Delayed Hospital Handovers, and Clinical Assessment of Patients Waiting in Ambulances Outside Emergency Departments

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Introduction

The relationship between the Emergency Services and Emergency Departments (EDs), and the people who work within both, is strong. RCEM and our members will always seek to work constructively with our colleagues within ambulance services where we face joint challenges, in order to improve patient care.

RCEM is aware that ambulances are often held outside EDs with delays experienced for patients who are still in them. These delayed hospital handovers are unacceptable.

RCEM completely rejects the increasing normalisation of attempts to care for patients in ambulances whilst they are waiting to come into ED, and is clear that trying to deliver Emergency Medicine to patients in ambulances is not safe, not effective, and results in a poor patient experience. When it happens, patients are likely coming to harm.

However, RCEM does not support unilateral adoption of rapid offload policies based on a fixed time limit for delayed hospital handovers, and recommends a more balanced approach involving risk sharing across the system. Rapid offload policies may increase the risk to patients by adding to overcrowding in departments which will already be full. It should not be necessary to view such policies as a tool to focus attention on exit block. If such policies are under consideration they should be agreed with Emergency Department teams and never imposed upon them.

Emergency Physicians, nursing staff, and other hospital-based healthcare professionals are not specifically trained to work in ambulances outside their departments. They should not be expected to do so.

The phenomenon of ambulances being unable to offload patients at Emergency Departments (ED) is an appalling indictment of the state of the health services in the UK. The reason patients are having to be held in the back of ambulances outside EDs is that EDs are crowded as a consequence of 'Exit Block'. It is not within their gift of EDs to enact the system wide solutions required to address the issues of 'Exit block'. EDs should not be blamed, or have unreasonable expectations placed upon them, as a result of health policy failure. Responsibility for this situation lies with governments across the 4 nations of the UK, and with local system leaders.

We make the following standards and recommendations. Please note that when the word "hospital" is used in terms of responsibility for action, this means a shared responsibility across a hospital, and not simply that organisation delegating responsibility for action to, or relying on resources deployed from, the ED alone.

Standards

1. Organisations must have a process to register patients when they are brought to hospital by ambulance.

2. It is reasonable to work on the basis that shared duty of care by a hospital for a patient begins when clinical handover is completed, or 15 minutes after ambulance arrival.

3. All hospital handovers should be complete 60 minutes after ambulance arrival, with most taking place within 15 minutes and almost all within 30 minutes [2][3]. Where these standards cannot be met then arrangements should be made to offer initial assessment of patients who are held in waiting ambulances within 15 minutes of arrival. This may occur either in the ambulances, or in the ED.

4. Hospitals must have policies in place to ensure all patients who are held on the back of an ambulance have regular assessments, with reassessment (signs of deterioration or change in patient condition). This will go some way to mitigate safety concerns as well as providing vital information to ED senior team when making decisions regarding the next patient to offload. Re-evaluation of whether patients can be managed in an ambulatory area should also occur where appropriate.

5. Hospitals and ambulance services must have procedures in place that ensure that patients receive critical medications if they are delayed in ambulances.

6. There must be clear joint ambulance service and hospital SOPs and governance structures around hospital handovers, covering what happens within the ED when they are delayed

7. Hospitals must have an agreed policy that ensures the availability of a resuscitation bed, and a high dependency adult and paediatric bed, in the ED, at very short notice, at all times. This policy should engage the resources of the whole hospital and not just focus on an ED response.

8. Hospitals must have an agreed policy for when the ambulance service needs to rapidly offload patients to allow ambulances back into the community to attend high-acuity (Category 1) patients or significant incidents. This must be in operation 24/7. This policy should engage the resources of the whole hospital and not just focus on an ED response.

9. Patients must be offloaded in order of clinical priority, rather than strictly by time of arrival. This is a decision made jointly by ambulance and/or ED senior clinical staff taking into account individual patient presentation, the resource availability within the ED and the safety of the ED as a whole. Offload priority should not be determined by ambulance / hospital managers or bed management teams. Assessment of clinical priority may include more parameters than acuity score alone.

10. All organisations must have escalation plans which engage the whole hospital and wider healthcare system, which are implemented **before** delayed hospital handovers occur. Where departments are implementing policies to reduce risk for patients waiting in the back of ambulances, the whole hospital should already be in full escalation. This includes the evenings, weekends and bank holidays. This should never be business as usual.

Recommendations

1. Emergency Departments should consider using Rapid Assessment and Treatment areas or systems to receive ambulance patients onto hospital trolleys and prioritise/frontload essential investigations and treatment. These spaces are designated clinical spaces and should not be temporary escalation spaces e.g. corridor.
    a. Hospitals must ensure that Rapid Assessment and Treatment areas, where utilised, do not become congested through inappropriate use for treatment, or observation of patients.

2. For patients in cardiac arrest or with on-going cardiopulmonary resuscitation needs, RCEM recommends that decisions regarding stopping resuscitation are not made in the ambulance.

3. Ambulance Services and Emergency Departments should have dedicated personnel, ideally including a Hospital Ambulance Liaison Officer (HALO), to provide safe and effective co-ordination between ambulance crews and the receiving ED.
    a. This role should include facilitation of communication where there are concerns about individual patients.

5. Ambulances are not designed to accommodate and deliver the basic needs of patients over prolonged periods of time. Arrangements should be made for patients to have access to hot food and hot / cold drinks, and to be able to access toilet facilities if required. Depending on time of day and extent of the delay, the sleep needs of patients must also be considered.

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. Hospitals should ensure that there is adequate SPA time allotted for this role.
    a. Data around what is happening in the back of ambulances should be collected

Notes

RCEM is aware that some Emergency Medicine services undertake clinical assessment of patients in ambulances, or are considering doing so and the following will be relevant tor those services.

Clinical assessment in ambulances is limited by overall space, access to the patient (physical, or around clothing), lighting conditions and noise. Although the same limitations apply to prehospital personnel the expectations and nature of decision-making is different, and Emergency Medicine teams are not trained or equipped to work in ambulances. In addition, there are limited opportunities for ED clinicians in lower workforce tiers to be observed in history taking and examination, and for any issues to be safety netted by other clinical colleagues.

Where hospitals **do** have policies that allow for the clinical assessment of patients in ambulances the following additional standards apply:

1. Any policy allowing for the clinical assessment of patients in ambulances must be agreed with the Emergency Medicine service.

2. Any decision to start seeing patients in ambulances, or to stop doing so, must be made by the most senior doctor on duty and be supported by hospital policies. The decision to see patients in ambulances is a clinical one, not operational or managerial. The factors that inform this decision are:
    a. The acuity and safety of patients in the ambulances
    b. The acuity and safety of patients in the department
    c. The skill mix of available staff
    d. The likelihood of implementing a meaningful clinical intervention in an ambulance

3. Paramedics and non-registered ambulance personnel must not be asked to supervise or undertake care they are not trained or covered to provide e.g. giving medicines they are not legally allowed to administer, or being responsible for infusion pumps. Local arrangements may be put in place to support the prescription and delivery of medications and / or treatments which are beyond the scope of ambulance crews.

4. Staff working in ambulances should be additional to the usual ED template, rather than requiring EDs to use already stretched resources.

5. Staff should not be expected to work in the back of ambulances if they do not wish to do so, and should not be pressured to do so.

6. If patients do undergo clinical assessment in the ambulance, this should be undertaken by more senior doctors who are fully aware of the limitations of assessment in this environment, particularly for complex patients or those for whom discharge is being considered.

7. Depending on logistical considerations, it may be possible to take bloods, perform ECGs, and to organise radiological investigations for patients in ambulances. Investigations which further help determine clinical priority e.g. hip X-ray in an elderly patient who has fallen, have clear benefit ... but this must be part of a local agreement between the ambulance service and the hospital.

8. Any documentation should include the fact that the patient was assessed in an ambulance. The need for reassessment of patients once they have been offloaded should be considered.

9. It is the responsibility of hospitals to indemnify their staff to practice in ambulances, and to ensure that liability for any injuries or insults sustained are covered by the hospital's insurance. This must be confirmed in writing to ED teams.

10. It is the hospital's responsibility to perform Health and Safety assessments on all working areas, including in this case the ambulances and the car park. H&S assessments should explicitly detail ways to minimise risk to staff in these environments and should assess incompletely mitigated risks.
    a. Hospitals must provide ED staff agreeing to work in ambulances with appropriate training to work in the area, and with PPE for weather protection and visibility. The environment must be adapted to minimise risk from moving vehicles (especially when reversing) and trip hazards such as ramps. This may require lighting of the parking area. In addition, noise and pollution levels should be formally measured and monitored, with adaptation of engine idling practices as required.

References

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3. *Principles for Safe Transfer to Hospital: Ensuring the Timeous Handover of Ambulance Patients. NHS Scotland, Scottish Government. April 2023* https://www.gov.scot/binaries/content/documents/govscot/publications/foi-eir-release/2023/12-e/foi-202300372294/documents/foi-202300372294---information-released---document/foi-202300372294---information-released---document/govscot%3Adocument/FOI%2B202300372294%2B-%2BInformation%2BReleased%2B-%2BDocument.pdf