ED interface with prehospital services

Authors

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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.

References

Hospital handover delays for patients in ambulances. Options Appraisal to reduce harm. Available at https://rcem.ac.uk/wp-content/uploads/2024/08/Hospital_Handover_Delays_for_Patients_in_Ambulances_Options_Appraisal_to_Reduce_Harm_v1.pdf