

Project reset in emergency medicine: Patient FIRST

Version history

- This document was first published in October 2020.
- We updated it in October 2021.

This followed two workshops in 2021 for emergency clinicians and NHS executives. We added suggestions and good practice examples from those events. These updates refer more specifically to the COVID-19 pandemic.

- We made further updates in September 2023.

These changes update references to infection control procedures that have changed since the height of the pandemic, as well as other minor references to the pandemic.

Introduction

The coronavirus (COVID-19) pandemic has changed many ways of working within urgent care settings.

These settings include emergency departments. The changes have affected all patient groups.

It's important that we understand and harness the learning from this for emergency care at local, regional and national level. We need to appreciate and support the elements that have improved patient care and safety. We also need to adjust and realign some of the processes that may not have improved patient care or safety.

CQC brought together a team of senior emergency department clinicians to develop 'Patient FIRST'. The team included expertise from paediatrics. All the clinicians work in emergency departments rated as good or outstanding. And they are CQC specialist professional advisors.

Patient FIRST is a support tool designed by clinicians, for clinicians. It includes practical solutions that all emergency departments could consider. Implementing these solutions supports good, efficient and safe patient care - for both adult and paediatric care. It also includes guidance for senior leaders at trust and system level.

FIRST stands for:

- Flow
- Infection control, including social distancing
- Reduced patients in emergency departments
- Staffing
- Treatment in the emergency department

Patient FIRST is for people directly or indirectly involved in delivering urgent and emergency care:

- trusts - to reflect and support that good urgent and emergency care is achieved through:
 - cultural shifts
 - complete buy-in within a hospital and across trust systems
- It's not simply departments working in silos

- leaders and managers - for how to improve the service and support the clinical staff
- enabling delivery of good urgent care models
- clinical staff - for what they should be aiming to achieve and ideas on how to do this

CQC makes sure health and social care services provide people with safe, effective, compassionate and high-quality care. Providers must make sure their services are safe, effective, caring, responsive and well-led. CQC supports the aims of the [Royal College of Emergency Medicine \(RCEM\) position statement](#) for emergency care.

Principles of Patient FIRST

Patient FIRST is based on five principles to support emergency care:

1. Patients must come first and safety cannot be compromised.
2. Emergency departments must focus on their core function of rapid assessment and emergency stabilisation of critically ill and injured patients.
3. Staff in emergency departments must have the authority to move people from the department after their initial assessment to a more appropriate pathway of care outside the emergency department.
4. Patients must have access to other services outside hospital to help ensure emergency departments are not the default pathway.
5. Delivering good quality urgent and emergency care must have the support of all services inside and outside hospital.

When meeting these principles, local system working provides better care for patients.

CQC found this through its assessment of services.

Our focused inspections during winter have been based on a structured framework. Trusts can use this to assess their own emergency department.

Clinical and executive feedback from the workshops we held in 2021

We held [two workshops in 2021](#), where clinical leads and executives from across the country discussed their experiences of improving patient safety within urgent care. They shared examples of how they had trialled and implemented change in their EDs, trusts, and in some cases, the wider urgent care system.

Following this, we have updated Patient FIRST to share these insights with the wider Urgent and Emergency Care (UEC) community. These signpost examples of good practice and processes that can help improve patient safety in emergency departments (EDs).

Suggested clinical drivers for change include collection and review of the following:

1. Suggested processes and ideas
2. Examples of good practice
3. Examples of data to drive improvements in patient safety.

These suggestions are not exhaustive, but will permit departments, divisions, and trusts to:

- Have a barometer of the current pressures on their urgent care pathway
- Have drivers to support change when and where required
- Monitor some elements that may influence safety within the urgent care pathway.

Promoting safety culture in emergency departments

Attendees from both workshops emphasised the importance of promoting a culture of safety at emergency department (ED) and wider trust level. They also recognised the need to motivate and empower staff by listening to their feedback. Both were deemed critical factors in improving performance, patient outcomes and overall safety.

Understanding all systems involved in service delivery is crucial. Especially when developing interventions to prevent errors and harm to patients. By listening to attitudes of individuals in your organisation, you can assess into how systems are functioning. It also helps you identify problems early and be more responsive to legitimate concerns.

Regular assessment of your organisation's safety culture can highlight areas for improvement. It also helps you monitor change over time. A strong safety culture can influence how patient safety is considered and implemented in your organisation.

Contributors

Our thanks to the National Emergency Medicine Specialty Advisor Forum for contributing to this guidance.

Flow

Aim

Flow in and out of the emergency department is vital for the safe and effective care of patients.

Good flow prevents crowding within the department. It reduces the risk of harm to patients and prevents poor outcomes.

Background

Trusts with capacity issues are more likely to see crowding in their emergency departments as a result of poor flow. As crowding is a symptom of flow and capacity issues, it requires change across the whole organisation, with high executive engagement. Taking this approach at a system-wide level has a much greater and sustainable impact on all trusts within the region.

Maintaining good and efficient flow requires a trust-wide culture of safe and efficient patient care. It needs engagement from the trust board and all teams throughout the hospital. From our inspection activity, we know that delivering high quality care needs enough capacity to enable safe and timely movement of patients.

In good trusts we have seen

Managing flow into the emergency department

There are times when patients with non-time critical presentations attend the emergency department. But the emergency department cannot add value to their care. Developing urgent and emergency care pathways avoids this. These pathways include:

- direct access to community services - for example district nurses, virtual ward, urgent community response teams and acute respiratory hubs
- direct access to primary care - including GPs
- direct specialty access for GPs - through telephone, email or 'hot' clinic appointments

- direct access pathways for ambulance services and GPs into same day emergency care
- acute hospital outreach to care homes - avoids unnecessary transfer of elderly and vulnerable patients. See Reduced number of patients to the emergency department section for more detail
- frailty in-reach into emergency departments to prevent admission and care back into community services.

Specific examples of good practice

1. Same day appointments are available in primary care. Patients can use these or clinical staff can redirect patients into primary care.
2. Falls and re-enablement teams work across acute trust and community services. Teams manage patients at home and avoid hospital attendance where possible.
3. Frailty teams in in-reach services to all ED patients over 75 or with a raised Rockwood score.
4. Availability of resource to provide virtual ward services to reduce likelihood of hospital admission and early discharge from ward areas reducing LOS.
5. Effective discharge lounge facilities with social care support to enable release of beds early in the day.

Managing flow within the emergency department

Patients could self-present to the emergency department or be referred. They need to see the right person at the right time. Robust clinical assessment and redirection pathways make sure this happens. Trained emergency department front door staff use agreed local protocols to access alternative care pathways. These alternatives could be within the hospital, trust or external services:

- external to the trust:
 - timely primary care appointments
 - community services
 - dentistry
 - pharmacy
 - other supporting services such eye services.
- within the trust:

- same day emergency care services 7 days a week for a minimum of 12 hours a day
- specialty assessment units, for example medical and surgical assessment unit, paediatric assessment unit, early pregnancy unit, obstetric service, labour ward and delivery suites, ophthalmology assessment service, sexual health services.
- within the department:
 - co-location and good flow between the emergency department and urgent care centre
 - patients see their existing specialist teams - if they are under active specialty care and have a problem relating to that specialty. This might be a post-operative problem, or complications of their chronic disease or its treatment
 - assess patients with no immediate need for intervention and stream them to the appropriate specialty
 - patients presenting with mental health problems, but no acute medical needs - see them in a suitable assessment area staffed by mental health professionals
 - patients presenting with non-critical musculoskeletal problems - see them in a designated area staffed by advanced physiotherapist or nurse practitioners.

Early clinical assessment of a patient by a senior clinician ensured rapid senior decision making to facilitate appropriate investigation, referral or discharge and reduced the risk of nosocomial infection.

Specific examples of good practice

1. Co-located access to a GP or urgent treatment centre stream. The model and flow between the two services was paramount. Joint governance permitted a better buy-in for delivering the same aims.
2. Establishing a separate mental health ambulatory unit. Patients presenting to the emergency department, and then referred to the mental health liaison team, all received a rapid initial contact. If the patient was medically suitable, they transferred to a separate area within the psychiatric unit. This was on the same site but in a different building. The mental health liaison team approved the transfer. Thus they avoided very disruptive or acutely unwell patients being transferred there. This

provided an area where the lower risk mental health patients were able to wait. The area was a less crowded and calmer environment. It was staffed by mental health support workers. Patients who needed psychiatric admission did not wait long within the emergency department. The teams involved felt this improving flow, patient experience and patient safety. Patients were more closely observed. And they were less likely to abscond before their full assessment.

3. Consultant care of the elderly in-reach to the emergency department. Early care of the elderly has been trialled in many hospitals. As has multidisciplinary team input to urgent care services for people who are frail. These services provide support for both early discharge and admission avoidance. They aim to keep frail patients out of hospital. And they can link into ongoing care and social needs such as homecare visits. For example, if a patient can go home but needs some further follow up or monitoring, they can visit them at home in the next few days.

Managing flow within and out of the hospital

Trusts with clear policies and strategies within the hospital(s) maintain flow. Those with early and dynamic discharge planning were more successful in preventing crowding. As were those that developed specialty ambulatory pathways. They audit and analyse delays in moving patients through pathways of care. This helps them to identify and deliver improvements.

Actions that some trusts have taken to improve flow include:

- patients are moved from the emergency department as soon as they were ready to go - 'Ready to Admit' or 'Ready to Progress' concept
- support from senior teams including medical director and chief operating officer is paramount
- patients do not wait in the emergency department for test results that were not critical to their emergency care
- specialty medical and nursing services do not physically review patients in the emergency department - helping to improve flow
- services that support the emergency department such as same day emergency care are consistently available - as required by the emergency department
- different clinical specialities came together to make sure that:
 - ward flow is optimal

- patients' length of stay within hospital are as short, of good quality, and as effective as possible
- issues for the inpatient teams are resolved in a timely fashion.

For example early consultant involvement and board rounds, regular review of length of stay, and review of patients in hospital more than seven days

- admission avoidance schemes - such as early consultant care of the elderly input, frailty service, falls services, specialty 'virtual wards'
- ward discharge teams (early and weekend discharges)
- emergency department observational unit beds are not included within the bed management pool. They are under the control of the emergency department team. Specialty patients are never admitted to these beds under any circumstances. This would reduce internal flow
- good support services are imperative including:
 - pharmacy
 - portering
 - rapid turnaround times of laboratory tests
 - immediate access to the full range of radiological investigations required, for example CT, MRI with a report available within one hour
 - social services
 - psychiatric services
 - community and other support services, for example district nursing.

Actions to maintain flow for non-admitted patients include:

- availability of transport home
- 'take home, tuck up' service for elderly or vulnerable patients to prevent unnecessary admission
- rapid COVID-19 tests for patients discharged back to care homes where required.

Specific examples of good practice

1. Flow escalation. The entire trust needs to be aware of the flow issues in a timely manner to resolve them. Many small 'things' might be needed to avoid more significant impacts in flow. A flow escalation manager can be an individual based in the emergency department. They tackle any issues relating to delays by other specialties or patient transport, chasing beds and making various phone calls. This

person needs to be empowered to escalate delays to specialty consultants and senior executives. So issues are highlighted and resolved early. This allows medical and nursing staff to use their clinical time more efficiently to focus on patient care and reduce decision fatigue.

2. Bed management meetings should be held at least twice a day. A clear, recognised scoring framework should be used. An example of this is [Operating Pressures Escalation Levels \(OPEL\) framework](#). The relevant action cards should be completed and followed to mitigate and relieve pressures across the whole system.
3. Clear escalation procedures for supporting initial assessment of infants, children and young people. These patients are assessed within 15 minutes of arrival when wait times increase. Rapid assessment is initiated and physiological observations maintain safety at such times.
4. Adopting standard operating procedures that allow for nurse-led discharge for children and young people in defined circumstances. [See examples of supporting documents for nurse-led discharge, such as for minor head injuries](#)

Clinical and executive feedback from the workshops we held in 2021

Suggested processes and ideas for improving patient safety

Promote system-wide collaboration

Working across the integrated care system (ICS) ensures a system-wide approach to urgent and emergency care. Emergency departments and trusts can promote the use of:

- cross service audits
- PDSAs (Plan, Do, Study, Act)
- overall service delivery innovation.

Representation of all stakeholders on emergency department delivery boards

Emergency department delivery boards should ideally have representatives from all stakeholder groups, with transparent and accountable decision-making processes in place.

Use prediction models to plan ahead

Use available prediction models to plan safe, efficient flow through emergency departments.

In addition to considering predicted attendance figures within EDs, departments could consider projected occupancy rates for:

- care home beds
- intermediate beds
- discharge to assess beds.

Handover and transfer process

Any transfer of patient care to another clinician (or ward) presents a potential safety risk. It is vital that critical patient information is provided upon handover.

Keeping a succinct and efficient manual or digital record of these events helps maintain safe care. This can form part of your regular reports and audits.

Examples of good practice

Use technology and data to improve decision making

Adopting a data-driven approach can encourage collaboration and optimise patient safety. For example, using existing apps or portals to display system-wide metrics on a real-time dashboard.

Easy access to live data can provide you with a holistic view of system-wide performance. For instance, data that shows ambulance system bottlenecks can aid decision making in real time.

Put in place appropriate triggers, and actions for escalation plans

Link your live ED safety metrics to escalation plans (such as OPEL). This enables you to create appropriate triggers, alerting ED to possible issues in real time.

These triggers ought to be appropriate, and correlate to effective actions. Both triggers and actions can be clearly signposted to all staff and stakeholders. This means staff can act quickly and safely to mitigate issues.

Example data sets that can drive possible safety improvements

The suggested data sets below evolved from discussions at the 2021 workshops and may be useful in assessing patient safety.

- Ambulance offload time
 - Ambulance offload time is an important measure for safety across the Urgent and Emergency Care (UEC) system. This can be considered both locally and across the integrated care system (ICS).
 - Reducing offload times at hospitals is critical. It enables paramedics and ambulance crews to spend more of their time responding to 999 callouts.
- Time to initial assessment / time to first clinician
 - Time to initial assessment is time elapsed between patient arrival in the ED and the initial assessment.
 - Time to clinician measures how quickly the clinician's full assessment of the patient occurs.
- Clinically ready to proceed (CRTP)
 - Research shows there is a risk of harm to patients if they are not transferred to inpatient areas when needed, as quickly as possible. There is a recognised risk when patients are left waiting on trolleys for long periods.
 - The ability to view a live feed of patients' CRTP status allows clinicians, co-ordinators and managers to plan ahead. They can then escalate when, and where, necessary to optimise flow.
- Data on acuity and dependency within ED
 - Keeping track of specific data sets that measure acuity and dependency within the ED gives clinicians an overview of acuity levels in their department. This allows the urgency and escalation necessary for downstream care.
- Time to definitive treatment
- Total time in the emergency department
- Use of same day emergency care
- Number of patients who are in the emergency department more than 12 hours after arrival

- Number of patients cared for in a corridor and the number of hours spent there
- Hospital bed capacity

References

[Position Statement: Winter pressures in children's emergency care settings \(November 2019\)](#)

[RCEM: Tackling Emergency Department Crowding](#)

[AMRC Clinical Guidance: Onward Referral](#)

[RCPCH Facing the Future: Standards for children in emergency care settings June 2018](#)

[Under pressure: safely managing increased demand in emergency departments](#)

Safety alerts

[RCEM Safety Alert: Early to Bed](#)

[RCEM Safety Newsflash: Time Critical Medicines](#)

Infection prevention and control

Aim

No patient or staff member will acquire a nosocomial infection as a result of their time in the emergency department.

Background

From our inspection activity we know that good infection control improves the quality of care and outcomes for people. We know that COVID-19 changed the way emergency departments operated. However we need to move back to core infection, prevention and control procedures.

NHS England sets out [10 elements of standard infection control precautions \(SICPs\)](#):

1. patient placement/assessment of infection risk
2. hand hygiene
3. respiratory and cough hygiene
4. personal protective equipment
5. safe management of the care environment
6. safe management of care equipment
7. safe management of healthcare linen
8. safe management of blood and body fluids
9. safe disposal of waste (including sharps)
10. occupational safety/managing prevention of exposure (including sharps)

Other measures adopted at the height of the pandemic that remain important are:

- general assessment and screening of high-risk infected patients across the range of infectious diseases
- appropriate isolation areas and facilities for all patients presenting with infections - for example, diarrhoea and vomiting, COVID-19, Ebola and Mpox
- protecting those that are vulnerable to infections - for example, people who are neutropenic or immunocompromised.

There is likely to be a need for structural reviews of departments to include:

- isolation areas
 - resuscitation room
 - other clinical areas, for example majors, minors, urgent treatment centre, paediatrics
- dedicated areas where aerosol generating procedures (AGPs) can be delivered safely
- areas for applying appropriate PPE based on infection risk and local and national guidance.

In good emergency departments we have seen

- good engagement with trust's infection prevention and control (IPC) leads
- adherence to local and national IPC best guidance practice, such as RCEM, NHS England and CQC
- good compliance with mandatory training for IPC
- observation in the workplace of up-to-date IPC processes and procedures following local and national policies - for example, hand washing, correct use of PPE and recognition of infectious patients
- a clear understanding among staff both within and outside the emergency department of appropriate PPE use for those patients who require an AGP
- appropriate areas for applying the correct PPE based on circumstance
- cleaning schedule that all staff adhere to
- access to prompt processes for screening and timely flow out of the urgent care system.

Specific examples of good practice

1. Early assessment and recognition of assessment to enable isolation and prevent infection spread
2. Observing good IPC procedures such as hand washing and PPE use
3. Good uptake and understanding of training relating to IPC issues
4. Procedures for preventing crowding in waiting rooms in relation to IPC - for example, full capacity protocol

Managing crowding in relation to infection control

Background

Emergency departments frequently:

- face surges of attendances - these may significantly increase the number of people within the footprint of the emergency department
- face exit block - patients who need to be admitted remain for extended periods of time within the department
- have staff within them that come from other departments to review patients - often as a team

In good emergency departments we have seen

- clear IPC signage relating to current standards
- methods to reduce the number of patients waiting at any one time
 - choose and book type models of care
 - virtual waiting rooms
- reduced numbers of staff who were not in the emergency department to review patients
 - limited entrances and exits – the emergency department is not used as a short cut to other areas of the hospital

When considering infection control for children, the processes for assessment, isolation and PPE should be the same as adults. Separate children's emergency department must adhere to local and national guidance regarding children.

Consider making PPE less scary for children. See [“Supersuits” by Katie Chappell](#).

Specific examples of good practice

1. Appointment based systems. Some groups of patients need urgent and emergency care but can be reviewed via an appointment-based system. This helps reduce peaks and troughs of attendances within the emergency department. Examples include:
 - a. patients with minor injuries referred via NHS 111
 - b. patients with injuries who self-present after initial review and investigations are completed.

Clinical and executive feedback from the workshops we held in 2021

Suggested processes and ideas for improving patient safety

Maintain patient visibility

Many EDs have had to make substantial changes to meet requirements for social distancing and other IPC measures. For example, moving waiting areas or partitioning spaces. This can, in some instances, negatively affect staffs' ability to see and observe patients at a distance.

Where this is the case, departments need to consider ways to ensure they maintain high levels of patient visibility across all sites.

Effectively cohort patients

It is important to avoid cohorting confirmed infectious patients with uninfected patients in the ED.

Regular monitoring and assessment

Trusts can carry out regular 'infection walkthroughs' in their EDs, so they can assess that:

- IPC protocols are in place and enforced
- segregated infection areas are fit for purpose
- donning and doffing areas meet required standards
- staff have been individually fit-tested and risk-assessed
- regular testing procedures for staff are in place.

Waiting room crowding

It is crucial to regularly assess the total number of patients in ED waiting areas against agreed capacity. Particularly in the context of infection risk from COVID-19.

Identifying potential crowding helps you decide when to use or escalate mitigation measures.

Examples of good practice

Point of care testing (POCT)

POCT speeds up decision making and reduces the length of stay for patients in the ED.

A mature, safe and well-functioning service will use POCT alongside early senior decision making. They will also use regular reporting to optimise use of this resource.

Adequate PPE provision for staff

Staff need to feel comfortable and safe in the ED. It is important to provide a consistent supply of laundered or disposable scrubs for staff working in areas with high numbers of infectious patients.

Example datasets that can drive possible safety improvements

- Nosocomial rates
 - Trusts are able to intelligently monitor nosocomial rates. To do so, it is important to keep patient records that track:
 - locations visited in the department
 - length of time spent in non-admitted areas
 - which members of staff treated or nursed them.
- Proportion of patients with suspected infection who receive point of care testing for flu and COVID-19
- Mean time for COVID-19 results
- Number of isolation cubicles with air exchange capability at least 10-12/min
- Number of negative pressure rooms
- Number of cubicles with doors as a proportion of total patient cubicles
- Proportion of staff fit tested for masks
- Reporting and monitoring of problems of PPE availability/usage through the incident reporting system
- Review of incidents reported regarding breaches to safe distancing capacity matrix or triggering of escalation plan.

References

[COVID-19: infection prevention and control \(IPC\)](#)

[Coronavirus \(COVID-19\): guidance](#)

Safety alerts

[RCEM Safety Flash: Buddy System](#)

[RCEM Safety Flash: Communication errors with PPE](#)

[RCEM Safety Flash: Salbutamol, peak flow and nebulisation advice during COVID-19](#)

Reduced patients in emergency departments

Aim

Emergency departments need to focus on the critically unwell or injured patients who need rapid assessment and interventions.

Background

Each year emergency departments have been seeing an increase in the number of patients attending. Demand is exceeding capacity. Patients are being cared for in inappropriate areas. And there are delays to assessment and treatment. For safe and effective care this must not continue. Now, there's the risk of nosocomial infections. The need to reduce the number of patients attending the department is even more important to protect all patients.

Local areas have put in place systems to reduce attendances before the patient reaches the emergency department. Through our work, we have seen:

- actively encouraging patients to 'talk first' via GP practice or NHS 111
- active engagement of patients with GP and other support services
- primary care and secondary care coming together to make sure patient needs are being met
- review, support and investment in community services
- engagement and feedback with NHS 111 services to improve referrals
- support for local ambulance crews with 'hear and treat' or 'see and treat'
- trusts providing links and support to pre-hospital systems - for example NHS 111, GP practices and care homes
- a move away from the patient coming to secondary care with more services moving into the community
- dedicated services to support specific patient population needs - such as community falls teams and admission avoidance schemes.

The system work needs to include liaison with the ambulance service to:

- make sure they bypass the emergency department so patients access the correct place first time - direct pathways to plastics, vascular, and ear nose and throat specialities
- reduce attendances for patients both self-presenting and arriving via ambulance - by supporting 'see and treat' and 'hear and treat', and keeping patients well in the community
- offer alternative pathways to crews - helplines, specialty clinics, same day emergency care, early pregnancy assessment units, and delivery suites.

In good emergency departments we have seen

Effective redirection and streaming systems in place so that patients can be safely streamed to the following by a senior led team:

- external to the trust
 - self-care
 - pharmacy
 - NHS 111
 - GP and primary care services
 - community services
 - urgent treatment centre (if external)
 - mental health services (if external)
- internal to the trust
 - urgent treatment centre if internal
 - emergency pregnancy services
 - delivery suite
 - same day emergency care
 - mental health services (if internal).

The emergency department and specialty teams have an agreement, with medical director support. Patients are taken to the 'best team to see' after their initial review. There's an expectation that:

- a patient known to a service will be directly seen by that specialty team
- a patient with a complication from a procedure will be directly seen by that team

- a patient assessed by the emergency department team as needing specialty assessment is accepted directly by that team and reviewed in a timely fashion.

The specialty teams should have time scheduled to make sure this is feasible. They should provide feedback on outcomes to the emergency department. Particularly if the patient could have better served by another specialty team. The specialty team refers the patient on if needed. Specialty teams must be open to receiving referrals from each other as well as from the emergency department.

For the trust to actively support and encourage patient and staff behavioural change:

- encouraging patients to call GPs or NHS 111 first
- using coordinators within emergency departments and GPs to make sure patients have a GP - and support them through the registration process
- at the point of discharge from hospital, advising patients how to get help if needed and to only 'go to A&E' in an emergency.

To link with local primary care clinicians to encourage:

- good communication and support networks between primary and secondary care - such as dedicated helplines - secondary care consultants advise GPs how to avoid hospital attendances and admissions
- GPs to 'call before they send' patients to ensure the patient is seeing the right specialty first time.

Specialty teams should make sure their patients do not attend the emergency department when possible. For example, for post-operative complications.

To develop pathways for specific groups of patients whose needs may best be met elsewhere

- percutaneous endoscopic gastrostomy (PEG) tube problems
- catheter problems
- peripherally inserted central catheter (PICC) line problems.

Specific to reducing demand for emergency care from those children and young people who attend more frequently, we have seen:

- joint working with local hospital at home teams, so nurses can deliver 'emergency department care' at home

- developing education packages for children with long-term illnesses - highlighting pathways to access appropriate care when unwell or community review by specialist community nursing teams
- health visitors, school nurses and GPs providing education packages to families with young children who frequently attend emergency departments
- consultant paediatricians in GP hubs in the community
- remote access to specialist advice for parents, carers and GPs - avoids delayed presentations of children and young people needing urgent care
- local public information campaigns clarifying when and where to seek help.

Specific examples of good practice

1. Specialty team agreement. An agreement drawn up and signed by all clinical leads and the medical director. Specialty teams accept, see and treat patients from streaming or assessment. This happens when the emergency department feels the patient is best suited to that team. There should be no need for emergency department junior staff to review these patients first.
2. Primary care access. All GP practices have daily allocated slots for urgent cases. These can be used by the patients, NHS 111 or the hospitals. Much of the work is completed via telephone triage and consultations. Face-to-face slots are also available. Slots are available at the appropriate time so they can be accessed in a timely fashion.
3. Non-clinical navigators. Non-clinical staff are based within the emergency department. They actively support the streaming and redirection team. The staff make sure the patient is seen in the correct place at the right time. For example, a dressing clinic or GP appointment. They also help patients to register with a GP practice while waiting with the emergency department/urgent treatment centre. This reduces the number of unregistered patients within the local community. And it encourages patients to use their GP first - for next time.
4. Direct access. NHS 111, 999 and emergency department all have direct access to alternative care pathways. This could be ambulatory care, early pregnancy assessment units, urgent treatment centre. It's important for all the providers to make sure patients go along the correct alternative care pathways. Demand and capacity must be mapped alongside a regular review of referral quality.

Clinical and executive feedback from the workshops we held in 2021

Suggested processes and ideas for improving patient safety

Changes to the NHS 111 service

Rethink clinical validation from inside NHS 111. For example, is it possible for all potential referrals to ED to be reviewed by a clinician, with ICS able to see the assessments?

Workshop attendees felt this could potentially reduce the number of unnecessary referrals to EDs from the service.

Promote system-wide collaboration and continuous learning

Workshop attendees supported the introduction of direct admission rights for ED senior decision makers. This enables safer and swifter transfer of patients to appropriate specialty admission units, as well as alternative pathways.

The need to promote system-wide collaboration and continuous learning was also emphasised. This aims to refine safety processes while iteratively improving patient pathways.

ED patients streamed to same day emergency care (SDEC), inpatient (specialty by specialty) or urgent treatment centres (UTCs)

There is evidence of a large increase in emergency attendances over the past two decades. This is partly due to a larger and ageing population. But workshop attendees also felt that emergency admission is not always the best pathway for some patients. Many could be more appropriately treated in a non-urgent setting.

To assess this, you could monitor daily levels of Same Day Emergency Care (SDEC) activity, from both ED and Primary Care.

Examples of good practice

Regional level real-time risk assessment

Attendees supported the use of regional level system risk assessment tools or apps that work in real time.

An agreed set of associated actions and responsibilities can be triggered from this data. These actions could then be filtered to the appropriate services.

Example datasets that can drive possible safety improvements

- Admission conversion rates
 - Admission conversion rates are a measure of:
 - the acuity of the department
 - decision making
 - processes downstream.
 - This enables you judge acuity levels and make evidence-based decisions. It will help with short and long-term planning, also with education.
- Re-attendance rates to ED
 - HES data indicates there were 1.39 million re-attendances to emergency departments in 2020-21. This is equal to 10.4% of all unplanned attendances in England.
 - Tracking re-attendance rate data will highlight recurring issues and identify potential causes. This enables evidence-based decision making to decrease re-attendance rates and improve patient safety.
- Proportion of patients clinically assessed and directed to same day emergency care (current vs aim)
- Proportion of patients clinically assessed and directed to another service off-site (for example urgent primary care/urgent treatment centres) or on-site (co-located urgent treatment centre, specialty assessment units, clinics)
- Proportion of patients sent to the emergency department by GP or other community provider without prior communication.

References

[RCEM and NASMeD Position Statement: The management of ADULT cardiac arrest patients taken to Emergency Departments \(EDs\) during the COVID-19 Pandemic](#)

[Rebuilding the NHS - RCP priorities for the resetting of services](#)

[Directory of Ambulatory Emergency Care for Adults](#)

Staffing

Aim

Staff will be in the right place, at the right time with the appropriate skills to care for patients and keep them safe.

Background

Staffing models need to be invested to deliver a safe and effective service for all patients.

Staffing models will depend on many things including:

- attendances
- skill sets and competencies of staff
- number of junior staff including trainees
- departmental layout
- trust layout of urgent care flow and admission processes
- acuity of workload
- case mix of patients
- additional needs such as teaching and training
- coronavirus impact:
 - changes to flow
 - segregation
 - shielding staff.

In good emergency departments we have seen

Staffing models for the next 12 months that are supported by the trust to enhance the urgent care pathway. There needs to be an increase in staffing numbers where appropriate to incorporate new roles such as:

- redirection
- streaming
- early senior decision makers
- specialty support.

For all staff joining both a new trust and new department, there needs to be:

- a clear induction programme that must include vital elements such as:
 - fit checking/testing
 - risk assessments (COVID-19 or otherwise)
 - support within the local environment
 - wellbeing to all individuals and how to access help when needed
- regular teaching sessions
- regular appraisal
- regular communication to share information with all staff on time.

Paediatrics staffing

All departments where children attend should have:

- a paediatric emergency medicine (PEM) consultant with dedicated clinical floor time in the paediatric emergency department (PED)
- at least two children's nurses per shift
- a play specialist.

Read the [guidance for mitigating challenges with children's nurse staffing](#).

Clinical and executive feedback from the workshops we held in 2021

Suggested processes and ideas for improving patient safety

Make use of recognised standards and regional benchmarking

Use recognised standards and regional benchmarking, such as the baseline emergency staffing tool (BEST-RCN) for:

- staffing
- assessing the skills mix throughout the department.

Consider new or extended roles in EDs

Consider new or extended roles in emergency departments including:

- allied health professions (AHPs)

- scribes
- housekeepers
- additional admin staff
- receptionists and admin staff
- physician's assistants (PAs)
- paramedics
- army medics
- security
- porters
- medical students.

Create or rethink use of models and job plans

Acute trusts can create or rethink existing models and job plans for non-ED consultants and workforce to:

- place appropriate value on generalists and medical on call
- ensure consultants are available to treat the increasing numbers of complex presentations. For example, those with multi-organ disease
- equate the focus on urgent and emergency care with elective care
- support specialists to provide 'in-reach' and senior specialty review to ED
- support admission avoidance.

Support staff wellbeing

Support staff by providing robust, clearly signposted ways to report and manage moral injury.

Introduce new initiatives that promote and support ED staff wellbeing.

ED nursing capacity and skill sets

A real-time overview of nursing capacity and deployment across the ED allows you to:

- safely prioritise patients, to deliver safe and timely care to the sickest patients in the ED
- retrospectively look for correlations between staffing patterns and adverse incidents
- assess and optimise the deployment of nurses and specific skill sets across the department.

Your capacity and deployment plans should meet the national standards.

Examples of good practice

Staff feedback/temperature check

Staff are the department's most valuable commodity. Organisations can collect staff feedback on a regular and frequent basis. The responses then need to be acknowledged and responded to as appropriate and able.

Staff feedback indicates the 'heat' or stress levels of the department. Understanding this can help management make informed decisions and take action.

Good examples of live monitoring exist in other industries. This is relatively easy to put in place. For example, staff feedback could be checked, recorded and included as part of regular ED huddles.

Workshop attendees also supported introducing exit surveys for leaving staff.

Mandatory training

A high-quality training programme with good compliance levels is essential for safety-led organisations.

Safety-led trusts provide:

- mandatory inductions for all ED staff, including locums
- mandatory ongoing training that is clinically relevant
- protected time to enable mandatory training and other development needs.

Example datasets that can drive possible safety improvements

- staff sickness rates
 - Staff sickness rates - and changes in those rates – can be regularly monitored and interpreted on a local and national level.
 - Rates can also be assessed for correlation with staff satisfaction, recruitment and retention.
- Undertake regular reviews of establishment requirements for all staff groups

- Reviews of consultant staffing levels to make sure they follow Royal College of Emergency Medicine (RCEM) and the Royal College of Paediatrics and Child Health (RCPCH) guidance
- Consultant vacancies
- Locum use at all grades
- Nursing staffing numbers and compliance with national guidance including those for paediatric nurses
- Nursing staff vacancies and use of bank and agency staff
- Review of incident reports raising concerns about number and skill mix of staff

References

[NICE: Safe Staffing for Nursing in Accident and Emergency Departments](#)

[NHS Improvement: Safe, sustainable and productive staffing in urgent and emergency care](#)

[RCEM Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK](#)

[RCEM Consultant Working and Job Planning](#)

Treatment in the emergency department

Aim

Clinical care and treatment will be delivered on time - aligned with best practice. Safety is never compromised.

Background

Emergency departments need to be able to focus on the critically ill and the injured. And they need to provide care and treatment in line with national guidance and evidence base.

In good emergency departments we have seen

- awareness and recognition of life-threatening conditions with the use of national alerts to educate all staff groups
- use of NEWS
- use of checklists
- robust and effective initial clinical assessment by senior decision makers
- effective handover processes
- efficiencies within processes, for example single clerking
- improved IT solutions, for example for observations, medical records
- good practice units apply early intervention for patients who need timely investigations. For example:
 - ECG for patients presenting with chest pain - performed and reviewed by clinician within 30 minutes of arrival
 - Sepsis 6 - delivered in first hour
 - CT for possible stroke - performed within an hour
 - hip X-ray for patients with fracture neck of femur (NOF) - performed in first hour
- effective identification and management of the deteriorating patient
- effective delivery of time critical medication - including new prescriptions (antibiotics) and medication that the patient is already taking - for example medication for Parkinson's disease, epilepsy, diabetes

- hospital-led responses and ownership of the urgent care pathway to ensure treatment is provided in the most appropriate setting
- an active and responsive local governance system
- use of point of care (POC) for time critical bloods - for example gases, full blood count (FBC), electrolytes, lactate.

Specific examples of good practice

1. An all emergency department staff WhatsApp group for teaching, training and regular updates. All staff have access to the group to receive information. But only a few staff can post information - limiting less important information.
2. Positive feedback. Make sure all staff receive positive feedback - as a team and as individuals for portfolios.
3. A full, locally led and delivered governance process. It feeds into the trust wide governance structure that all senior staff are aware of. This should include:
 1. an urgent care risk register
 2. incident reporting and trends
 3. serious Incidents – reports and learnings
 4. mortality data
 5. patient experience to include complaints and compliments
 6. safety alerts
 7. clinical audit programme.
4. Use of urgent care standard operating procedures. Linked within the governance system to sign them off and review them when updates are needed.
5. Active use of [National Safety Standards for Invasive Procedures \(NatSSIPs 2\)](#).
6. An adult mental health triage tool. This helps risk stratify a person who presents with a mental health crisis. It includes recording of 15-minute observations - reducing the chance of harm to themselves and the risk of absconding.
7. ECGs are only checked and signed off by ST3 or above. So the ECG is interpreted correctly and timely management starts if needed.
8. Immediate review and sign off of POC blood results so that timely management can begin.
9. Senior clinician review of patients with high or increasing NEWS.
10. Early senior review of infants, children and young people presenting with red flags for sepsis. Or for a child with complex needs or child protection concerns.

Clinical and executive feedback from the workshops we held in 2021

Suggested processes and ideas for improving patient safety

Regularly review diagnostic standards

It is important to conduct regular audits of available diagnostic standards. You can also review how these standards can be used to improve patient safety. For example, time to CT and time to Pathology.

Diagnostic results ready to view

At the moment significant clinical time is lost checking for diagnostic results. You can avoid this by introducing real-time notifications for diagnostic results. For example, x-rays and pathology results.

Some trusts may be unable to invest in this technology or will have less mature IT systems. If this is the case, you could potentially use runners or flow-coordinators to check and enter these results.

Mental health practitioner to review within an hour upon referral

Many hospitals now have an in-house psychiatric liaison team. It is important to ensure this service (or its external equivalent) is:

- responsive
- safe
- transparent
- can be escalated where necessary.

Internal professional standards (IPS)

Internal professional standards are a clear and unambiguous description of the values and behaviours expected in an organisation. They are most powerful when:

- centred on patient care
- written and agreed by clinical leaders
- openly supported by the executive team.

Examples of good practice

These examples illustrate ways that EDs and trusts can introduce robust governance processes that are transparent, accountable and drive improvement

Meet nationally agreed clinical standards

Adherence to nationally agreed clinical standards can improve patient safety in your ED. For example, standards from NICE, the British Thoracic Society (BTS) and the Royal College of Emergency Medicine (RCEM).

To ensure compliance with the latest information available you can regularly audit your use of standards.

Pain / analgesia audit

Diagnosis and treatment of patients with acute pain is a vital part of emergency care.

A responsive, caring organisation will regularly monitor and audit:

- the assessment of pain
- the administration of analgesia
- the continuing reassessment of pain throughout the patient journey.

Prioritising pain relief has profound benefits. It helps patients physically and emotionally by:

- reducing harm caused by symptoms
- reducing blood pressure and heart rates
- reducing distress, which helps patients provide accurate histories
- providing a calm environment for staff and patients.

MH (mental health) risk assessment for ED

You can regularly audit mental health triage, and mental health assessments. This ensures this patient cohort is adequately assessed and prioritised.

Example data sets that can drive possible safety improvements

- time to diagnostics

- Using national targets for processing laboratory diagnostics can help you benchmark performance.
- Trusts with mature IT systems could create reports that display bottlenecks in real-time. This will identify potential issues and help you introduce changes that improve your processes.
- Escalation processes need to be in place with a responsive outcome.
- Mitigation procedures and resilience need to also be considered into any plan of action. For example, efficient use of POCT can mitigate against delays.
- time to antibiotics for sepsis
 - This measure gauges the speed of diagnosis, senior review and treatment for sepsis. An important emergency presentation.
 - Combining this data with patient outcomes could help refine future use of antibiotics. It would also help identify areas of education needed at local and national level.
- time to ECG (electrocardiogram) and sign off for chest pain
 - Emergency departments across the country are seeing increased patient numbers. Despite this challenge, quick access to ECGs for patients with chest pain must continue.
 - Delays in ECG testing can impact the speed of diagnosis for myocardial infarction. Monitoring this is an important part of ensuring patient safety.
- frailty/dependency score in ED
 - Workshop attendees supported the collection of frailty and dependency data from undifferentiated patients. In the short term, this enables trusts to assess the reach required by frailty teams. It also helps them plan for the longer term. For example, planning services to incorporate within EDs.
 - This data set is essential for planning and designing in the future. Ensuring services are effective and that EDs are safe, dementia-friendly environments.
- medication errors
 - It is important to promote a culture of reporting medication errors and near misses in an accurate and timely way.
 - Reports can note circumstances such as when, where and why the incident occurred. This will enable review of the conditions in the ED at the time that

may promote errors occurring. Such things can be reviewed within governance processes and ensure that such processes reflect the issues occurring. For example, reflective within the risk register.

- This data can also be used to inform learning and action plans, or as a benchmark to monitor future performance.
- left without being seen (LWBS)
 - When patients wait long times to see a clinician, some choose to leave without being seen (LWBS). Whereas some may seek help at another place or time, some will inevitably come to harm.
 - For this reason, you can monitor this by tracking:
 - number of patients who LWBS
 - percentage of total patients who LWBS
 - These are considered good quasi-measures of potential risk to patient safety.
 - More mature systems will be able to trace and flag patients, particularly children, who fall into this category. For example, contacting those who received diagnostic tests or informing their GP.
 - They can also use data to identify patterns and predict future spikes in ED attendances. This data can also be viewed alongside staffing levels to improve future staff provision. Getting your staffing levels right will directly improve patient safety.
- Time to definitive treatment
- Length of wait for specialty review
- Observations and National Early Warning Score (NEWS2) completed at correct interval for patient's condition
- Senior sign off for RCEM recommended clinical presentations
- Local review of processes:
 - local audits such as ECG sign off
 - sepsis audits
 - RCEM audits.
- Review of incidents relating to treatments

Publications and guidance released since the 2020 launch of Patient FIRST

[NHSE: UEC recovery 10 point action plan](#) (PDF)

[NHS: National framework for healthcare professional ambulance responses](#) (PDF)

[RCEM & College of Paramedics joint statement: ambulance handover delays](#) (PDF)

[Royal College of Emergency Medicine \(RCEM\) report on infection prevention and control \(IPC\)](#) (PDF)

[RCEM CARES](#)

[NHS: Getting it Right First Time \(GIRFT\)](#)

References

[Facing the Future: Standards for children in emergency care settings](#) (PDF)

[RCEM Position Statement: Sepsis and the Emergency Department](#) (November 2019)

[RCEM Position Statement: Cauda Equina Syndrome](#) (25 February 2020)

[RCEM Position Statement: Clinical Responsibility for Patients within the Emergency Department](#) (29 November 2016)

[RCEM Guidance: The Patient who absconds](#)

[RCEM: Invasive procedure checklist for EDs](#)

[Imperial College Healthcare: The ABC of Handover](#)

[NHS England: National Safety Standards for Invasive Procedures \(NatSSIPs\)](#)

[Sharing best practice from clinical leaders in emergency departments](#)

For paediatrics

[The RCPCH Report 'Reimagining the future of paediatric care post-COVID-19'](#)

The care environment

[RCPCH: Facing the Future - standards for children and young people in emergency care settings](#)

[RCPCH: Winter pressures in children's emergency care settings - position statement](#)

["Supersuits" by Katie Chappell](#)

[Dani Hall. The smile behind the mask, Don't Forget the Bubbles, 2020](#)

Patient flow

<http://bit.ly/proformashare>

[RCPCH: Winter pressures case studies](#)

Safeguarding

[RCPCH: COVID-19 - guiding principles for safeguarding partnerships during the pandemic](#)

[The Facing the Future standards](#)

Emergency care this winter

[RCPCH &Us is working with young people to reflect on their experiences of COVID-19 and the lockdown](#)

[RCPCH wellbeing hub](#) - a collection of useful wellbeing resources

RCPCH QI Central: [example of a quality improvement initiative during COVID-19](#)

Safety alerts

[RCEM Safety Flash: Buddy System](#)

[RCEM Safety Alert: Missed aortic dissection](#)

Appendices

Appendix 1: 'What does good look like in ED' - Patient FIRST

Pressure resilience in EM 5 - PR5 plus

1. Clinical care

- i. Initial assessment. There must be a safe, validated and reliable system in place at the front end to identify critically ill patients, whether arriving by ambulance or walk-in. This should include a robust infection control process, to identify patients with infectious diseases, or risk of, at attendance.
- ii. Critically ill. Once identified, there needs to be a robust system in place to manage these patients, as directed by national guidelines. This should be audited regularly.
- iii. Deteriorating patients in ED. There should be an easily reproducible and accessible system in place to identify deteriorating patients in any part of the department, as well as a process to ensure this is acted upon.

2. Infection prevention and control

Overall aims should be to prevent the spread of and control infectious diseases:

- i. Between patients.
- ii. Patient acquiring infection from clinical staff.
- iii. Staff acquiring infection in their workplace.
- iv. And manage patients with infectious diseases or risk of, according to recognised clinical guidelines in the right environment, for example, COVID-19.

3. Patient flow

There should be a structured approach to patient flow to ensure that all components of the system are appreciated and managed appropriately, and always escalated when necessary.

4. Work force

There should be an appropriate staffing model in the Emergency Department, one which takes variation in demand into account, not just average demand. To include a flexible system to manage infection risk, for example COVID surge.

5. Leadership and culture

For the above initiatives to be successful, it is imperative that there is resilient leadership which encourages a positive and caring culture within the team, that has safety and patient care at the forefront.

[Patient FIRST - Appendix 2: Evidence](#) (prints best on A3 paper)