Royal College *of* Emergency Medicine

RCEM Guideline

Extended Emergency Medicine Ambulatory Care

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Introduction

The concept of Same-day Emergency Care (SDEC) as a means of reducing admissions to hospital and providing more efficient emergency and urgent care to patients with a variety of presentations is being actively promoted by health policy makers. This has led to renewed interest in Emergency Physicians looking after patients for a more extended period, with the same object in mind.

However, there are significant concerns amongst many Emergency Physicians about the scope of practice, and that the concept will be used to improve performance rather than to improve quality of care. There are also significant concerns about resource implications, and whether funding will follow the activity.

The purpose of Extended EM Ambulatory Care (EEMAC) is to improve patient and staff experience by moving a subset of patients out of the ED into a different environment, to complete their care. This may lead to:

- Admission reduction if patients were being admitted simply to meet time-based targets applicable to the ED, and when their care should otherwise have been completed by the Emergency Medicine service
- Reduction of target-based pressure on staff and associated workarounds
- More efficient care
- A more comfortable space to wait for investigation and results, and in which to work

While the mode of operation of EEMAC will vary in terms of access, workforce and location RCEM has agreed a set of principles in this rapidly evolving area.

It is reasonable to expect this guidance will be updated within a short timeframe as the concept develops across the four nations.

These standards do not refer to SDEC undertaken in other settings (e.g.) Medical SDEC, Surgical SDEC, Gynaecology SDEC. 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.

This guidance relates only to adults

Standards

- EEMAC facilities must not be introduced without the agreement of the local Emergency Medicine Service.
- EEMAC facilities must be co-located with an Emergency Department and under the ownership and control of the Emergency Medicine service.
- EEMAC facilities must be separately commissioned and additionally resourced, rather than simply drawing from resources from the Emergency Department. This means:
  - The space must be additional. The development of EEMAC facilities should not compromise the estate of existing ED or SDEC services; and
  - The staff must be additional. The number of clinicians and other staff needs to reflect the fact this these facilities will be a separate area (“carve-out”), match the demand, and must not denude the Emergency Department of staff.
- Funding arrangements must be agreed prior to introduction.
  - Payment for EEMAC must include a component for the preceding ED-based element of care, along with separate payment for the care which occurs in EEMAC facilities.

RCEM recommends that there is parity in funding arrangements to those for SDEC facilities within the same organisation are adopted. This activity must not be absorbed within extant ED financial envelopes.

- The Emergency Physician in Charge has absolute primacy over which patients are admitted to EEMAC facilities.
- There must be senior oversight of patients in a manner equivalent to the emergency department.
- No patient must ever be moved to EEMAC facilities simply to avoid a breach of a time-based standard.
- Patients who are likely to require admission must not be admitted to EEMAC facilities.
    - *NB: Patients proven to require admission must be returned to the ED to await a bed, unless one is imminently available. Their recorded time of arrival should be when they first arrived in the ED, not the time at which they were returned.*

- All patients for EEMAC must require urgent treatment; planned care is provided elsewhere.

  NB: Patients should not be brought back in a planned fashion to an EEMAC facility (including on the following day).
- All patients must need care that is best delivered by an Emergency Medicine speciality team. This means they must be presenting with conditions which Emergency Physicians are trained to manage and agree to manage. In addition:
    - all patients suitable for an existing medical, surgical, or other SDEC pathways must continue within those pathways. EEMAC must not become an alternative venue for them if they are not in operation, or are at capacity; and
    - no patients suitable for management in an Urgent Treatment Centre (or equivalent) should be managed in EEMAC.
- Investigation time frames must have the same turnaround times as ED.
- Activity must be recorded using ECDS data sets and recorded as type 5 ED activity.
- Access must be maintained at times of pressure and the physical space must not be bedded.

Recommendations

Inclusion

- Adult patients requiring ongoing assessment or complex diagnostics, who:
    - Are best looked after by the Emergency Medicine service
    - Fall within the scope of practice of Emergency Physicians and agreed criteria
    - Require more than 4 hours in the ED to complete their care
    - Have a high likelihood of discharge within 8 hours of admission to the EEMAC facility OR the opening hours of the unit
    - Would otherwise have been admitted and with agreement of the Emergency Physician in Charge.

NB: The definition of an adult will be that used locally to determine whether patients are admitted under paediatric or adult services.

Exclusion

- Patients who clearly require inpatient admission at the point of referral.
- Patients awaiting discharge or transfer to other facilities.
- Patients awaiting a specialist team opinion with uncertain outcome.
- Patients with a NEWS score or acuity score that is equal to or exceeds the locally agreed guidance.
- Patients with injuries requiring surgical treatment.
- Patients who are acutely confused or intoxicated.
- Patients with an acute mental health crisis who are at risk to themselves or the public or who are likely to require a medical or mental health admission.
- Patients awaiting resolution of social issues which will prevent discharge.
- Patients for planned procedures (e.g. biopsies, planned infusions, transfusions and intravenous treatments, blood tests after ward discharge and dressings, reviews by inpatient teams etc.).

Access

- Patients should only be referred to EEMAC from the ED, following assessment or consultation with a tier 3 EM clinician or above.
- All patients should be appropriately differentiated and risk stratified.
- Patients should not be referred to EEMAC from other services, including primary care.
- Referral processes should be simple.
- Times of referral into the service reflect opening times (which will be department specific) and the ability to allow treatment completion.
- Identification of patients suitable for EEMAC may include scoring systems, specific pathways and clinical conversation.

Other Process Points

- The maximum length of stay in an EEMAC facility should be 8 hours, ideally less.
- The area should not be part of escalation in a full capacity protocol.
- Key risk stratifying investigations should be performed before a patient is transferred to an EEMAC facility (e.g. ECG).
- Point Of Care Testing may be used if it supports the service.
- Discharge may be to any appropriate place including home, GP, virtual service, community service.
- An electronic discharge letter should be generated at discharge.

Suggested KPIs

- Patients should be transferred for EEMAC within 120 minutes of arrival to an ED or UTC.

- Observations should be recorded within 15 minutes of arrival unless completed within the preceding 60 minutes.
- Turnaround times for pathology request to results: less 2 hours.
- Turnaround times for imaging request to report: less 2 hours.
- Percentage of patients who come through EEMAC and who end up being admitted, benchmarked against local and national standards.
- Number of EEMAC patients as a proportion of all UEC activity on the site.
- Total time from arrival in EEMAC to discharge home, admission, or transfer back to ED <8 hours.
- Electronic letter sent to GP on the day the episode completed.

Other Measures

- Incidents and complaints.
- Patient Feedback.
- Staff feedback.
- Capacity issues due to workforce or space.
- Impact on use of Corridor Spaces or other areas referred to, for example, as Temporary Escalation Spaces.

Workforce

- The workforce consists of emergency medicine clinicians with a supporting multi-disciplinary team. This establishment will be in addition to the normal EM establishment and includes:
    - Clerical
    - HCA
    - Nursing
    - AHP
    - Pharmacy; and
    - Medical staff.

  NB: Nursing and medical staff should be of an appropriate seniority, reflecting the clinical risk associated with EEMAC.

Facilities

- EEMAC facilities should be situated in a separate area but co-located to ED footprint. The facilities should not denude the ED footprint
- Comfortable chairs and recliners are ideal
- There is no available formula for capacity calculations
- Access to refreshments is essential
- Assessment trolleys for consultation, examination, blood tests and ECGs are essential, and should be within the footprint of EEMAC facilities

Background and Controversies

Early work in this field focused on ED based Clinical Decision Units. The nomenclature relating to "Ambulatory" Emergency Care (AEC) in the ED 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 drew these ideas together. It allowed inpatient 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. More recently, NHS England has been pushing for so called EM-SDEC units.

Nomenclature

Drawbacks of the original EM-SDEC nomenclature were:

- Emergency Medicine is by its very nature emergency care delivered on the same day.
- EM-SDEC was envisaged as a service for patients with urgent rather than emergency care needs, although some patients presenting with an emergency may complete their care in SDEC (e.g. anaphylaxis, seizures). It is important to separate the current name, from the concept.
- There is confusion with the role of other SDEC concepts
- There are a lot of similarities between the proposed EM-SDEC units and ED CDUs, to the point where they have the potential to become confused with each other. Many EDs no longer have CDUs following the pandemic. The essential difference is that CDUs are typically bedded units and are always open 24/7. CDUs will also attract an inpatient tariff. It is possible to have an both types of facility available to one department if the purpose and criteria for each are clearly defined and followed. RCEM has published guidance on CDUs as part of GPEMS.

RCEM recommended the nomenclature Extended Emergency Medicine Ambulatory Care (EEMAC), to try and accurately describe what such units are intended to offer.

Impact on ED Crowding

EEMAC units are unlikely to have a significant impact on ED crowding. Attempts to badge such units as the answer to crowding are misguided and confuse roles. EEMAC units have benefits, but not in this regard. Crowding is due to exit block, and EEMAC units will have a minimal impact on exit block in and of themselves. Expectations and investment decisions should be made with this in mind.

Concerns Over Data Manipulation using "off the clock" units

The idea of "SDEC" is attractive to leaders and managers with an interest in hitting Emergency Care access standards such as the 4-hour standard, but RCEM is clear that its purpose should not be to take patients "off the clock" simply to improve performance, rather to improve clinical care, and patient and staff experience. For this reason, ownership by the Emergency Medicine team, careful patient selection and rigorous operational management are required. RCEM is clear that the Emergency Medicine team must have absolute primacy over admission and operational decisions, at all times.

Concerns Over Becoming a “Dumping Ground”

There are concerns that EEMAC facilities will become a place for patients where there is no agreement on responsibility for care or clinical plans. There are also concerns that inpatient teams will push for inappropriate use, usually as a result of their own operational pressures. The countermeasures to this are careful inclusion and exclusion criteria, and absolute ownership and primacy for the ED team over admission and operational decisions.

Opening Hours

EEMAC is a process for patients whose care can be completed without the need for a prolonged stay. There is an argument that EEMAC units should be open 24/7 given their proposed function. Units open 24/7 will need to have clearly agreed operational standards to avoid being mis-used as “off the clock” areas for patients requiring admission. However, staffing requirements will likely limit opening hours as units develop. Opening hours should be extended as resource and confidence allows, and it is reasonable that EEMAC facilities should be open for the same hours, and no longer, than SDEC facilities in the same hospital. Extending EEMAC facilities opening hours beyond those of existing SDEC services risks mission creep, along with mismatched expectations of ED teams compared to others.

Patients Requiring Admission to Hospital

Continuing on the theme above, RCEM recommends that unless organisations have rigorous operational processes to prevent patients languishing off the clock, all patients requiring admission must be returned to the main ED. If this occurs then their clock should revert to the time of their original arrival in ED.

Streaming or Admitting Directly to EEMAC

RCEM is cautious about the notion of admitting patients to EEMAC directly following streaming, given that EEMAC facilities will be most useful for patients with a high or moderate degree of differentiation, and given the concerns described above. For many patients this mandates clinical assessment from an experienced clinician (we would suggest at RCEM Tier 3 or above). A similar, but more powerful, argument applies for patients referred from other out of hospital services. This would especially be the case where face to face assessment from a senior clinician, such as qualified GP, has not occurred. Ultimately however, this is a matter for local Emergency Medicine services.

About this Document

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Review

Within three years or sooner if important information becomes available.

Declarations of Interest

None

Disclaimers

None

Research Recommendations

The effectiveness of short stay admission strategies in the reduction of crowding is unknown. This would be an excellent field for operational research

Audit Standards

As per document

Key Words for Search

Ambulatory Care

Methodology

Consensus

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