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 it's 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
Departments must develop a local programme of meaningful QI activity.	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]
Departments must promote QI education and team development.	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.
Department QI, Governance and Clinical leadership must cooperate to establish areas of improvement priority.	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
Departments' Educational Supervisors must ensure they are up to date with QI methods and assessment needs to support effective supervision.	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
Departments must consider ways to improve links to the community and people with lived experience to help improve, redesign, and invigorate emergency care delivery	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

References

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