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Screening in the Emergency Department

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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.

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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.

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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	Non-mandatory
Homelessness Paediatric safeguarding	Alcohol, Drugs, Tobacco use, Hypertension, Chlamydia, HIV, Delerium, Intimate Partner Violence, Syphilis, Viral Hepatitis, Obesity

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