The Royal College of Emergency Medicine

Best Practice Guideline

Emergency Department Care

July 2017

Summary of recommendations

1. Emergency Departments should strive to consistently provide all 50 care standards listed.

2. These standards should be regularly audited.

Scope

This guideline has been developed to help medical and nursing staff within Emergency Departments (ED) to provide better care for their patients.

As a 50-point checklist, it covers the following themes:

- The patient environment
- The ED team
- Education about care
- Patient pathway through the ED
- Continuing care
- Care of the elderly patient
- Care of children
- Care of patients with complex problems
- Measuring care and leadership

Reason for development

The culture of focusing on national targets and financial balance whilst neglecting acceptable standards of care was exposed in the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*[1] (2013), chaired by Robert Francis QC. The Royal College of Emergency Medicine (RCEM) recognises such occurrences are not isolated to one organisation or to one department[2].

The first recommendation of the Francis report is that "*all staff should contribute to a safe, committed, compassionate and caring service*".

The National Advisory Group on the Safety of Patients in England 2013[3] issued as its first guiding principle: "*place the quality (and safety) of patient care above all other aims for the NHS*".

Introduction

EDs should aim to provide a safe, committed, compassionate and caring service. This guideline provides a checklist of care initiatives directed at improving patient experience. Standards within are graded as either 'Fundamental' or 'Developmental'. Fundamental standards are those which every ED should routinely achieve. Developmental standards are those which departments should be working towards. EDs are encouraged to regularly analyse their practice using this document. Achieving these standards requires commitment and support. Where a standard cannot be met, this should be escalated to people who can take appropriate action.

Understanding the different types of standards

Fundamental: need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels and service provision need to be in accordance with at least these fundamental standards. No provider should provide any service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

Developmental: set requirements over and above the fundamental standards.

The patient environment			
Item	**Standard**		**Points to consider**
1	Are all areas of the ED clean and well lit?		Including the waiting room, reception front entrance and its surroundings?
2	Do all toilet facilities in the ED clearly display a completed daily cleaning log?		A minimum of twice daily cleaning is advised.
3	Is the physical condition of the ED in good order?		Broken or stained ceiling tiles, for example, may give a poor impression to patients lying on trolleys: "*if they care for the building like this, how will they care for me?*"
4	Do clinical areas enable patients to retain dignity and privacy, including facility to register with privacy?		Can sensitive questions be overheard by other patients and staff? This includes clinical discussion and handover.
5	Are waiting areas furnished with: • Reading material • A television • WiFi access • Information regarding process • An updated waiting time		A number of EDs have a charity book stall. A news channel on silent with line feed perhaps? Is this made clear to all appropriate age groups including teenagers? What can the patient expect: triage, nurse practitioner or doctor assessment, care, the four hour target etc. See RCEM Best Practice Guideline *Giving Information to Patients in the Emergency Department*.
6	Are relatives and carer catered for? • Is there sufficient cubicle seating for patients' relatives and carers? • Can patient and relatives communicate? • Are bereaved relatives cared for sensitively?		Are patients told that they can use their phones? Is there a bank of phone chargers available for patient use? Are bereaved relatives routinely offered a follow up appointment with a senior ED physician?
7	Is there a message for recumbent patients on the ceiling tiles in the Resus room?		E.g.: "You are in the Emergency Department at Standard Hospital".

Item	Standard		Points to consider
8	Is there a dedicated psychiatric assessment room that conforms to PLAN[4] standards?		
9	In the case of a dying or recently deceased patient, is the relevant clinical area: • Quiet? • Private? • Sensitively designed? • Readily identifiable as such to approaching staff?		Consider hanging laminated butterflies, indicating the need for staff to keep noise level and language appropriate. Some rooms for bereaved relatives are designed with an adjacent room for the deceased.
10	Is the signage and information for the patients sufficient, to enable easy navigation to, through and from the ED?		The ED can be disorientating. Has it been made easy to locate and understand the 'pathway' through the ED department?
11	Is patient feedback sought and acted upon? Are patients' comments (positive and negative) shared with staff?		Consider: • A monthly care newsletter • Friends and family surveys • Gathering and disseminating feedback from care rounds[5] Many department have Lay Representatives/Patient Voice Representatives at departmental meetings. Is there a nominated ED (senior medical) patient champion?
The ED team			
Item	**Standard**		**Points to consider**
12	Do all staff feel valued? Does the department meet the RCN staffing ratios/ requirements, including those for children's nurses?		Are there frequent shared examples of positive feedback, either at handover or in writing (or both). Consider care awards in recognition of achievement. Are staff thanked for their efforts by the lead clinician or senior nurse on completion of post? Is there regular effective feedback to staff? Is there support for those involved in stressful situations? See RCEM Guidance & Resources webpage. Are systems in place to prevent, identify, support and rehabilitate staff burn out?
13	Is there a joint regular scheduled combined medical and nursing handover?		Effective team working requires collaboration between medical and nursing teams. Joint handovers facilitate this.
14	Are senior doctors approachable and available?		"*Be approachable and available for the Juniors*" See RCEM *Non-technical Skills - Top 10 Tips*. Are the processes for contacting and involving senior staff clear?
15	Are staff routinely able to take breaks?		Tired staff are less likely to come across as caring and they are more likely to make clinical errors.

Item	Standard		Points to consider
16	Is there an effective process to report and respond to problems with IT, estates and equipment?		Poor IT support can harm patients and demoralise clinical staff. Staff and patients should be able to identify and report issues with the patient environment. Are reported issues resolved quickly?
17	Is the equipment in the department easy to locate, clearly organised and labelled?		Repeated searches for essential equipment lowers morale. Is the department re-stocked daily? Delays in locating equipment can affect patient care.
18	Are staff from other specialties engaging in clinical work in the ED supported?		Are they welcomed, helped in finding the patient, equipment, paperwork/software interfaces and told who to report to on closure? Have they received correspondence outlining these aspects?
Education about care			
Item	**Standard**		**Points to consider**
19	Have all staff had training in, and deliver: • Customer care • Compassionate care Is it clear to all staff that the NHS mission is to provide a safe, committed, compassionate and caring service?		Many Trusts have a policy of Value Based Recruitment and training in value based communication. As per RCEM's *Francis Report Recommendations: a checklist for Emergency Departments*. Consider offering a welcome letter outlining this to all new members of the team.
20	Is "care" embedded within ED induction for all staff? Does it form a part of ongoing teaching and handovers?		Consider using clinical scenarios to discuss the care of patients and their relatives/carers.
21	Are staff encouraged to report concerns regarding care? Do they know the procedure to follow when they do not believe their concerns have been listened to?		
22	Are staff aware of how to respond to patients or relatives who wish to complain?		
23	Are registered staff aware of their statutory obligation to observe a duty of candour where a patient has come to harm or death as a result of clinical error?		

Patient pathway through the ED			
Item	**Standard**		**Points to consider**
24	Do nursing staff at patient entrances have easy and timely access to a senior doctor for treating sick patients, prescribing analgesia for severe pain?		
25	Are patients, arriving by any means, warmly greeted by a named person? Do staff introduce themselves by name, and identify their role and position?		For those EDs running Rapid Assessment and Triage, is the "meet and greet" incorporated within these procedures[6]? Are patients offered a glass of water at triage or at Paramedic handover/RAT? (C.f. after discussion if concerns regarding stroke)
26	Are patients routinely given *forecasts*[5]?		*"You're likely to have broken your hip….and will need surgery tomorrow…they'll have you up and moving the very next day"* or *"we'll have a proper look at you, get you (another) ECG, some blood tests and an X-ray and then assess what you are like on your feet…you can expect this to take a couple of hours."*
27	Are patients clearly told how to access staff when they have needs or concerns? Is this access facilitated by the department, to make it as easy as possible?		Are patients on trolleys routinely told how to use a call bell that is within reach? Are there posters explaining how to inform staff of concerns, or patient requirements? Consider how easy this is for patients. Has it been 'road tested' by staff (e.g. 'mystery shopper')?
28	Has the ED inspected the RCEM crowding guideline and toolkit in anticipation and in response to exit block?		RCEM *Francis Report Recommendations – A Checklist for EDs*.
29	Does the ED make use of a safety barometer, escalate by following agreed action points and chase an unsatisfactory response?		
30	Does discharge planning: • Include bespoke written and verbal advice • Include check of social and welfare concerns Ensure follow up and prescriptions provided and clear if needed.		See *Giving Information to Patients in the Emergency Department* from RCEM. Is there a system of assuring and documenting these?
Continuing care			
Item	**Standard**		**Points to consider**
31	Is comfort rounding routine?		Are pillows routinely offered to those patients who will be admitted?
32	Is there a daily trolley round offering food, drink, toiletries etc?		Does the ED have volunteers?

Item	Standard		Points to consider
33	Is there clearly displayed, up to date information regarding taxis, bus timetables, bus stop locations, cash points etc?		
34	Is written information provided for patients and carers for those returning to care institutions?		Incorporating appropriate details such as diagnosis, management, new/altered medications, ED contact details, next of kin informed (yes/no) and recommended action in case of further episodes.
35	Is there easy access to translation services, including British Sign Language?		Do staff know how to access translation services? Is there an up to date staff foreign language speakers list? Are information leaflets available in other languages?
36	Does the ED follow the advice contained within the RCEM document *The Mental Capacity Act in Emergency Medicine Practice*?		See RCEM Guidance webpage.
Care of the elderly patient			
Item	**Standard**		**Points to consider**
37	Is dementia friendly training mandatory and up to date among all ED staff, including receptionists, cleaners and security?		
38	Is dementia care of a high standard?		Has the department been examined and responded to a report by a dementia friendly group e.g. the Alzheimer's Society? Is there a care package for dementia? Are such patients given a dementia wristband? Are the departmental toilets dementia friendly? Are directions to them, and return to ED clearly signposted? Does the ED provide an appropriate number of dementia friendly cubicles? See Airedale NHS Foundation Trust's *A dementia friendly ED*.
39	Is a skin vulnerability assessment performed on arrival for all frail, elderly patients? Are those with vulnerable skin promptly placed on mattress toppers (that enable imaging) or a bed or airwave?		
40	Are the delirious offered distraction therapy?		E.g. A twiddlemuff or dementia dolls.

Item	Standard		Points to consider
41	Does the ED follow the advice contained in the following documents? • *End of Life Care for Adults in the Emergency Department* • *Quality Care for Older People with Urgent & Emergency Care Needs* • *Half a Dozen Things to Know About Dignity in Dementia: improving care in general hospital settings (CEM summary of Royal College of Nursing National Project (2011)*		See RCEM Guidance webpage.
Care of children			
Item	**Standard**		**Points to consider**
42	Is there demonstrable evidence of the safeguarding of children? • Is there evidence that all staff are trained to the levels set out in the document opposite? • Are staff aware to whom to escalate? • Do staff know who the Trust safeguarding lead is?		Intercollegiate Document *Safeguarding Children and Young People: roles and competencies for health care staff*.
43	Are facilities available for the distraction of distressed children?		E.g. Tablets, a starlight distraction box, DVDs etc.
44	Is care instituted as soon as possible? • Are all children offered appropriate and prompt analgesia? • Are the parents/ relatives/carers/all young children with vomiting and diarrhoea +/-dehydration encouraged to start oral rehydration therapy on arrival?		RCEM *Management of Pain in Children*.

Care of patients with complex problems			
Item	**Standard**		**Points to consider**
45	Does the department have access to learning disability health care staff and is there evidence that the service is used?		
46	What evidence is there demonstrating ED compliance with the following RCEM Quality in Emergency Care Best Practice Guidelines: • *The patient who absconds* • *Emergency Department Patients in Police Custody* • *Caring for adult patients suspected of having concealed illicit drugs* • *Guideline for information sharing to reduce community violence* • *Management of Adult Patients who enter Emergency Departments after Sexual Assault and/or Rape* • *The Mental Capacity Act in Emergency Medicine Practice* • *Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance (ABD)* • *Management of Domestic Abuse* • *Chaperones in Emergency Departments* • *Alcohol: a toolkit for improving care* • *Frequent attenders in the Emergency Department* • *Giving Information to Patients in the Emergency Department*		All available via RCEM Guidance webpage. Does the ED have a domestic violence champion? Including teenagers. Patients identified as 'very high frequency attenders' (e.g. 30 or more attendances per year) should have a multidisciplinary meeting and case management; including social care and primary care, with a review of the bespoke management plan.

Measuring care and leadership			
Item	**Standard**		**Points to consider**
47	Has the ED made measurable improvements in response to their CQC reports, RCEM and local audit, and patient feedback?		
48	Does the department have leads for: • Care • Other significant groups e.g. adolescents, patients with dementia, frequent attenders etc		
49	Are standards related to patient care improved through audit and quality improvement?		Such as comfort care metrics.
50	Can you demonstrate that patients are happy with the care provided, and staff are proud of the care provided.		Is the department engaging with the patients about care standards?

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Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None

Audit standards

None

Key words for search

Patient care, Emergency Department

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well-designed randomised control trials.
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting.
3. Evidence from well-designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies.
4. Evidence from well-designed non-experimental studies from more than one centre or research group.
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

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