counted” should always be remembered. However, the wise use of appropriate metrics has the potential to help improve the standard of care that can be delivered.

Standards

1. Emergency Departments must collect data according to standards contained in the informatics chapter of this document.
2. Emergency Departments must have a quality management and improvement program in place (see Quality Improvement chapter) which should involve measurement and where appropriate, improvement of, performance against:
 - a. Key national health service standards
 - b. RCEM standards
 - c. Locally derived standards where relevant
3. Emergency Departments in England must participate in the Getting It Right First Time (GIRFT) program for emergency medicine.
4. Emergency Departments must have access to both live and retrospective performance metrics (see Crowding chapter).

Recommendations

1. Emergency Departments in the devolved nations should consider participating in the GIRFT program for emergency medicine
2. Emergency Departments should participate in the RCEM Quality Improvement Programs
3. Where metrics are being developed the principles and criteria described below should be applied

Background

To be successful measures that we use in Emergency Medicine need to fulfil the following criteria: ⁽²⁾

- It must be possible to collect the data
- It should be easy to collect the data
- The data should relate to meaningful outcomes, either for quality of care, or for patient and staff experience
- The measures should be centred on current health priorities
- The measures should be applicable across patient groups OR all major patient groups should be represented if more than one measure is required
- In addition, metrics should focus on: ⁽³⁾
 - Prioritisation of the sickest patients in terms of time to be seen
 - Prioritisation of the sickest and most complex patients being seen by the most experienced clinicians
 - Ensuring that there is not prioritisation of any single condition at the expense of the undifferentiated patient

Metrics can be viewed as either a tool for accountability or improvement. Metrics for accountability should be few in number, and intuitive. Emergency Department metrics should be relatively robust against ‘gaming’ (a reactive subversion such as “hitting the target and missing the point” ⁽⁴⁾).

The most common frameworks used for measurement of quality in Emergency Medicine (5,6)

➤ Structure	➤ Effective
➤ Process	➤ Patient-Centred
➤ Outcome	➤ Timely
➤ +/- Balancing measures	➤ Efficient
➤ Safe	➤ Equitable

Most metrics in Emergency Medicine, centre on process or structure. Outcome based indicators are much harder to develop.

- A **standard** is an agreed way of doing something. A metric measures performance around a standard.
- A **Key Performance Indicator** measures actual performance against a standard, with the aim of achieving a specific result
- **Benchmarking** compares the level of attainment reached either against a defined standard, or against other organisations.

Any form of comparison between organisations or departments will generate discussions about

- Data quality
- Case-mix: (i.e.) differences between patient groups
- Differences between organisations

Collecting high quality data requires information technology systems. The Emergency Care Data Set provides a standard dataset for UK Emergency Medicine (See informatics Chapter).

Comparison of case-mix is challenging. Examples of case-mix measures include

- Patient demographics (age, gender, ethnicity and socio-economic variables), and acuity. The latter cannot be measured by any single measure
- Triage category reflects urgency rather than severity. No initial assessment process, or triage scale has demonstrated clear superiority over any other in the three domains.
- Early warning scores such as NEWS and n-PEWS provide a common language around physiological scoring, but were originally designed for inpatient environments. Context is key; the type of patient presentation may be more important, not all ED patients require a full set of vital signs.
- The Injury Severity Score is used in UK trauma registries
- Clinical Frailty Scoring in patients aged over 65yrs.

Differences between organisations can sometimes be brought out through the use of structural metrics e.g. numbers of treatments spaces / cubicles available versus number of attendance, staffing levels; however, differences in culture, leadership, and organisational effectiveness are much harder to measure. It is these which often provide the answers to differences in performance.

Key operational performance metrics include hospital handover delays for patients arriving by ambulance, time to triage, time to meaningful initial assessment, the 4-hour emergency access standard, the number of patients spending more than 12 hours in the ED, and the number of patients who do not wait to be seen. RCEM's recommendations around the 4-hour emergency access standard, and the 12-hour standard, are contained in the section on Crowding.

The Getting It Right First Time (GIRFT) Emergency Medicine programme ⁽⁷⁾ has devised a suite of metrics which look at key areas of emergency department activity including demand, capacity, flow and outcome as part of its summary emergency department indicator table (SEDIT). Whilst predominantly focussed on process measures such as Admitted Patient Delay (APD) it also utilises outcome data related to litigation to provide a global overview of an emergency department's performance and includes the use of a summary metrics eg. GIRFT-EM Index of patient flow. The GIRFT SEDIT allows EDs to compare their performance across multiple areas compared to other EDs as well as the ability to benchmark against EDs with similar case mixes.

Key operational metrics will ideally be available to the clinical team in real time. Barriers to improving them are best understood and addressed in context rather than retrospectively when the context has been lost. It also encourages management teams to actively engage in understanding, and improving, what is happening in the moment. This can reduce unhelpful cycles of blame and counter-explanation.

Metrics do not work in isolation. They form one part of the Quality Improvement picture. They must be carefully derived and carefully used within leadership and management paradigms that appreciate the complexity of healthcare delivery, and the application of improvement science in complex environments. The axiom "what gets measured gets managed" highlights the power of metrics and their ability to transform healthcare if used wisely.

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ED interface with prehospital services

Authors

Caroline Leech | Alison Walker

Introduction

This section defines the standards related to Emergency Department practice to ensure collaborative working with the local prehospital service/s for optimal patient care.

Standards

1. All hospital handovers must be complete by 60 minutes after ambulance arrival, with most taking place within 15 minutes, and almost all within 30 minutes. Please refer to RCEM / COP guidance on hospital handovers
2. Hospitals must have an agreed escalation policy, working in concert with ED escalation triggers, if the ambulance service needs to rapidly offload patients into ED to allow ambulances back into the community to attend high-acuity patients. This must be available 24/7.
3. Every ED must have the ability to create a resuscitation bed, and a high dependency adult and paediatric bed, at very short notice, and at all times.
4. Responsibility for patient care lies jointly with the hospital and ambulance service from the point the ambulance arrives at the department. There must have a process to register patients, and to start assessment and clinical management/treatment of patients even if they are located on the back of an ambulance rather than in the physical estate of the ED.
5. Paramedics and non-registered ambulance personnel must not be asked to supervise or undertake care they are not covered to provide e.g. giving medicines they are not legally allowed to administer, or to be responsible for infusion pumps. Cohorting of patients by ambulance clinicians must only occur if this has been approved formally by the ambulance trust.
6. All organisations must have approved pathways of patient care covering the assessment, treatment and onward care for any patients who are pre-alerted with major trauma, suspected Stroke or ST elevation myocardial infarction.

Recommendations

1. ED clinicians should be familiar with and follow the current AACE/RCEM pre-alert guideline, once published
2. ED clinicians should be familiar with the regional Major Trauma Triage Tool and any “silver trauma” triage tool used by their local ambulance service/s and be aware that hospital destination is coordinated through ambulance services systems.
3. Patients who have been pre-alerted by a prehospital clinician for clinical concern should be assessed immediately on arrival. This may be in a location other than the resus room.
4. Acute hospitals must have systems in place to reduce the use of inappropriate treatment spaces. If rapid ambulance offloads occur, it is expected that patients are held in corridors temporarily for only very short periods of time before being allocated an assessment space in the hospital.
5. Emergency Departments should have Rapid Assessment and Treatment areas or systems to receive ambulance patients onto hospital trolleys and prioritise/frontload essential investigations and treatment.
6. Emergency Medicine Services should discuss hospital handover performance data in their governance meetings. There should be clear, executive level ownership of, and accountability for, the organisation’s strategy to reduce handover delays. Hospital handover delays should be reported at organisations’ public boards and any incidents reviewed at Trust Board level, including incidents in the community when there were hospital handover delays at the hospital and no ambulance to send (in partnership with local system patient safety leads).
7. Emergency Departments should appoint their own leads to oversee the development and implementation of clinical handover protocols, and to work on maintaining positive relationships between their teams and prehospital services.
8. Emergency Departments should have a system to enable follow-up information about the patient’s clinical course and diagnosis to be provided to prehospital clinicians after handover

Background

The interactions between Ambulance Services and receiving Emergency Departments are key to ensure safe and effective emergency patient care.

These include processes for receiving pre-alerts for patients requiring immediate clinical assessment or treatment on arrival to the ED, receiving and documenting patient observations, and the handover of patients from ambulance clinicians to ED staff after arrival at hospital.

Handover delays are believed to contribute to harm to patients and staff in EDs as well as to other patients in the community who receive delayed ambulance responses. Harms may include associated deaths or morbidity in the community; harm to patients from laying on an ambulance stretcher for an extended period with reduced access to toileting, hydration and food; as well as impacts on the training and wellbeing of ambulance clinicians. RCEM and the College of Paramedics have published an options appraisal to guide leadership teams around this issue.

Escalation systems for predicted or ongoing delays in ambulance handover or offload are essential using acute hospital operational systems, with executive oversight.

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Emergency Preparedness and Resilience and Response

Authors

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Background

Under the Civil Contingencies Act 2004, an Acute Trust is a Category 1 NHS responder. The Emergency Department is usually the receiving system for patients involved in a major incident or CBRN incident and lead on decontamination (where appropriate), triage and initial clinical management of these patients.

NHS England hold overall responsibility for the health response to a major incident or CBRNE incident in England and have a number of useful documents on their website in relation to these. Each ICB has a EPRR lead to co-ordinate local responses and communications.

In Wales, this responsibility is held by Public Health Wales. **Emergency preparedness Leaflet..pdf** In Northern Ireland, this is held by the Department of Health. **Emergency planning and response | Department of Health**

In Scotland, overall responsibility for health EPRR falls under the Scottish government directorate: Chief Operations Officer, NHS Scotland. This department provides emergency planning guidance to Scottish Emergency Departments, which falls into one of the 14 Territorial Health Boards (CCA cat. 1 responders). It also provides guidance to other key EPRR CCA cat. 1 responders, including NHS Scottish Ambulance Service, NHS24 & Scottish National Blood Transfusion Service including **Preparing for Emergencies Guidance - gov.scot**

Standards

1. Role cards must be available staff working in the ED to define actions in the event of a major incident.

NHS England » Summary of published key guidance for health, emergency preparedness, resilience and response (EPRR)

Preparing for Emergencies Guidance - gov.scot

Recommendations

Education

1. HMIMMS or similar course, completion (selected senior ED staff and managers)
2. Training in EPRR to be part of all appropriate specialty's departmental training programs
3. Training programme in major incident management at the appropriate level for all ED clinicians.
4. Mandatory EPRR training or assurance of EPRR knowledge specific to their clinical or operational or management role for all staff from senior managers to appropriate clinicians.
5. CBRN response requires a whole hospital response, not solely the Emergency Department. The aim is that the emergency department can continue to provide business as usual care alongside a CBRN response.

Clinical EPRR Lead roles in ED

1. Separate MI and CBRN Medical and Nurse Lead roles in ED, with time assigned in job plans to deliver EPRR.
2. Systems and education to encourage further involvement of/development of ED SAS EPRR leads to support ED QIPs related to EPRR.
3. National support for further information sharing with ED SAS and other middle grade doctors, as OOH in many EDs they will be the first senior doctor to lead in the initial stages of a major incident or CBRN incident alongside senior nursing colleagues.

Governance

1. EPRR should be a standing items on ED governance meetings and on Trust committees and Board updates.
2. ED Clinical (medical and nursing) and operational leads should have authorities to comment on provide assurance on and attend Business Continuity planning meetings, Acute Services executive and nonexecutive led committees, and Trust Board to share expertise.
3. There should be systems to “close the loops on EPRR system assessments using audit and other evaluations and feedback systems to and from clinical staff.
4. Regular, funded, multiagency exercises should be undertaken by NHS systems as defined by external criteria, audit outcomes and internal requirements.
5. ED staff should have protected SPA or studyleave time to take part in CBRN or major incident exercises and also to attend debrief/learning events in order to participate on system quality improvement.

EPRR Equipment

1. Clear systems for supply and rapid resupply (internally and through procurement contracts) of adult and paediatric equipment likely to be needed in a major or CBRNE incident. This might include centralising and standardising major incident stores.
2. Financial planning for capital programmes to replace out of date or damaged EPRR equipment.

Cross Regional

1. Rapid roll out of the Ten Second Triage Tool (TST) and the Major Incident Triage Tool (MITT) to all EDs by December 2025, monitored through NHSE regional and national systems with quarterly reporting to NHSE EPRR CAG.
2. Local and regional agreements between Acute Trusts and Ambulance Trusts, to agree arrangements if a TU is overwhelmed by self-presenters. To support transfers to other sites and increase expert capacity once the scene is stood down.
3. Local leads linked into regional trauma and critical care transfer networks, smaller TUs need to be ready to assess and stabilise P1 patients, before transfer to tertiary centres.
4. Time for participation in ICB or NHSE regional EPRR exercises.

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Initial Assessment

Authors

**Adrian Boyle | Kirsty Challen | Ed Smith
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Introduction

One of the core functions of an emergency medicine service is to ensure that a patient with an acute healthcare need is managed in a timely manner and by an appropriate clinical team for their presentation. For this to be achieved, all emergency medicine services require systems to deliver rapid and safe initial assessment of presenting patients.

Initial assessment should be a consistent process that reliably identifies

- Patients with the most urgent (life or limb threatening) conditions
- Patients at risk of deterioration if their condition is not treated urgently
- Patients whose needs may be better served outside the Emergency Department.

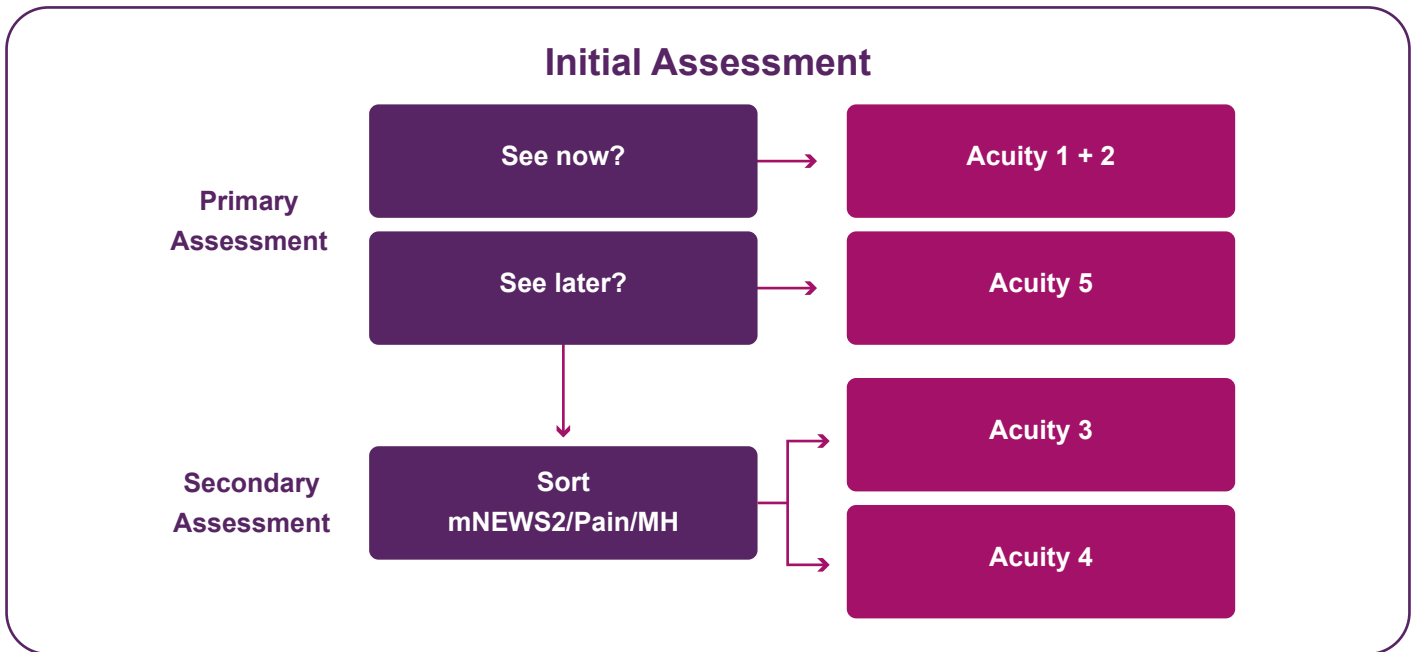
Initial assessment is defined as involving one of the following processes **Triage, Streaming or Rapid Assessment and Treatment (RAT)**. Triage systems have been established to prioritise patients according to their presenting (chief) complaint and their level of acuity. As healthcare services outside the ED continue to develop there is an increasing benefit in streaming presenting patients to the most appropriate service.

Standards

1. Patients who are registered as Emergency Department attendees must be initially managed by ED staff and fall within its quality improvement and governance systems.
2. All patients attending the Emergency Department should be registered within five minutes of arrival. Queues for registration should be actively managed to avoid occult waits for triage.
3. Initial assessment of Emergency Department attendees must be provided by a registered clinician with appropriate training.
4. Where clinicians from other services work within initial assessment systems there must be joint development of those systems, and shared governance arrangements.
5. Initial assessment should commence within 15 minutes of the patient's arrival or registration.
6. Initial assessment areas must facilitate confidential conversations, enable access to patients with disabilities and their carers, and maintain patient dignity.
7. Patients waiting to be seen in a See and Treat stream should not wait for longer than one hour to be seen. If the wait is longer than this, the patients should have an assessment by a clinician (triage, streaming etc.)
8. Redirection is a choice offered to patients with the full awareness that there is no formal transfer of care to another service.
9. The clinical record must include as a minimum chief complaint, acuity and patient disposition.
10. Emergency departments must use early warning scores for adults, pregnant adults and children.
11. Initial assessment processes must support IPC measures, including minimising crowding in ED.

Recommendations

1. Emergency medicine services should consider adopting a two-stage process for initial assessment, as below.
2. Navigation should not be used to redirect patients to off-site services and should be undertaken by a registered clinical practitioner.
3. Departments should consider providing Rapid Assessment and Treatment services at times of peak demand.
4. Criteria for streaming patients to other services within the hospital (eg. SDEC) should be locally agreed and co-owned with those specialties.
5. Patients who have been streamed should be moved to the accepting service/area as soon as the decision is made that their clinical needs are best met by that service. The purpose and function of streaming should be effectively communicated to the patient.
6. Diagnostic investigations for the purposes of streaming should be kept to a minimum, in order to manage workflows. However, some simple interventions as part of initial assessment may be required in order to risk stratify the patient eg. an electrocardiogram (ECG) for a patient presenting with low-risk chest pain prior to a decision about streaming to a medical SDEC unit.
7. Staff undertaking initial assessment should have support to assess patients who do not speak or understand English.



Background

There are three main objectives of good quality initial assessment

1. Promoting Safety

This includes prompt recognition of time critical illness and injury, isolation of potentially infectious patients to avoid nosocomial infection, identification of vulnerable patients (eg. safeguarding, risk of absconding) and prevent ED crowding.

2. Assessing Acuity

To ensure that the most time-critical patients are treated by the right service within appropriate time frames, and that appropriate prioritisation occurs for the remainder.

3. Promoting Efficiency

In the system to ensure that patients do not wait unnecessarily for investigations, diagnostic decision making or treatment and prevent ED crowding.

A two-stage model may offer benefits in quickly identifying serious illness or injury. The two discrete stages may be combined and performed by one individual, or separated, and this may change in response to clinical need, patient numbers or staff capacity.

Early Warning Scores

Provide a common language across healthcare to communicate the severity of illness examples include NEWS-2 and various paediatric warning scores. They must be interpreted in context of the patient presentation, as there will be patients with serious illness or injury presenting with normal scores. It is not always required to complete a full set of vital signs in a patient, it may be an appropriate clinical decision not to record observations, for instance if the patient has an isolated extremity injury.

Navigation

Directing patients to the most appropriate co-located service, practitioner or stream prior to clinical assessment or triage. Navigation is not based on clinical judgement or assessment. Navigation is best and most safely undertaken by a registered clinical practitioner and should not involve redirection to off-site services. Should navigation occur ahead of registration, the contact should be recorded irrespective of the patient disposition, and this record should be linked to any subsequent ED notes, to ensure that an audit trail is maintained.

Triage

Identifying acuity, and prioritising patients on that basis completed before a full assessment to support effective management of demand and flow as well as identifying time critical requirements for patients. Triage prioritises patients where demand exceeds capacity to fully assess them within an appropriate time frame. Triage and Early Warning Scores are not mutually exclusive. Triage is a face-to-face encounter that should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact.

Streaming

The process of allocating patients to different physical areas / services, pathways or processes, in order to improve efficiency and effectiveness. The options for streaming patients will be determined locally depending on the services available on site however there will be an expectation that streaming is delivered in a safe and effective manner to all patients and pre-actively balances the risk of streaming patients away from the ED. Potential on-site services to which a patient might be streamed include:

- Urgent Treatment Centre
- On site GP services (if separate from UTC)
- Children's assessment unit /Paediatric SDEC
- Medical SDEC
- Surgical SDEC
- Frailty service / Frailty SDEC
- Early Pregnancy Unit
- Maternity services
- Mental health liaison service

Streaming is a clinical activity and is undertaken by appropriately trained clinicians who follow locally agreed clinical governance processes. A streamed patient does not leave the hospital site. The benefit of effective streaming is to ensure that the patient is seen by the most appropriate practitioner for their healthcare need as rapidly as possible. Streaming may be considered to be 'complex' if in-addition, there is the initiation of investigations (eg. bloods, radiology) that aims to bring the clinical decision-making processes forward.

Redirection

The process of 'Sending people away' to an appropriate off-site or separately managed service. Patients may be redirected to an appropriate service after streaming or triage contact with a clinician. The patient is likely to require information regarding the availability of healthcare personnel of the destination service to make an informed choice. Patients should only be redirected off site if clinically appropriate – for instance the patient should not be sent to the pharmacy for head injury advice. An up-to-date Directory of Services is required for effective redirection, this is the responsibility of the healthcare system and not the ED.

See and Treat

The patient is seen initially by an experienced clinician who can complete their entire episode of care. See and Treat refers to a system of directly seeing patients who have been deemed to be presenting with a minor illness or injury, without further triage or assessment. The advantage of this is that they are seen directly by a single, appropriately trained clinician, who can complete the episode of care for that patient. Patients may be streamed or navigated to the See and Treat stream, using appropriate protocols.

Senior Doctor Triage

Rapid Assessment and Treatment (RAT) or Early Senior Assessment (ESA): The patient is seen on arrival by a senior clinician who can make a rapid, detailed, clinical assessment and commence appropriate investigations and treatment. This should enable time-critical conditions to be identified and interventions delivered rapidly. RAT requires a team of individuals (nursing and support staff, as well as a decision-making clinician) to deliver effectively. It takes longer than streaming or triage, often up to 20-30 minutes depending on the patient. However, it has the potential to add value to the process of assessing the patient because of the involvement of a decision-making clinician. RAT can safely replace all other forms of initial assessment, provided that the wait for accessing RAT is not excessive. Implementing and sustaining RAT requires specific resourcing, including dedicated staff and space to work, as well as the understanding that it is demanding and physically tiring to undertake.

Acuity

A measure of the severity of the patient's condition and the urgency with which they need to be seen and assessed by a clinician qualified to do this through training and experience.

Glossary of terms used in initial assessment

1. Redirection

'Sending people away' to an appropriate off-site or separately managed service

2. Navigation

Directing patients to the most appropriate co-located service, practitioner or stream prior to clinical assessment or triage.

3. Triage

Identifying acuity, and prioritising patients on that basis

4. Simple Streaming

Brief clinical assessment and directing patients to the most appropriate service, practitioner or stream. May include triage. May include redirection.

5. Complex Streaming

Initial assessment and triage. Involves directing patients to the most appropriate service, practitioner or stream and commencement of investigations in order to bring the clinical processes forward. May include redirection.

6. See and Treat

The patient is seen initially by an experienced clinician who can complete their entire episode of care.

7. Senior Doctor Triage

Rapid Assessment and Treatment or Early Senior Assessment The patient is seen on arrival by a senior clinician who can make a rapid, detailed, clinical assessment and commence appropriate investigations and treatment. Represents a form of complex streaming

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Screening in the Emergency Department

Author

James France

Introduction

The primary role of the ED is to assess and treat acute illness and injury, other areas of the healthcare system exist whose core function includes screening eg. General Practice. However, an ED attendance may represent a unique opportunity to engage with 'hard to reach' patient groups (eg. Those experiencing homelessness) either by virtue of their presenting illness / injury or merely their presence in a healthcare setting. EDs are particularly well placed to screen for alcohol misuse or intimate partner violence (IPV) by virtue of the characteristics of ED attenders, however evidence is emerging that screening for conditions unrelated to the ED attendance may also be effective.

Standards

1. Screening information must be obtained after triage / initial assessment process and should not interfere with timely access to care. Initial triage processes should limit the focus and content of questions to information pertinent to the patient's condition to determine the priority in which patients should be seen and allow a limited risk assessment should they decide to leave without being seen.
2. Screening must only occur if there is sufficient capacity such that the primary role of the ED and key quality metrics are largely unaffected.
3. Any screening process that is developed must minimise the burden placed on ED clinical staff and there must be clear governance processes in place particularly with regards who has the responsibility for follow-up after screening and dealing with the impact of 'false positive' screening.

Recommendations

1. When considering implementing screening processes prioritise those conditions which frequently present symptomatically to the ED e.g. injuries secondary to alcohol and are amenable to intervention within the resources of the ED.
2. Screening processes should be developed to work within ED workflow and minimise impact on patients and ED staff.
3. Use evidence-based screening interventions where possible.
4. Local disease prevalence and risk factors should be central to deciding whether to implement a screening programme.
5. Screening interventions should be sustainable both in terms of ED resource (staff time etc.) and the wider costs and benefits to the healthcare system as a whole.
6. Involve patients in the implementation of any screening programme / initiative.
7. There are clear benefits to embedding screening into electronic health records, however caution must be exercised when considering making any form of screening mandatory.
8. The use of screening measures as performance metrics is generally discouraged.

Background

Triage / initial assessment is a rapid evaluation of patient acuity to establish the order and/or location where the patient should be seen. The routine inclusion of general (unfocussed) screening questions in the initial triage process creates a preventable delay in caring for patients and can potentially lead to harm.

There is a clear distinction between ‘screening’ patients with certain types of presentations for associated conditions which may not be disclosed without direct questioning and ‘opportunistic’ screening where the patient is found to have a risk factor or condition as a consequence of routine activity or specific screening activity by the ED. For example, a patient attending the emergency department with a facial fracture, it would not be unreasonable to ask questions regarding IPV or alcohol use; weighing the patient and measuring their height to calculate the patient’s body mass index (which will not have any impact on ED management) to establish whether the patient is obese would be considered ‘opportunistic’. EDs operating opportunistic screening programmes which go beyond direct questioning (face to face or electronic) and leads to additional investigations (e.g. blood or urine tests) should ensure the relevant GMC guidance on consent is followed.

There is a real risk that the use of screening measures as performance metrics can lead to unintended consequences e.g. the over prescription of antibiotics. The denominator of the screening measure is especially important, it rarely justifiable to have ‘all ED attenders’ as a denominator, rather a specific focussed patient group is likely to be more relevant.

Examples of ED screening includes (not exhaustive)

Mandatory

Homelessness
Paediatric safeguarding

Non-mandatory

Alcohol, Drugs, Tobacco use, Hypertension, Chlamydia, HIV, Delerium,
Intimate Partner Violence, Syphilis, Viral Hepatitis, Obesity

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Care of Older People in the Emergency Department

Authors

James France | Rachael Morris

Introduction

All older people have the right to a health and social care assessment and should have access to treatments and care based on need, without an age-defined restriction to services¹. Health services should not be 'ageist'.

Standards

1. Hospitals must provide an Acute Frailty service for at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of a patient's arrival in the Emergency Department or SDEC unit.
2. Pain scores must be obtained in all older aged patients at triage.
3. The ED staff must support patients to remain as independent as possible whilst they remain in the ED.
4. Each Emergency Department must have a Geriatric Emergency Medicine/Frailty lead.
5. All staff working in the Emergency Department must complete dementia and delirium training.
6. All EDs must have ready access to time critical medication used commonly by older people, such as Parkinson's Disease medication, insulin and anti-epileptic medicines.

Recommendations

1. All EM staff should have protocols for the management of 'silver trauma.'
2. ED staff should undertake Clinical Frailty Scale (CFS) scoring if it will make a meaningful difference to their ED management.
3. Skin integrity and pressure area review should be assessed and documented using a reliable tool such as the Waterlow score.
4. EM staff should adapt their environments to the needs of the older person.
5. ED staff should be mindful that older aged patients are disproportionately affected by ED crowding (including delayed ambulance offloads) and endeavour to mitigate against this including the use of documented 6hrly 'care rounds' and trying to avoid corridor care for those with cognitive impairment.
6. EM staff should adhere to hospital specific guidelines for safeguarding of older people, in addition to the multi-agency policies and procedures ¹.
7. Comprehensive Geriatric Assessments are an evidence based intervention that promotes health and prevents readmission, however they should be best completed after, not during, an emergency department stay.
8. The 4AT tool should be used for the assessment of delirium
9. Early discussion with the patient and any nominated family members to determine their treatment priorities including alternatives to admission eg. frailty Same Day Emergency Care (SDEC) are strongly encouraged.
10. Accurate discharge information, including any medication changes is essential, as well as ensuring any treatment plans are communicated with carers in the event of the patient not being able to remember fully.

Background

The Clinical Frailty Scale (CFS) is recommended by NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network² to identify the individual's level of frailty two weeks prior to presentation¹. The CFS is a tool for those aged 65 years and older. Many Emergency Departments use 75 years and older as the recommended age for frailty scoring. ED staff should only undertake CF scoring if it will make a meaningful difference to their ED management.

Identifying frailty as soon as the patient arrives into the Emergency Department, or earlier by the ambulance crew which can then be handed over at triage, allows the patient to be immediately seen and cared for by the appropriate frailty team such as a Geriatric Emergency Medicine Service or Acute Frailty Team, or streamed directly to an Older Persons Assessment Unit or GEM area. Knowing the patient's baseline frailty state (rather than how they are acutely presenting at time of arrival into the ED), allows for pragmatic conversations regarding response to therapy, rehabilitation goals, initiation of frailty pathways and being seen by appropriate teams in the hospital, consideration of alternatives to admission if safe and appropriate.

Pain is often under recognised in the Emergency Department especially in older aged patients and those with a cognitive impairment such as dementia. If the patient is unable to communicate verbally, non-verbal cues should be looked for such as agitated behaviour and facial grimacing. The Abbey Pain Tool may be useful to use with patients who are unable to verbalise their pain score. It is important to ask the patient's carer / family member if they believe the patient to be in pain and how the Emergency Department team may be able to identify pain if unable to verbalise.

'Silver trauma' assessment should take into account the differing injury patterns and physiological responses (co-existent morbidities and polypharmacy) of the older person. Lower thresholds for CT scanning and high suspicion for occult injuries are central to safe and effective care; traumatic brain injuries and chest wall injuries are the most common cause of death. Departments must have clear protocols for common clinical scenarios eg. anticoagulation reversal, as well as admission pathways whether isolated injuries (eg. pubic rami fracture) or multi-system involvement.

Environmental considerations for older patients living with frailty and those living with dementia include a quieter assessment area away from the noisy and over stimulating main Emergency Department, enough room for family members or carers to accompany the patient and close access to toilet facilities. The Emergency Department should be 'age-friendly', with signs in large font accompanied by pictures as a visual aid. Signs to toilets should be bold, visible and multi-cue i.e. a picture of a toilet beside a toilet sign. All signage should be at eye level 1. Consideration of floor and wall colourings along with breaks in patterns should be taken into account to support those with Parkinson's Disease. Orientation aids such as large font clocks and calendars displaying the day, month and year to help orientate the patient to their new environment.

Older patients living with frailty are one of the most vulnerable patient groups presenting to the Emergency Department. They will often not vocalise their care needs and instead Emergency Department staff must seek to identify them. This includes, nutrition and hydration with some patients presenting after a period of time when they have not eaten or drunk for many hours. Emergency Departments should have a range of cups, plates and cutlery with adaptations to support the patient to independently eat and drink for themselves. A range of drinks and snacks should be on offer and ideally hot food. Patients may have reduced mobility and need quick and easy access to the toilet.

The Geriatric Emergency Medicine/Frailty lead should work collaboratively with relevant specialities such as Care of the Elderly, Stroke, Trauma and Orthopaedics and where possible, community colleagues such as General Practice frailty leads, NHS@home teams, carers support teams, voluntary sector. The GEM lead should lead engagement in local and national audits, Quality Improvement Projects relating to best care of older adults in the Emergency Department. Learning from these projects should be shared with wider ED teams to help upskill all members of the Emergency Department in best care for older patients.

Older patients living with frailty presenting to the Emergency Department are most often best cared for by a multi-disciplinary team, made up of Doctors, Nurses, Therapists, pharmacists and other allied health professionals. The NHS Long Term Plan states that 'all hospitals with a 24 hour A&E will provide an Acute Frailty service for at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of a patients arrival in the Emergency Department or SDEC unit' 4. Frailty teams can be Emergency Medicine led by those with a special interest in GEM or any other speciality with a 'front door' frailty interest. Geriatric Medicine led. A dedicated GEM service is able to provide all care for patients at the time of their arrival into the ED, regardless of level of acuity of illness or injury. Other frailty services may ask that patients are seen by ED first, to exclude certain conditions such as fractures and the need for acute care.

Comprehensive Geriatric Assessment (CGA) is a structure for the thorough assessment and management of a person's medical, psychological, functional, social and environmental circumstances and needs. It improves patient and service outcomes 5 and increases the likelihood that patients survive and are back home 3 to 12 months after discharge⁶. The frailty service / GEMs teams working with the ED should provide appropriate criteria (from routinely collected ED information) to determine which ED patients should receive a CGA. Given the time constraints the ED has to work within (4hr emergency access standard) and the iterative nature of CGA, careful consideration needs to be given as where this assessment takes place; the ED is not necessarily always the most appropriate place.

ED staff should be adept at recognising common frailty syndromes including, Frailty Delirium, Falls, Polypharmacy, suspected fracture neck of femur (#NoF) and end of life (EoL) care. It should be recognised that delirium is a medical emergency with associated high rates of mortality and morbidity⁷. Following identification of delirium, pathway should be initiated to help identify precipitants and provide appropriate acute management eg. TIME bundle⁸. Consider referral to community based teams if the patient has had two or more falls in the last 12 months or has problems with walking or balance⁹. For older aged patients a medication review is suggested, to include medication reconciliation, identification of polypharmacy, anticholinergic burden, drug interactions and side effects, compliance with medication and understanding of use. For older aged patients the STOPP/START tool is an example of a medication review tool. Any medication changes must be conveyed to the patients General Practice team and in writing to the patient.

Patients who have a clinical suspicion or confirmation of a hip fracture should have the Big Six interventions/treatments before leaving the ED¹⁰ (pain relief, delirium screen, NEWS2 score, bloods & ECG, pressure area assessment and IV fluids started). EDs should have ready access to Treatment Escalation Plans (TEPs) and Recommended Summary Plan for Emergency care and Treatment ReSPECT information. If there is an acute necessity for a ReSPECT conversation, i.e. it is thought the patient will die in the Emergency Department, effort should be made to include the patient and their nominated family members in the conversation. Rapid access to 'just in case' medications should be available for use in the department and as a TTO for patients requesting a rapid discharge home if their wish is to die at home. In this case a community prescription chart should also be kept in the department. Psychological and spiritual support should be available for the patient and their loved ones, often provided by the Chaplaincy Service.

An accurate and meaningful discharge letter and telephone handover is particularly important for patients who are unable to retain the information themselves or communicate it to care providers, such as those living with dementia. It is also useful to document the time last medications were given and any medication changes.

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Children in the Emergency Department

Authors

James France | Shane Clark | Ian Higginson

Introduction

About 20-25% of all attendances to an “average” Emergency Department will be children

Children may be treated in specific ‘paediatric only’ emergency departments (PED) or as part of a ‘mixed’ adult and children emergency department. The standards and recommendations which follow are applicable to for all emergency departments which treat children. The legal definition of a child is a person below the age of 18 years, however many departments have an operational definition of 16 years. Adolescence is between 12 and 25 years, however in terms of specifically addressing the needs of the adolescent age group most would consider the target audience as aged 16-17. All children and young people attending an emergency department must receive the same access to high quality care as adults. To achieve this, it is necessary to acknowledge the differences in patterns of illness, injury, physiology and psychology in children and young people attending our departments. It is also necessary to acknowledge the different practicalities. Set out below are standards and recommendations to meet the varied needs of neonatal to adolescent patients.

Standards

1. Paediatric waiting and assessment areas must be separate from adult areas and the environment within the children’s area should be designed to reflect the needs of children and their parents/carers. ^[1]
2. An initial assessment of the patient needs to take place within 15 minutes of arrival and should be tailored to the individual needs of the patient, including the assessment and treatment of pain. ^{[2], [3]}
3. EDs treating children must have at least
 - a. One consultant with Paediatric Emergency Medicine (PEM) dual accreditation, and with allocated sessions to paediatrics and
 - b. At least two registered children’s nurses on duty in the children’s area at all times. ^[4]

Standards

1. Emergency departments must use a specific paediatric early warning score and ensure appropriate triggers and actions are in place. ^[5]
2. Departments should implement the relevant RCEM “Sign-of” standards with regard to children.
3. All departments must have clear safeguarding policies in place for children and young people including child sexual exploitation as well as ensuring appropriate staff competencies. ^{[1],[10]}
4. For patients presenting with mental health related issues, the assessment process must start at triage and include a capacity assessment. ^[1]
5. Psychosocial assessments must be undertaken in a timely fashion by appropriately trained staff for patients in the adolescent age group. Admission must not be the default option. ^[6]
6. When children require admission there must be clear policies in place with regards which in-patient team will take the lead role, compliance with national standards (eg. 4-hr emergency access standard) and transition arrangements between paediatric and adult services. ^{[6],[7]}
7. Major Incident planning must take into account the needs of children and this should also be reflected in training exercises. ^[1]

Recommendations

1. Service design and delivery should be built around achieving the standards described in “Facing the Future: Standards for children in emergency care settings.”^[1]. This document is currently in revision
2. Emergency Departments should have a clinical leadership team for PEM within their departments. This should include a PEM consultant, and a lead nurse for the Paediatric Emergency Department.
3. Departments should, as part of workforce planning, seek to employ sub-specialist PEM qualified consultants in proportion to their department’s ratio of paediatric attendances.
4. Departments should have clear guidance for staff with regards consent and the refusal of treatment in children.^{[6], [8]}
5. Departments should take part in violence reduction initiatives.^[9]

Background

Paediatric Emergency Medicine (PEM) is increasingly recognised as a sub-speciality of Emergency Medicine.

Paediatric Emergency Departments should be specifically designed and staffed to meet the needs of children and young people, and the needs of their families / carers. In addition, their design and staffing should be based around demand-capacity modelling, and the specific functional and operational requirements. They should not simply be regarded as “bolt-ons” to adult departments.

Children need to be kept safe when they visit the ED. This means physical safety, so that security is paramount, and safety from sights and sounds that they might find distressing. It also means that safeguarding considerations need to be built into every interaction and process which occurs.

Design

The needs of children and young people vary across different ages, and design of such areas is becoming increasingly complicated. This isn't just about small chairs, toys, and decoration. For instance, spaces need to accommodate the needs of children not only of different ages, but also different needs (for instance children with mental health problems, learning disabilities, or with sensory processing difficulties). Waiting areas need to be catered for the fact that children come with their families, whilst provision of facilities for play, breast feeding, nappy changing, and for the preparation of bottles or food are all important. Equipment needs to cover the full range of potential presentations in children of all sizes. A large number of presentations in children relate to infectious diseases, whilst the pastoral needs of families, along with the complex procedures involved around the death of a child, mean that bereavement facilities need to have special attention.

The needs of adolescents, however defined, are becoming increasingly important to address. This is partly the consequence of the changing pattern of presentations, particularly around mental health, and partly the consequence of overcrowding in EDs meaning that adult areas are even more unsuitable for both adolescents and young adults than they have been in the past.

Workforce

PEM is evolving as a field and is complicated by overlaps with paediatrics, and by the fact that for doctors there are two routes into the field (Emergency Medicine and Paediatrics). Within the nursing profession there are separately trained Children's Nurses, along with nurses who work in the ED and who come from a general nursing background.

From an Emergency Medicine perspective Emergency Medicine clinicians are not "adult" clinicians, they are generalists. Expertise in the assessment and management of paediatric patients is a core requirement for all doctors training through the RCEM curriculum. ACPs may choose to credential in adult emergency medicine, paediatric emergency medicine, or both. Other clinicians, such as ENPs, will commonly see patients across the age range as part of their practice. Children's Nurses bring additional skills to the care of children in Emergency Departments, but it should be remembered that general Emergency Department nurses also possess a range of skills, and many are highly experienced in the management of children.

The workforce in Paediatric Emergency Departments may be provided by the ED alone, by Paediatric departments, or more likely as part of blended solutions involving clinicians, nurses, and other professionals from different backgrounds. This can be challenging in terms of managerial structure, provision of operational and clinical leadership, clinical governance, education and training. There is no "one-size-fits-all" model but there is a requirement for a clearly identified leadership structure and team, along with clarity of responsibility for quality management and improvement. Education and training should be integrated with major programs within both the ED and paediatrics.

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Minor Injuries

Authors

Adrian Boyle | Sally-Anne Wilson | James France

Introduction

Minor injuries is a branch of practice of Emergency Medicine that refers to injuries that do not normally need admission to hospital. The name minor injuries has been unnecessarily pejorative, as inadequate diagnosis and treatment can result in substantial disability. Fractures, dislocations, joint injuries and amputations account for around 5% of all emergency department attendances.

Standards

1. Written patient information about common musculoskeletal injuries, such as sprained or fractured ankle, wound care, small burns, must be easily available. Digital versions, for example utilising QR codes is an alternative if this is the patient's preference.
2. Clear pathways must be available to outpatient specialist clinics, such as fracture clinic and eye units.
3. Staff working in minor injury units must have easy access to senior decision-making clinical advice supported by image transfer and / or telemedicine so that patients are not transferred unnecessarily solely for opinions.
4. There must be a clear pathway to physiotherapy for people who will benefit after an acute injury.
5. Emergency departments should support the provision of virtual fracture clinics, as well as the traditional face to face clinics.
6. A clinical area that treats patients with minor injuries must have ready access to x-ray facilities and equipment to enable the assessment and treatment of common eye injuries. The minor injury area should have a separate clinical space for plastering and plaster removal which is compliant with the relevant health and safety legislation. Wound assessment and treatment should be performed in an appropriate clinical environment which minimises the risk of nosocomial infection.
7. All ED plain radiography should be reported by either a radiologist or reporting radiographer, ideally in real time. EDs must have systems in place to ensure all radiology reports are checked.
8. Provision of a Statement of Fitness for Work must be issued by the ED to those patients who are clearly not going to be fit for work after the 7 day 'self-certification' period.
9. Departments must ensure appropriate safeguarding arrangements are in place for potential vulnerable patients presenting with 'minor injuries' eg. children, the elderly, victims of domestic violence etc.

Recommendations

- 1.** A type 1 emergency department should have a minor injury unit co-located or very close to allow easy streaming and transfer.
- 2.** Patients who suffer an injury away from their local hospital that requires fracture clinic follow up should be referred by their initial treating emergency department to their follow up hospital. The initial treating ED should ensure either the electronic transfer or that a copy accompanies the patient of the relevant clinical information eg. ED notes, X-rays.
- 3.** Departments are encouraged to use alternatives to Nitrous Oxide (for example Pentrox[®]) for short lasting painful procedures in view of its adverse effect on the environment.

Summary of bony injuries that do not routinely need follow up in a face to face fracture clinic. These can be discharged with written advice and appropriate removable splinting or slings.

Shoulder

Undisplaced acromio-clavicular joint Injuries
Clavicle fractures in children under 12 years of age

Elbow

Undisplaced radial head or neck fractures
Traumatic elbow effusions

Wrist

Isolated triquetral fractures (all ages)
Paediatric torus and buckle fractures

Hand

Fifth metacarpal neck fractures without rotatory deformity

Foot and Ankle

Isolated fibular tip fractures
Base of fifth metatarsal fractures except for Jones fracture
Closed distal toe phalanx fractures except hallux

Example poster with suggested management advice

Specific fracture managements in the Emergency department

Clavicle to elbow			
Diagnosis	Initial treatment	Follow up	Specific info required of MPFC
Fractured clavicle Paediatric under 12 years of age	Broad arm sling for 3 weeks with regular shoulder, elbow and wrist exercises	Leaflet and discharged. Likely time to return to normal activities 5 weeks	If displaced / off ended refer to fracture clinic
Acromio – clavicular joint sprain / separation	AP and axillary views. Broad arm sling for 3 weeks with regular shoulder, elbow and wrist exercises	Leaflet and discharged. Likely time to return to normal activities 5 weeks	If separated > 100% width of clavicle to go to fracture clinic
Fractured head / neck of radius	Broad arm sling for 4 weeks with regular shoulder, elbow and wrist exercises	Leaflet and encourage movement. Likely time to return to normal activities 8 weeks	If multi – fragmented or displaced > 2mm refer to fracture clinic

Forearm to Hand			
Diagnosis	Initial treatment	Follow up	Specific info required of MPFC
5 th Metacarpal neck fracture	Bedford finger splint or neighbour strapping for 4 weeks with regular hand wrist exercises	Leaflet and discharged. Likely time to return to normal activities 8 weeks	Check rotation or angulation > 45 degrees and if present refer to first on call
Mallet finger injury non bony	X ray, mallet splint with taping to allow full flexion / extension of middle IPJ. Encourage finger exercises	Leaflet and discharged to hand therapy for splint for 8/52. Can remove splint for gentle washing	If bony mallet more than 25% of joint surface to refer to fracture clinic
Distal radius torus / Buckle fracture Paediatric	Below elbow soft cast / wrist splint. Parents to remove splint / cast at home at 4 weeks	Leaflet and encourage movement. Likely time to return to normal activities 8 weeks	If > 30 degrees angulation refer to fracture clinic. Make sure pure torus not undisplaced bi – cortical fracture (this goes to fracture clinic)

Foot and ankle			
Diagnosis	Initial treatment	Follow up	Specific info required of MPFC
Ankle sprain / soft tissue injury / avulsion fracture	Consider walking boot and crutches. Mobilise full weight bearing as pain allows. To slowly wean from boot over 6 weeks. Encourage elevation and icing. Encourage ROM exercises out of the boot	Leaflet and discharged. May remove boot for washing and sleeping as pain allows	Consider physiotherapy referral for rehabilitation
Avulsion fracture 5 th metatarsal base	Consider walking boot and crutches. Mobilise full weight bearing as pain allows. To slowly wean from boot over 6 weeks. Encourage elevation and icing. Encourage ROM exercises out of the boot DARCO shoe	Leaflet and discharged. May remove boot for washing and sleeping as pain allows	
All closed toe fractures (metatarsal to distal phalanx)	Consider DARCO shoe/walking boot. Mobilise full weight bearing as pain allows. To slowly wean from the boot over 6 weeks. Encourage elevation and icing. Encourage ROM exercises out of boot	Leaflet and discharged. May remove shoe / boot for washing and sleeping as pain allows. Likely time to return to normal activities: 8 weeks	

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Care of patients with Mental Health Problems in the Emergency Department

Authors

Mark Buchanan | Adrian Boyle

Introduction

This chapter should be read in conjunction with the estate standards for people with mental health problems in the emergency department.

Standards

1. Each Department must have a Mental Health Lead with dedicated time. The role of the Lead includes engaging with the mental health liaison team, police and social care promoting best care for patients attending with a Mental Health presentation.
2. Patients must have mental health triage by ED nurses on arrival to briefly gauge their risk of self-harm, suicide, and risk of leaving the dept before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.
3. Patients at medium or high risk of self-harm or suicide must be searched for objects or medication that may be used to self-harm.
4. Patients at medium or high risk of suicide or of leaving before assessment and treatment are complete must be observed closely whilst in the ED. There should be documented evidence of either continuous observation or intermittent checks (recommended every 15 minutes), whichever is most appropriate.
5. If a patient states that they want to leave or decline treatment, then there must be documentation of the assessment of that patient's capacity to make that particular decision at that time, based on a face-to-face conversation and not rely on records from previous attendances.

Standards

1. When an ED doctor reviews a patient presenting with self-harm or a primary mental health problem, they must conduct a brief risk assessment of suicide and further self-harm.
2. Previous psychiatric history must be documented in the patient's ED clinical record. This must include previous self-harm or suicide attempts, previous admissions and current treatment.
3. A Mental State Examination (MSE) must be recorded in the patient's ED clinical record.
4. From the time of referral, a member of the mental health team must see the patient face to-face and offer appropriate assistance to both patient and referrer within one hour. Full assessment may be delayed if the patient is not yet fit for assessment.
5. Parallel assessment must be seen as the default approach. This means that patients are assessed concurrently, not consecutively, for both physical and mental health problems. This requires the patient to be well enough to undergo a psychiatric assessment.
6. People who have attended the ED for help with self-harm must receive a comprehensive biopsychosocial assessment with appropriate safety or care planning at every attendance, unless a joint ED/Psychiatric written management plan states that this is not necessary or unhelpful.
7. Details of any referral or follow-up arrangements should be documented in the patient's ED notes

Recommendations

1. Emergency Departments should have a search policy which clearly states when a patient can and can't be searched
2. Departments should have a trust's policy for restrictive intervention and should follow guidance for Rapid Tranquilisation (NICE or their own guideline). At all times this must be in the patient's best interest.
3. 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.
4. Patients awaiting Mental Health Beds should have daily Mental Health reviews. These should be including assessing whether an admission is still the least restrictive option, advice on management of agitation and medication changes.
5. An appropriate programme should be in place to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues.

Background

The care needs of patients with mental health presentations are often complex: they may reach the ED in a state of crisis and with emergency physical healthcare needs.

It is essential that EDs can provide these patients with timely, effective, and compassionate care for both their mental and physical health needs.

What we do know is that adults with mental health needs are three times more likely to attend an ED and are five times more likely to have an emergency admission to a general hospital. Patients with mental illness also suffer disproportionately from physical illness.

Nearly 12% of all patients with mental health needs spend more than 12 hours in an ED from their time of arrival. They are twice as likely to spend 12 hours in the ED when compared to any other patient group.

Many patients with mental illness report very poor experiences of seeking and receiving care in emergency departments and should be treated with compassionate care and receive parity of esteem.

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Clinical Responsibility for Patients within the Emergency Department

Authors

James France | Simon Smith

Introduction

This section defines which clinical team has responsibility for a particular patient
Please also see section Referral for Inpatient Care Standards.

Standards

1. It is essential for patient safety and continuity of care of patients in the Emergency Department (including ED observation units/ CDU) that it is always clear which team has clinical responsibility for each patient.
2. Once a patient has been referred onto a specialty, it is the responsibility of that specialty to organise ongoing care. It is not safe, reasonable or appropriate to refer a patient back to the emergency medicine service. Declining referrals is not appropriate, as this does not ensure patients receive the necessary ongoing care ^[1].
3. Whilst waiting for specialty teams to respond to a referral the patient in question remains the responsibility the ED team, this includes reacting to changes in the patient's clinical condition and investigation results. However, specialties should have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and must not insist on investigations that do not contribute to the immediate management of the patient. ^[2]
4. Once a patient in the ED is seen by a specialty team then that patient becomes the responsibility of the specialty team. The Emergency medicine service team will continue to provide clinical support to patients who deteriorate and require emergency care, and within the resuscitation area.
5. EDs must have clear policies / guidance with regards to the action staff should take and who to escalate their concerns to in the event of a patient under the care of a specialty team deteriorating; this will likely depend on the degree of deterioration (eg. NEWS2 score).
6. Handover of clinical responsibility must be clearly delineated and accurately documented in real time.
7. Patients must be aware of the clinical teams caring for them and of the responsible clinicians. Similarly, clinical staff must be aware of who has clinical responsibility for their patients.
8. Specialty patients placed on Observation Wards / CDUs due to capacity issues within the rest of the hospital (i.e. not ED patients) must remain under the care of that specialty team and clear policies must be in place to ensure that these patients are reviewed regularly by their appropriate specialty team.
9. When patients are transferred from the Emergency Department, there must be a re-assessment to determine whether the clinical status has changed, especially in cases where a delay has occurred.

Recommendations

1. Where there is concern regarding the quality of a referral, this should be addressed with the duty ED Consultant.
2. Concerns about the clinical management of patients under the care of specialty teams who continue to reside in the ED should be escalated to a senior doctor in that specialty. If concerns persist after completion of this action escalation should be to the senior ED doctor on duty and where these concerns are significant then this should be discussed with the duty ED consultant.
3. In specific circumstances, such as Trauma Calls, it is expected that the ED team will lead the team and co-ordinate initial care, however clear local guidance needs to be in place regarding which specialty team will take overarching responsibility of patients requiring multiple specialty input. Whilst 'Exit Block' or lack of suitable bed may dictate that the patient remains in the ED beyond 4 hours, these patients need to be under the care of a named in-patient specialty team, even if awaiting transfer to another centre.

Background

Fellows and members of RCEM have raised concerns around the potential for a lack of clarity to exist as to which clinician has overall responsibility for a patient who is physically in the Emergency Department (ED) but who has been referred to a specialty team. Delays (often a result of crowding ^[3] can occur in the acute pathway, including transfer from ED (increasingly, patients are transferred to alternative hospitals or sites for ongoing care), and waiting to see specialty team. At times of high hospital bed occupancy rates, beds in Clinical Decision Units (CDUs) or observation units may be used for specialty patients awaiting a bed on a specialty ward. Issues around whose care these patients are under can cause delay in patient care, patient review and patient discharge, and could result in clinical incidents.

If the patient is in the ED (or ED observation unit/CDU) they are being cared for by the ED nursing team. The ED nursing team have ready access to the ED clinician team 24/7 but this is not always the case for those patients being managed by the specialty teams. One of the consequences of ED crowding / 'Exit block' is that some patients who are referred to a specialty team never actually get admitted to a ward or an assessment area and have their entire episode of care in the ED, often having to spend a considerable amount of this time in a non-clinical space (e.g. a corridor), before being discharged by a specialty team.

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Referral for Inpatient Care Standards

Author

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Introduction

This section defines what is expected when a patient is referred for inpatient care.

Standards

1. Hospitals must maintain an up to date digital on-call rota of all specialties who receive referrals from the emergency medicine service. Contact details must be obvious.
2. There must be agreed internal professional standards in each hospital.
3. Once a patient has been referred onto a specialty, it is the responsibility of that specialty to organise ongoing care. It is not safe, reasonable or appropriate to refer a patient back to the emergency medicine service. Declining referrals is not appropriate, as this does not ensure patients receive the necessary ongoing care.
4. Whilst waiting for specialty teams to respond to a referral the patient in question remains the responsibility the ED team, this includes reacting to changes in the patient's clinical condition and investigation results. However, specialties should have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and must not insist on investigations that do not contribute to the immediate management of the patient.
5. Once a patient in the ED is seen by a specialty team then that patient becomes the responsibility of the specialty team. See 'Clinical Responsibility for Patients within the Emergency Department'.
6. In case of dispute, the Medical Director of a hospital must delegate specialty admission decisions to the on-call Emergency Medicine Consultant.
7. Where a patient is referred to a different site, a copy of the patient emergency department attendance must accompany the patient.
8. Where an inpatient specialty provides only remote advice, this must be made clear in the patient notes.
9. Emergency Department IT systems must be capable of recording the date and time of referral to a specialty team.

Recommendations

1. The referring clinician should be clear whether a referral is for advice or for admission.
2. Use of names rather than roles improves communication and accountability.
3. The referring clinician should clarify the urgency of the referral, whether time critical or urgent.
4. Automated referrals, through electronic health records for straightforward admissions should be encouraged to minimise unnecessary delays.
5. For severely ill or injured patients, a structured guide such as SBAR should be used.

Background

Referring a patient, and receiving a referral safely, is an important function of emergency medicine practice. Emergency Medicine clinicians frequently report that referring patients to inpatient teams is time consuming, inefficient, prone to dispute and potentially unsafe. An optimal referral quickly communicates the urgency of the patient's condition, the anticipated needs and expectations of care.

Referral pathways for common emergency department presentations and diagnoses that require hospital admission should be agreed and communicated. There are a number of presentations, such as head injury, rib fractures and poisoning where clarity about the admitting specialty can save a lot of dispute and time.

Internal professional standards signal that there is a whole hospital commitment to emergency work. These should be set by the Medical Director's office. An example, which can be adapted for local use is shown below.

Recommended Internal Professional Standards

1. An emergency medicine clinician will see new patients on or as close to arrival as possible in the ED.
2. The emergency medicine speciality team should not admit a patient likely to be able to go home just to avoid a breach of the emergency care standard.
3. Inpatient specialities will have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and should not insist on investigations that do not contribute to the immediate management of the patient.
4. Patients referred from primary care (or any other clinical service) should be routed directly for specialty assessment. If this does not occur and the patient attends the emergency department, the patient should be transferred to the specialty considered most appropriate by the emergency medicine team unless immediate medical intervention is required.

Recommended Internal Professional Standards

- 1.** Patients will only be sent to the emergency department as a result of advice by speciality teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. In this situation, the emergency medicine team will continue to provide clinical support to patients within the resuscitation area, and then refer to the most appropriate speciality for on-going management of the current clinical problem.
- 2.** No inpatient speciality doctor should refuse a request to assess any patient referred by the emergency medicine service. If subsequently it is considered that an alternative speciality would provide more appropriate care, it is the responsibility of the first speciality (and not the emergency medicine team) to arrange the transfer.
- 3.** The Emergency medicine service team should continue to provide clinical support to patients who deteriorate and require emergency care, and within the resuscitation area.
- 4.** The Emergency medicine service team should highlight any patient recently discharged from an inpatient admission, or under current investigation, or treatment for assessment by the suitable speciality. This should help the speciality team to avoid unnecessary admissions.
- 5.** If there is a failure for different specialties to agree on accepting a patient, the ED consultants should have the authority to admit any patient to any level one bed in the speciality that they consider best able to meet that patient's clinical needs.

Care of vulnerable patients and those likely to experience Health Inequalities in the Emergency Department

Authors

Fedel Federico | Hooi-Ling Harrison

on behalf of Public Health specialist interest group

Introduction

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. The ED provides universal access to care regardless of ethnicity, socioeconomic background, and underlying health status serving as a 24/7 access point and safety net to the most deprived and vulnerable in our population. The GIRFT report of 2019/20 demonstrated that there were more than twice as many ED attendances for the 10% of the population who live in the most deprived areas compared with the 10% who live in the least deprived areas ⁽¹⁾.

“Inclusion Health” populations are those that experience the extremes of deprivation and health inequalities. These groups include the homeless, sex workers, vulnerable migrants (undocumented migrants, refugees and asylum seekers) or Gypsies and Travellers. This section will focus on these inclusion health populations.

It is estimated that approximately 300,000 people are experiencing homelessness in England (2017) ⁽²⁾. Among homeless people, the mean age at death was 45.9 years for males and 43.4 years for females in 2019 ⁽³⁾. Asylum seekers and refugees made up approximately 21% of immigrants to the UK in 2022 ⁽⁴⁾ and there are approximately 800,000 undocumented migrants ⁽⁵⁾ – many of whom will be homeless and not admit to their status for fear of data sharing with the home office. Inclusion health populations are significantly less likely to be registered with a GP meaning preventable healthcare needs are not treated in a timely fashion, in addition to making ED attendance more likely - homeless people in England are 60 times more likely to visit the emergency department in a year than the general population ⁽²⁾.

Attending an Emergency Department represents an opportunity to address health inequalities through a holistic assessment of a person's health needs and drawing in support of wider partners to help prevent the more adverse outcomes from disease or injury, and further reduce the need for unplanned care. The full document can be found on the RCEM clinical guideline page 'Homelessness and Inclusion Health' ⁽⁶⁾.

Chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill health needs with mental health needs and drug and alcohol misuse ⁽²⁾. Drug- and alcohol-related causes contribute to the most frequent reasons for attendance and admissions of persons experiencing homelessness in the ED and inpatient respectively. There is a need for prevention measures to reduce the prevalence of drug and alcohol, injury and poisoning-related admissions to the ED, enhanced service provision at the community level, and multisector collaborations ⁽¹⁾.

Standards

1. Emergency Department staff must fulfil their statutory duty to identify those patients who are homeless or at risk of being made homeless.
2. Emergency Departments must obtain and record up to date contact details for all patients who are homeless or at risk of homelessness.

Recommendations

1. The Emergency Department should provide information regarding hostels, local hubs, street outreach teams where these services exist for any patient who is homeless or at risk of homelessness.
2. All patients who are homeless or at risk of being homeless should have an opportunity to discuss issues related to alcohol or drug misuse and that the emergency department has written advice regarding local services.
3. A homelessness staff information pack should be available and reviewed annually, with details of homeless services, local street outreach, day centres, alcohol, drug and specialist targeted health services, and information on out of hours services.
4. All emergency departments should have processes in place to ensure staff are aware of how to arrange emergency accommodation for homeless patients both in and out of hours and staff should be aware of the SWEP.
5. When discharging a patient who is homeless or at risk of homelessness, staff should consider the impact and feasibility of the discharge plan (including follow up, medications, isolation) in the light of homelessness, and document this consideration. e.g. Homeless people who inject drugs (PWID) attending with suspected DVT will be unlikely to return for USS next day.
6. All Emergency Departments should have processes in place to ensure staff know who to inform when a homeless patient or a patient at risk of homelessness is admitted through the department into the main hospital.
7. The ED should have processes in place to identify those groups at high risk of health inequality (health inclusion groups), which may be associated with Homelessness
8. The ED has access to an Inclusion Health team.
9. The Trust or Health Board has a Homelessness Officer who liaises directly with the emergency department.
10. An alcohol and drug assessment, brief advice and referral is available according to NICE guidance.
11. The ED has access to regular educational updates on inclusion health (i.e. specific health conditions, impact of psychological trauma, cultural competence, services available to vulnerable groups, legislation) so that staff are aware of the services available to patients in the inclusion health categories, and how to access them.

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Discharge to General Practice

Authors

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Introduction

To provide guidance on effective communication with patients and General Practitioners for emergency department staff discharging patients back to primary care. This should be read in conjunction with other associated guidance **Emergency Department Out of Hours Discharge Medications, Giving Information to Patients in the Emergency Department, Management of Investigation Results in the ED**

Standards

1. Prior to discharge ensure the patient understands their diagnosis and treatment plan.
2. Do not tell patients to routinely see their GP after discharge.
Only suggest to patients that they need to book an appointment to see their GP if there is something that specifically needs addressing. This does not preclude, in appropriate cases, 'safety netting advice' regarding seeing GP if the patient's condition is not improving or deteriorates. There are some conditions where a review after an emergency department attendance is appropriate, such as review of asthma or suture removal, but the purpose should be defined.
3. If it is necessary for a patient to see their GP after discharge, ensure that the reason for this is documented in the ED discharge letter and that there is a reasonable expectation the GP surgery will be able to address their patient's clinical problem.

Standards

- 1.** In general, GPs must not be asked to chase up the results of investigations requested by the emergency department.

However, exceptions may reasonably include those tests which if not taken during an emergency episode of care may cause diagnostic difficulties later on and which are easily avoidable e.g., MSU, mast cell tryptase.
- 2.** The ED discharge letter is a key element in ensuring safe continuity of patient care, it is essential to ensure that it is accurate and has all the appropriate information for GPs to continue to provide care for their patients. It must be sent in a timely manner, preferably electronically, but at least within 24 hours.
- 3.** Provision of a Statement of Fitness for Work must be issued by the ED to those patients who are clearly not going to be fit for work after the 7 day 'self-certification' period [2]. Requesting that patients attend their GP surgery for a Statement of Fitness for Work in cases that will clearly exceed the 7-day self-certification period is wasteful of GP resource e.g., clavicle fracture in a builder.
- 4.** Information regarding registering with a GP must be readily and easily available to all patients attending the ED.
- 5.** Those patients not registered with a GP must be strongly encouraged to do so and provided with details of local surgery as well as general advice.
- 6.** EDs must ensure all patients' details (address, GP surgery, telephone number etc.) are checked on arrival to ensure demographic details are correct and up to date.

Recommendations

- 1.** Ensure when discharging a patient, the patient is aware of their diagnosis, what treatment and investigations they have had and what the next steps are for them in terms follow-up (if any) and medication use as well as resuming normal activities. The use of patient information leaflets for common ED conditions is strongly recommended.
- 2.** Refrain from setting unrealistic expectations.
For example, ‘...go and see your GP they will arrange an urgent MRI scan for you...’ Instead, if you think it is necessary for a patient to see their GP after discharge suggest they make an appointment to see their GP to review their progress. Similarly, refrain from suggesting that patients should go and see their GP primarily for a referral to a specialty team as the GP may feel this is not the right course of action for their patient and will have to deal with the consequent perceived ‘unmet patient expectation’.
- 3.** GPs are usually highly experienced practitioners who know their patients better than the ED, if it is felt a patient requires a further non-urgent test (which it would not be appropriate for the ED to perform) or a referral after discharge, it is advisable to suggest this rather than demand it. “Patient attended with an episode of atrial fibrillation which spontaneously resolved. Please consider if he might benefit from an echocardiography appointment as an outpatient and discussion regarding anticoagulation, CHADSVasc score 3”.
- 4.** When GP follow-up is appropriate, it is better to have a discussion with the patient prior to discharge acknowledging further follow-up is necessary and that this is best discussed with their GP and what the possible options might include and that this will be a discussion between the patient and their GP. Consider whether the GP, in a surgery without access to immediate investigations and constrained by time limited appointments, is likely to be able to sort out the patient’s issue effectively.
- 5.** Direct referrals (after discharge from the ED) to specialists should be used for patients with a firm diagnosis that will clearly require urgent assessment (e.g., TIA, fractures, first fit, ureteric stones, recurrent epistaxis etc.) or where there is significant concern of an urgent nature e.g., suspicion of cancer (2 week wait). The GP should be informed of any referral as part of the ED discharge letter.

Recommendations

1. IT Systems should be in place to allow EDs to easily view the patient's General Practice electronic health record.
2. The ED should provide a written discharge letter for the GP within one working day of discharge, ideally via email. ED IT systems are often able to generate such letters, the content of which varies; however, it should be sufficient to enable the GP to understand why their patient has attended the ED, what the outcome was and whether any further follow-up will be required and by who. It should be remembered that GPs have to review large volumes of paperwork and using structured headings helps rapid focused review of the discharge letter.
3. In cases where it is imperative there is no opportunity for missed or lost letters/emails etc. direct conversation with the GP should take and be documented in the ED notes e.g., new safeguarding concerns.
4. When communicating with the GP via the ED discharge letter keep the information brief and relevant and make it clear what (if anything) you are asking the GP to do and why. Key information to communicate includes any medication changes as well as the diagnosis. If you feel it is necessary to inform the GP of test results, then consider only including relevant 'abnormals' or negatives.
5. EDs should ensure clear processes are in place for those patients attending from 'out of area' and make the necessary provisions to ensure the GP receives an ED discharge letter.
6. EDs should have a policy with respect to whether patients automatically or only 'on request' receive a copy of the GP discharge.

Background

The most cost effective and efficient healthcare systems are based on a strong primary care model as the first point of care. A General Practitioner (GP) or primary care clinician has often developed a relationship with a patient over several years or even decades it is essential that the emergency department (ED) does not undermine the GP-patient relationship, irrespective of what the patient may say about their GP service. Furthermore, the GP will have a 'wide angle' view of what services are available.

The ED provides transient and brief episodes of care, and it is the GP that retains overall responsibility for a patient's on-going management. It is the role of the emergency department (ED) to provide emergency and urgent care, problems that fall outside of this category should be left to the GP. It is not the role of the ED to be providing second opinions for patients who are unhappy with the GP management plan. A patient may very well have seen their GP about the same problem for which they attend the ED, if there appears to be an obvious treatment or investigation that has not been done then it is more than likely that this is because the GP has felt it is not necessary, given their greater knowledge of their patient, than it is because they have not thought about it. The definition of general practice [1] is that it 'is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient'; unlike emergency medicine which retains no ongoing responsibility for the care of patients who are registered with a GP.

The general practice resource is a finite one, it is important that it is used appropriately, that expectations are realistic and that unnecessary consultations are minimised. Clear communication between the ED and general practice is essential to ensure safe and effective continuity of care.

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Patient Information in the Emergency Department

Authors

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Introduction

This section covers the basic requirements for provision of information to patients in Emergency Departments in the United Kingdom. It covers advice that should be available both when the patient attends, during their time in the department, and when they leave the ED. Other relevant RCEM guidance includes **Discharge to General Practice, Emergency Department Care, ED Patients in Police Custody, Management of Domestic Abuse, Chaperones in the Emergency Department**

Standards

1. Patients who are waiting in a waiting room to be seen, must be able to access update information regarding estimated waiting time which is relevant to them (ie. stream specific).
2. Written advice must be freely available and it is helpful to have standard advice openly accessible to everyone on the organisation's internet site, as well as openly available in printed format within the department. Departments must not assume all patients are able to access online material.
3. The treating clinician is responsible for providing the discharge advice (whether verbal, written, online) and ensuring it is in an accessible format for the patient.
4. When altering or adding medication, this must be written down for the patient as well as being communicated to the GP in the ED discharge letter.

Recommendations

1. 'Welcome to the Emergency Department' information should be available.
2. All patients should be given regular verbal advice during their time in the Emergency Department (e.g. of the interventions that are occurring, and the rationale for these).
3. Patient information should be available in a format that is appropriate for the patient, and quality of the writing and production should be high (i.e. printed and legible).
4. The clinical record should include whether discharge advice was provided and in which format(s).
5. When altering or adding medication; this should be written down for the patient as well as being communicated to the GP in the ED discharge letter.
6. All EDs should be able to provide patients with written information on how to register with a General Practitioner (GP) and be able to provide a list of GP surgeries relevant to their catchment area.
7. All EDs should be able to provide patient advice leaflets for the following; Homelessness or risk of being made homeless, Drug and Alcohol Services, Sexual Health Clinics, Domestic Violence / Intimate Partner Violence Support.
8. Initiatives which aim to provide help and resources to patients who may not be willing or able to disclose the real reason for their attendance e.g. intimate partner violence, should be considered by EDs.
9. For patients being discharged into police custody EDs should have procedures in place to ensure the patient has appropriate discharge information and that information which is central to ensuring the patient's safety whilst in custody is shared with the Police service after the patient has given the necessary consents.

Background

An ED can be a disorientating place for patients, and it is important that they are not only able to navigate easily around the physical environment but also know where they are in terms of their 'journey' through the various processes that occur during their visit to an ED. Keeping the patient informed about why they are waiting and what they are waiting for; is both courteous and also likely to lead to increased patient satisfaction as well as reduce levels of anxiety and possibly reduced violence and aggression ^[1]. When considering how and what information is provided to patients it is important to choose an appropriate medium (verbal, paper, signage, display screen, online etc.) based not only on the type of information but the needs and ability of the patient to be able to access, this may entail having material available in multiple languages.

A significant proportion of this guidance relates to paper-based information, particularly patient advice leaflets regarding specific conditions. Much of this will be relevant to online guidance as well; however, care must be taken to ensure that patients are able to access any online advice and are not inadvertently affected by digital health inequality. There are very sound pragmatic and environmental reasons to provide links (e.g. OCR codes) to online advice but departments should have the ability to provide advice that is directly available to the patient at the point of discharge if required. The ability to document the provision of discharge advice is important from both a quality of care, as well as a medico-legal standpoint.

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Patient Experience

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Introduction

Every person who receives emergency medical services, including those that involve the ED, has a 'patient experience' (PX). This can be described in terms of patients' reactions, amongst other things, to staff, facilities and systems. All the preceding sections of this document help define what the patient should expect of the ED in all these areas. Standards should be set and recommendations made with the patient clearly as the focal point.

While PX is an inherently subjective issue, it is emphatically not a secondary concern in health care, to be considered after other technical, clinical, or medical matters have been dealt with. It is a primary concern that forms an integral part of the overall 'service' provided. There is a considerable body of evidence which confirms that positive patient experiences correlate with better patient outcomes – e.g., reduced morbidity, mortality - as well as improved staff satisfaction, decreased health costs and improved organisational reputation. ^[1]

What follows deals with PX as an outcome. It covers the collection of data, qualitative and quantitative, around PX, and also the way that such feedback is turned into action.

Standards

1. The NHS Friends and Family Test (FFT) must be administered to give a baseline indication of overall patient experience. Given its limited scope, however, it must not be relied upon to give service managers direction and focus for making improvements.
2. Where feedback on emergency health care (e.g., letters of complaint or appreciation) is given to a hospital, or an emergency department directly, staff in the ED must always either respond directly to that feedback or make the substantive contribution to that response. Unless there are legal considerations which make it inappropriate, staff in the ED must always be included in communications with patients/ carers.
3. Responsibility for ED responses must be assigned to a designated consultant to ensure consistency of administration. Such responsibility must be for a pre-determined period, and shared over time within the consultant group, making appropriate allowance for the administrative load that this may create for any individual consultant.

Recommendations

- 1.** Methods designed to collect PX data, referred to as Patient Reported Experience Measures, should be created to enable proactive management. The elements of PX that should be investigated are well defined within the Care Quality Commission's (CQC) Urgent and Emergency Care Surveys. ^[2] e.g., waiting times, staff empathy, shared decision-making, communications, discharge and physical environment. Such tools, typically developed and owned locally, should be simple and provoke discussion and action. RCEM should act as a repository for best practice in this arena.
- 2.** Where formal and more complex quantitative feedback is sought, from an information management perspective, it is strongly recommended that standardised tools are created that enable cross-system comparison/learning. In such cases, central coordination should play an important part.
- 3.** Formal feedback gathered at the time of attendance from those attending the ED, whether as patients or carers, should be interpreted with great care. However, patients/carers should be provided with information about how to give feedback in the days following attendance, emphasising why it is important to give information and how it will be used.

Recommendations

- 1.** Members of staff at all levels should be given the opportunity and encouraged to observe and report on their own EDs to identify where PX can be improved. This could mean that:
 - a.** Medical students and post-graduate doctors in training - observe the workings of the department and report/audit as part of their portfolio development, bringing to bear their own experiences of other departments in which they have worked.
 - b.** Nursing staff - similarly to medical students as part of their training and continual development.
 - c.** SAS doctors, LE doctors, Consultants – network with colleagues in other Trusts to share/compare/observe initiatives.
 - d.** Agency Staff – undertake a formal review at the end of their assignment, using a CQC framework to highlight the best opportunities for PX/quality improvement.

- 2.** Whatever process is developed to collect data, there should be a formal mechanism for reviewing/discussing what is learned and for setting actions for team leaders and members to take – the feedback loop. The purpose of such a process is both practical e.g., to correct system faults but also cultural - to ensure that PX is a matter for regular discussion and kept in the forefront of minds. The regularity of meetings to discuss feedback will depend on the purpose.
 - a.** Daily/Weekly – operational focus on immediate issues
 - b.** Monthly/Biannually – most importantly for the leadership group, to discuss feedback from all sources e.g., letters, social media, Patient Liaison, staff meetings, and identify patterns/issues/ actions. These discussions should include the impact that recent changes in the ED have had on PX. Further, it should consider planned changes over the coming period to identify potential harm to PX and mitigating actions.

Background

The real focus on PX should be in the design of new services, and ensuring that the patient is taken fully into account when changes are made that might affect them.

Hospitals/EDs collect a mass of data on how well these processes and systems work in practice, and report it regularly to a variety of audiences. In fact, measurement of processes and outcomes takes place at an 'industrial' level. But while there is an abundance of data, it is not always in a format that helps inform the ED leadership.

The problem with PX that needs to be dealt with, as a cultural imperative, is ensuring that decisions and actions are taken on the basis of the information already available. There should be a bias towards action and away from data collection for its own sake. This should be evident to staff within and outside the ED and to patients who typically share their experiences in the hope that others benefit from good practice repeated and bad practice eliminated.

From an ED leadership perspective, feedback on performance has to be treated as a vital asset, rather than something of which to be fearful.

All of the above commentary and recommendations accept that EDs are, and perhaps always will be, under great, pressure and that time and energy is in short supply. Despite this, PX should remain a top priority, just as are those areas that have 'harder', and perhaps more objective, measures.^[3]

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Management of Investigation Results in the Emergency Department

Authors

James France | Simon Smith

Introduction

The ED is a high-volume requestor of both pathology and radiology. These requests maybe made by numerous grades of doctors, nurses and advanced care providers for patients in the emergency department. Most of these patients will initially be under the care of the ED, however referrals to in-patient specialty teams are often diverted to the ED for a number of reasons e.g. the ED acting as single point of entry to the hospital for any episode of urgent or emergency care, or patient diversion to the ED due to lack of in-patient specialty capacity. There is increasing pressure for Emergency Departments to not only have safe systems in place to ensure that no fracture or abnormal result is missed, but also to be able to provide assurance (often electronically) with regard to all reports (pathology, radiology) having been seen, irrespective of whether the result / report is abnormal or not; this can be very time consuming.

Standards

- 1.** Patients must be kept informed in a sensitive and appropriate manner of the findings of investigation results, the actions taken as a result, and in a manner that is in keeping with the principles of Duty of Candour.
- 2.** All Emergency Departments must have a 'Standard Operating Procedure' for the handling of investigation results (radiological and non-radiological) that covers the following issues for those patients under the care of the Emergency Department, or discharged from the Emergency Department:
 - a.** The process of review and action taken must be identifiable and traceable, and completed in a timely fashion. This must be 'real-time' for time critical investigation results, and within 72 hours for non-urgent results.
 - b.** Responsibility for review and actions resulting from the results / report review must be clearly defined and recorded, to ensure consistency, as should the processes for referral and handover of this responsibility.
 - c.** The systems in place for referral follow up and further action required.
 - d.** The process of review, and action taken as a result must be recorded in an auditable manner, preferably utilising electronic sign-off of results. The record must be available to all members of the clinical team to avoid duplication of activity.
 - e.** Mechanisms for informing the patient of the action taken.

Standards

1. Emergency Departments must ensure systems are in place to allow radiology and pathology teams to provide verbal reports (urgent or critical) rapidly and in a consistent manner throughout the whole 24hr period.
2. For patients who are admitted under a non-ED team, then the responsibility for reviewing and subsequent actions arising from radiology reports rests with the team caring for that patient or the discharging team.
3. There must be programmed activity (as Direct Clinical Care) available within Consultant job plans for reviewing investigation results (radiological and non-radiological)
4. All reports of abnormal radiological investigations requested by the Emergency Department team must be reviewed by a clinician, taking the clinical scenario into account, and necessary actions that may be required.
5. Patients in whom a radiological investigation was requested whilst in the Emergency Department but at the time was in the care of a specialty team, then follow-up of any abnormal result must be by that specialty team. The processes for this must be robust to avoid failure to action (see examples below).

Recommendations

1. All results of non-radiological investigations performed in the Emergency Department should be reviewed and acted upon by a clinician, in the context of the relevant clinical scenario, generally in 'real-time'. There are some exceptions to this, see discharge to GP guidance.
2. The Emergency Department and the Radiology Departments are encouraged to hold regular meetings to review requesting protocols, timeliness of reporting and volumes and trends of requests particularly regarding non-plain film X-rays.

Background

Non-radiological investigations, such as results of blood tests are quality assured by the laboratory system, and the result made available to clinicians (usually on the hospital Information Technology system). Frequently these systems highlight abnormal results, misinterpretation of the result is uncommon; of greater concern is discharging a patient without realising there is an outstanding result. Most of these systems have the functionality to incorporate a completely electronic auditable trail of the history of requesting, receipt of sample and acknowledgement of test results. Pathology results (e.g. biochemistry, haematology) tend to be reported within a 1-2 hour timeframe, whilst the patient is in the ED. Abnormal pathology results tend to be easily recognised in-view of well-defined clinical ranges and tend to be reported quickly. Exceptions to rapid reporting for pathology for commonly ordered ED pathology tests include urine, blood and swab cultures results.

Radiology results (e.g. X-rays) require clinician interpretation and can be subject to misinterpretation by the clinician (e.g. missed fracture) and this is particularly important when in-experienced clinicians are being relied upon to interpret X-rays. 'Hot reporting' of some types (e.g. appendicular skeleton) X-ray films 09-17:00 Monday to Friday by trained radiologists or radiographers is the norm in some departments, but not all and the reporting of other types of X-ray films e.g. Chest X-rays are often not part of his process. The result is that a radiology report could be available whilst the patient is still in the ED, within 10 minutes of having had the X-ray taken or it could be 10 days before the report is available. Those ED patients having specialist radiological investigations e.g. CT scans whilst in the ED, generally tend to have a report available either whilst the patient remains in the ED or whilst the patient is being cared for by an in-patient specialty team.

Pathology reports tend to arrive in 'real time' whilst radiology reports have the potential to arrive both in 'real time' via 'Hot Reporting' mechanisms but also some days later (after the patient has been discharged or admitted) and these reports might either be verbal, written or via email and may involve an element of duplication. A further level of complexity may be added by reports being sent to the location (e.g. ED) that the patient was in when they had their investigation rather to the requesting consultant (e.g. a stroke physician).

Lastly, Radiology reports can have addenda added (often by Radiology Consultant review) after the patient has been discharged. Often these are significant findings that require immediate action (common examples include small subarachnoid bleed, cervical spine fractures), significant findings requiring urgent action (common examples are lung tumours, bowel wall abnormalities), and 'incidental' findings requiring non-urgent action (for example adrenal adenomas, small lung nodules).

Few Emergency Departments have access to outpatient clinics and national guidance around communication of diagnostic tests to primary care focuses on those patients discharged from hospital wards without any specific mention of Emergency Departments [2]. Whilst it is entirely appropriate that the ED follows up a patient with a 'missed fracture'; for non-urgent conditions it is reasonable to ask primary care to take on the responsibility of organising any further non-specialist tests that arise as a result of their patient attending an emergency department. See Appendix 1 for features of Fail-Safe Result Notification System.

Appendix 1

Fail-Safe Result Notification System^[3]

Principles and recommendations of a Fail-Safe Result notification System

1. Prompt notification of all imaging reports by the imaging department.
2. Prompt review, acknowledgement and action on all imaging reports by the referrers.
3. A system to facilitate identification and action of reports which have not yet been read, acknowledged or acted upon.

A collaborative approach to alerts and notification of imaging reports

1. A safe and effective result notification system requires a concerted effort from all involved, using an electronic system supported by human interactions.
2. Alerts should be in place in three imaging categories: new cancer diagnoses or new recurrences, critical findings that time-critical, and significant addenda that may alter clinical management.
3. It is the responsibility of the healthcare organisations to adopt a fail-safe system that enables identification of reports that have not been reviewed and acted upon [or plan to act] and embed a mechanism to follow up these reports.
4. Every imaging referral [or through a pre-agreed system] must include a valid contact detail to which an urgent communication can be made if required, including an out of hours contact.
5. A Results Coordination Team should help ensure reports are returned to the correct clinical team, verbally inform the referrers that critical reports are available for immediate review and escalate imaging alerts that have not been reviewed and acted upon [or plan to act]. The aim of the Result Coordination Team is to ensure that no patient suffers adversely because of delayed or miscommunicated radiology reports. The Results Coordination Team should be primarily focused on patient outcomes and not merely concerned with institutional compliance around alert and acknowledgement systems.

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Author

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Introduction

Research is a core component of all mature specialties, and a key part of good clinical care. Patient outcomes have been shown to be better in hospitals that are research active, where there is higher staff satisfaction, and the Care Quality Commission (CQC) now includes clinical research activity within its remit for hospital inspections.

Compared to many more established specialties, academic emergency medicine is young and dynamic. We no longer need to rely on the evidence base generated in other disciplines using different populations. Those working in emergency care are best placed to know what questions to ask. To achieve our aims, research needs to be embedded in everyday emergency care.

Standards

1. Emergency Departments must have a designated research lead and must be actively recruiting to NIHR Portfolio research studies.
2. All major trauma centres and university affiliated hospitals must have an EM research lead with job planned time and appropriate infrastructure support. They must be involved in research programs and should be consistently recruiting to NIHR Portfolio research studies.

Recommendations

1. Research should be embedded in everyday emergency care
2. All clinicians practising emergency medicine should be able to access and undertake research
3. The opportunity to take part in research should be available to all of our patients.
4. Research infrastructure, including the availability of research nurses to support recruitment to research studies, should be in place. The average emergency department involved in research should aim to have research nurse cover from 0900-1700, five days per week.
5. In addition, all clinicians working in emergency care should have access to a journal club, where recent evidence is critically appraised and implications for clinical practice are identified.

Background

The Royal College of Emergency Medicine fully supports the concept that research is a core component of good clinical care. Research should be embedded in everyday emergency medicine; all clinicians should be able to access and undertake research, and the opportunity to take part in research should be available to all of our patients. The opportunity to participate in research studies should include all areas of the department, including the paediatric emergency department.

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Quality Improvement, Assurance and Audit in the Emergency Department

Authors

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Introduction

An Emergency Department's safe, effective and timely care is dependent on well-developed pathways for the most common and serious presentations requiring significant inter-speciality agreement and cooperation. Development of processes and refinement for optimisations requires Quality Improvement (QI) activity and the application of its methodology. This is vital to drive up standards of patient care. Continuous improvement is predicated on system leaders and front-line staff developing a comprehensive understanding of the domains of quality, a vigilance to identify problems and the healthcare system and senior leadership providing support and resource to proactively rectify them. QI is dependent on the mobilisation of staff who are closest to the quality issue and is typically not delivered in a top-down fashion. This requires allocating time for QI activity and education to develop QI competence throughout all staff groups. ^[1]

The GMC stipulates that doctors "should participate in any national audit or outcome review if one is being conducted in your area of practice." ^[2] This would include RCEM's national QI programme and can help support revalidation and ARCP progression which educational Superiors have a central role in fulfilling as assessors. QI is everyone's responsibility however, regardless of seniority or professional group and requires working across the MDT to change culture and embed sustained change. Senior leaders are however responsible for creating a culture of improvement and candour that instils confidence in more junior staff to tackle healthcare delivery conundrums. Supporting the development of efficacious governance systems that create active feedback loops to help prioritise and inform activity as well as enable change is also critical.

Meaningful quality work requires an emphasis on action and measurement to evaluate impact beyond excessive data collection and problem over scoping. The legacy of audit cycling and 'closing loops' still hangs over the medical community with singular packages of work delivered after arduous data compiling with limited legacy or impact. This contrasts with QI methodology that drives iterative changes measured in nearer real time and escalating interventions as stakeholder buy-in increases along the improvement journey. Currently this methodology is not applied with sufficient rigor and many projects still struggle. There has been recognition from the Academy of Medical Royal Colleges and RCEM that a greater emphasis on involving junior staff in well-resourced hospital priorities with more mentorship is needed to foster advanced QI competence and improve motivation as well as increase successes.^[4]

The Emergency Department is a critical service to its local population, EDs should engage with patients and the public in service design. Department level QI activity involving patients and the public should be considered where expertise and resource allows; to ensure patient-centred programmes of work are developed.

Standards

Standard	Recommendation
<p>Departments must develop a local programme of meaningful QI activity.</p>	<ol style="list-style-type: none"> 1. Engage with national audit and quality programmes including RCEM's national QIPs. 2. Establish a local QI lead to coordinate and support activity. 3. Promote transparency by communicating clearly what improvement activity is occurring and it's impact. 4. Provide the recommended Educational Development Time or equivalents to staff groups to support improvement activity and education. ^[4]
<p>Departments must promote QI education and team development.</p>	<ol style="list-style-type: none"> 1. Host Quarterly (minimum) QI meetings for staff to present work, trouble shoot and engage senior stakeholders. 2. Incorporate QI methodology training development into all staff groups educational programmes. 3. Establish QI Champions within key staff groups (Junior and Senior Medical and Nursing, AHP) to support the QI lead.
<p>Department QI, Governance and Clinical leadership must cooperate to establish areas of improvement priority.</p>	<ol style="list-style-type: none"> 1. Use Datixs, complaints, national safety alerts and staff knowledge of workplace issues to develop project lists which trainees and others may draw upon to initiate projects. 2. Identify high-value projects with significant resources and stakeholder support to include Trainees and other staff to foster opportunities to develop advance QI competencies. ^[3] 3. Support stakeholder engagement and buy into projects being undertaken
<p>Departments' Educational Supervisors must ensure they are up to date with QI methods and assessment needs to support effective supervision.</p>	<ol style="list-style-type: none"> 1. All supervisors should be familiar with the Academy of Medical Royal Colleges Guidance on QI and ARCP ^[3] 2. Depending on self-assessed confidence and knowledge levels attend RCEM's QI Train the Trainers or similar courses to promote greater consistency is assurance and QI coaching
<p>Departments must consider ways to improve links to the community and people with lived experience to help improve, redesign, and invigorate emergency care delivery</p>	<ol style="list-style-type: none"> 1. Establish links with patient groups to provide opportunities for involvement in service change ideas generation, review and prioritisation. 2. Departmental QI leads to develop knowledge and training in this area

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Environmental Sustainability in Emergency Medicine

Author

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Introduction

In the context of our greater understanding of the climate crisis and its health effects, there has been a recent drive in addressing the environmental sustainability of healthcare, with in England the creation of Greener NHS and national targets for healthcare systems to get to net zero carbon between 2040 and 2045.

Environmental sustainability is an emerging area within emergency care and as such there are yet no clearly defined standards. There are however clear recommendations in this field.

Recommendations

1. To become accredited with the GreenED programme.
2. To train in sustainable quality improvement

Background

The climate crisis is the greatest health threat of the 21st century[1], healthcare systems around the world have started to address this.

RCEM has published a position statement on environmentally sustainable emergency healthcare[2] which has five recommendations on how the specialty of emergency medicine can address its environmental sustainability.

The carbon footprint of the UK health system is approximately 4% of the UK total, therefore, to achieve net zero we are obliged to reduce the carbon footprint of our practice.

Low carbon or net zero emergency healthcare does not yet exist however to move towards this goal RCEM has developed the GreenED[3] framework which guides departments on making sustainable changes. The GreenED framework will continue to develop, with the goal of getting to net zero emergency care.

A vital part of this process will be through quality improvement work. Our second recommendation is for emergency care practitioners to train in sustainable quality improvement work or susQI. This has been developed by the Centre for sustainable Healthcare[4]. By using SusQI you embed sustainability into current QI theory and practice and thus provides tools to enable healthcare workers to provide sustainable health system transformation.

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Emergency Department Crowding

Authors

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Introduction

ED crowding occurs when the demands on an ED exceed the capacity of that service, hospital, or health system to meet them. It manifests most visibly as delays to offloading ambulances, delays to be assessed and treated, and as long waits for admission with patients often situated on trolleys in corridors or in other inappropriate spaces. Less visible, but well recognised and more important, are increased morbidity and mortality for patients, and moral injury, burnout and reduced retention and recruitment for ED staff.

Emergency Department crowding represents the greatest threat to the timely delivery of emergency care in the UK and across the world¹. It is present to a greater or lesser extent, in many healthcare systems, and although not a new phenomenon, it has been steadily worsening over time. This does not make it inevitable. Causes of crowding are complex and can vary between different health systems, hospitals, and over different time periods. It is a source of considerable frustration to Emergency Physicians when crowding is framed as an 'ED problem.' The consistent factor in ED crowding is that the causes are in the unscheduled healthcare system, and that the solutions lie, for the most part, outside of the ED.

Standards

1. Where hospitals accept emergency admissions, bed occupancy must be around 85%. The optimal figure will vary between organisations.
2. RCEM Emergency Department design, informatics, workforce and sustainable working standards must be met by organisations with a type 1 ED.
3. All hospital handovers must be complete by 60 minutes after ambulance arrival, with most taking place within 15 minutes, and almost all within 30 minutes.
4. Every ED must have the ability to create a resuscitation bed, and a high dependency adult and paediatric bed, at very short notice, and at all times.

Standards

1. Initial assessment processes must meet RCEM standards.
 - a. Patients will ideally receive initial assessment by a specifically trained clinician within 15 minutes of arrival.
 - b. Patients will ideally receive a full clinical assessment within an hour of arrival. However, it is acceptable to prioritise patients with higher triage categories or other markers of urgency / acuity where demand outstrips resources.
2. The 4-hour emergency access standard threshold is an NHS constitutional standard. The threshold must remain at 95% subject to formal, scientific, review.
3. For emergency departments to be able to deliver the 4-hour emergency access standard, no more than 10% of their cubicles must be occupied by patients waiting for admission or who have been referred.
4. No patient must be in an ED for more than 12 hours after arrival. This must be measured and reported publicly, in a timely fashion.

Recommendations

1. RCEM'S recommendations are summarized in the "Management of Emergency Department Crowding ²," and our policy recommendations are summarized in the "RCEM Acute Insight Series document "Crowding and its consequences ³."
2. The management of ED crowding is a whole system responsibility. It is vital to understand that Emergency Medicine services cannot solve this on their own. Interventions are complex, requiring whole system engagement and understanding. Solving a problem in one part of system can create another problem elsewhere. This is about balancing risk and needs active engagement from senior leaders across the health and social domains.
3. There is an extensive scientific literature about interventions to reduce emergency department crowding⁴. However, this is limited by variable quality in the studies.
4. **UK & Devolved Governments**
 - a. Resource the health and social care system so that there is capacity and capability to meet the 85% occupancy and 95% site-specific four-hour standards in the long term.
 - This will require strategic and long-term policy development and investment in hospital facilities, workforce, and informatics
 - Prioritise high-risk hospitals within the maintenance backlog. This will enable urgent repairs and replacements, ensuring safer conditions and better care for patients and staff.
 - Additional investment is required into community and social care in order to ensure patients are only admitted when care cannot be provided elsewhere, and are discharged safely and promptly when their medical care is complete.
 - The care of patients with mental health problems requires specific prioritisation.

Recommendations

1. NHS England and devolved equivalents

- a.** Publish key performance metrics relating to crowding by hospital, rather than, for example, Trust or Board.
 - Off-site facilities such as UTCs should not be used to dilute the performance metrics for a whole organisation.
- b.** Ensure that there are enough appropriately staffed hospital beds available, so hospitals have the space and resources available to be able to care for patients needing emergency admission and can run at appropriate occupancy.
- c.** Develop numerated and evidence-based workforce plans. Ensure workforce planning takes into account less than full time working, sustainable working practices, changing population health needs. Workforce plans must contain details relating to each specialty, including Emergency Medicine.
- d.** Ensure that investment choices, and energy, are directed where there is evidence of improved clinical care, or of reduction in the harm associated with crowding.
 - Prioritise output interventions and improving throughput, rather than focusing on demand management strategies.

2. Local Health Systems and Hospitals

- a.** ED design, workforce configuration, and sustainable working practices should be in line with RCEM guidance.
- b.** Informatics systems should be integrated across systems. Within hospitals they should support ED operational and clinical function and be aligned with RCEM guidance.
- c.** Output, throughput and input interventions detailed the document “Management of Emergency Department Crowding” should be adopted, with the priority in that order, with focus on higher impact interventions.
- d.** Escalation policies should be effective and in line with guidance provided here. The use of boarding and of full capacity protocols is cautiously supported by RCEM.

Background

Crowding represents a persistent, worsening, and existential threat to the delivery of timely patient care to patients in Emergency Departments and healthcare systems throughout the world.

Harm caused by crowding affects patients in terms of worsening mortality, morbidity, reduced quality of care, and poor patient experience.

Harm due to crowding also affects staff and has a serious adverse effect on staff experience, leading to moral injury, burnout, and lack of staff retention. This places the future of the emergency medicine workforce at risk.

Crowding is a marker of failure in health policy and leadership. Responsibility for solving this issue lies first with health service policy makers and national leaders, and then local system and organisational leaders. With responsibility should come accountability.

Potential solutions to the problem of Emergency Department crowding must be viewed as whole system interventions and do not sit solely within the Emergency Department.

The study of, and interventions associated with, crowding can be divided into Input, Throughput and Output ⁵. One issue with this commonly quoted model is that it is the wrong way round when describing the importance of potential solutions. It also fails to emphasise the crucial role of health policy. The key determinant of crowding is output. Throughput is important, but improvements in processes will have a limited effect if there is significant exit block. There is little evidence that input solutions have a significant impact on crowding and, in particular, on the harmful effects of crowding, yet they continue to be the focus of many significant interventions. The value of this investment is unclear. In our guidance we have inverted the usual order of play to emphasise this.

Output

ED outflow. Overwhelmingly this is a lack of hospital beds for patients needing them. The inability to admit patients to inpatient beds when needed is also described as access block or exit block. Output interventions are the responsibility of leaders and commissioners of services required to provide alternatives to the ED, and of services designed to facilitate patient discharge and reduce inpatient bed occupancy. It will require health policy changes and strategic investment and planning to increase hospital, social care and community-based capacity.

Throughput

What happens within the ED. Determined by factors such as physical space, informatics, people, and processes. Throughout solutions can be influenced by the ED team, but also by other clinical and management teams.

Input

Referring to influences before the ED such as patterns of demand, demand management strategies, pre-hospital interventions etc. Input interventions are within the remit of commissioners of community and other out-of-hospital services and commissioners.

In selected situations several uncomfortable actions may be justified to reduce the risk from crowding. Doing this does not imply acceptance or tolerance of crowding and should not be used as a substitute for escalation, or implementation of longer-term solutions.

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Introduction

Organisational culture is determined by a complex combination of shared values, behaviours, attitudes, assumptions, expectations, and practices. The Emergency Medicine environment is highly stressful and challenging, with negative behaviours more likely to surface and permeate. These behaviours have a direct and indirect impact on patient care and safety, along with staff morale, sickness, and retention. When colleagues are treated compassionately, fairly and with respect they are more likely to feel safe, valued, be innovative and deliver high quality emergency care to their patients.

Standards

1. All patients and staff must be treated fairly and with dignity and respect, irrespective of their social identity or background.
2. All hospitals must have accessible departments and systems. Staff with temporary or permanent disabilities and those who are neurodivergent must have timely and accurate risk assessments and must be offered aids and adjustments to enable them to fulfil their work and educational contracts.
3. Recruitment policies and processes must be fair and transparent, and diverse representation must be reflected in all staff roles and levels.
4. If staff raise concerns, these must be responded to quickly via a transparent and accessible policy and recorded clearly, objectively and confidentially.
5. Staff must be actively encouraged and empowered to speak up if they have concerns over clinical care or patient safety. Investigation of incidents must be systematic and transparent. Open, honest and timely communication of the incident and outcomes must be shared with patients and their families. Learning and remedial training must be provided to staff to reduce repeated incidents and ongoing harm.
6. Induction systems must be comprehensive and robust, ensuring that they are tailored to the needs of staff e.g. international staff who have not worked in the UK.
7. At induction, staff must be clearly signposted to reporting mechanisms for raising concerns including how to report bullying, harassment, or discrimination.
8. All staff must strictly adhere to their professional Codes of Conduct. This includes acting with honesty and integrity and maintaining high standards of professionalism, both inside and outside of work. If staff are found to be in breach of these, appropriate action must be taken.

Recommendations

1. EM leaders should practice and promote inclusive and compassionate leadership by listening to staff, encouraging representation wherever possible, being aware of and respecting individual challenges and cultural differences, offering equal access to opportunities, and supporting staff to achieve their full potential and be able to bring their true selves to work.
2. Staff should be actively encouraged and empowered to speak up if they have concerns that they are being bullied, harassed, or being treated unfairly.
3. If not included in standard organisational requirements, all staff should have training in EDI, Civility (including Bullying and Harassment) and Conflict Resolution via e-learning modules, ideally supplemented by in-person workshops.
4. It is further recommended that departments should provide Active Bystander Training and Civility Saves Lives Training (if not already provided by organisations)
5. Clinical and educational supervisors should commit to continuous training and self-reflection to ensure that they are challenging and mitigating bias and being as inclusive and equitable as possible to ensure fairer training outcomes.
6. All Emergency Medicine services should appoint an Inclusion & Civility champion, to foster and facilitate a culture of open honest communication and to encourage a team-based approach to culture, civility and EDI (Equity, Diversity and Inclusion).
7. There should be a zero-tolerance policy to violence, threatening behaviour or abuse of staff by members of the public who have capacity; and immediate and appropriate action should be taken via an easy to access and follow trust policy. The police should be contacted where appropriate.

Background

Organisational culture in Emergency Medicine has emerged as a significant contributory factor to workplace behaviour and performance, including patient outcomes, and patient and staff experience. A commissioned report by Mary Dixon-Woods from the Thirlwall Enquiry highlights how complex and deeply entrenched toxic cultures can directly impact patient safety.

Health discrimination and inequalities have been well documented for years. The statistics however remain relatively static with minoritised and vulnerable patients continuing to suffer significantly worse outcomes.

The Work Force Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) show that BME staff and staff with disabilities suffer worse experience and career outcomes as a result of bullying and discrimination. The Breaking the Silence Report and Surviving in Scrubs campaign have highlighted the issue of gender based discrimination, harassment and sexual assault in healthcare. The GMC Survey 2024 has shown that EM is the second worst specialty for Sexual Safety.

Worsening crowding, diminishing resources and unmanageable workloads are contributing to frustration, exhaustion and moral injury. EM has the highest level of burnout compared to other specialties, with more than one-third of EM trainees at high-risk of burnout.

Reducing burnout, addressing discrimination, eliminating negative interpersonal behaviours, and improving culture and safety will be incredibly challenging due to the wide range of complex individual, systemic, and structural factors that currently contribute to it, however ignoring them will result in a broken and abandoned specialty.

Compassionate, inclusive, and insightful leadership, self-awareness and education, and transparency and accountability, will be key to understanding and overcoming the barriers to change. Embodying the change that we would each like to see is a good first step.

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