Effective Approaches in Urgent and Emergency Care

Paper 1

Priorities within Acute Hospitals

When people are taken to hospital as an emergency, they want prompt, safe and effective treatment that alleviates their symptoms and addresses the underlying causes of their illness. In short, they want care that is aimed at getting them better, quickly and safely.

These expectations are reasonable and achievable.

Getting patients better, quickly and safety requires the systematic implementation of known good practice; a consistent approach by all clinicians; collaboration within and between organisations; and great leadership along the pathway.

This paper highlights a cluster of good practice tactics that have been proven to reduce bed occupancy, cost and harm events, while increasing the satisfaction of front line clinicians and the rest of the team. Implementation relies on leadership, effective governance and good management practice – and the courage and tenacity of the team to do the right thing on behalf of their patients.

1. There should be early *senior* review of *all* patients along *all* parts of the pathway

The Emergency Department

- Consider implementing RAT[1] for 'majors' patients.
- Implement See and Treat [2] for patients with minor injuries and illnesses.
- Reduce or eliminate triage.[3]
- Ensure that there is effective departmental co-ordination of activity.

Assessment Units / Acute Medical Units

- Implement consultant-led rolling ward rounds[4], or RAT. Avoid batching[5] patients to be seen on 'set piece' ward rounds.
- Ensure consultant presence is available seven days a week and into the evenings.
- Establish clear pathways for patients requiring specialist care, so they can be cared for in the most appropriate setting as quickly as possible[6].
- Set up dedicated, multidisciplinary health, therapy and social care teams based in the unit.

Specialty Wards

- Ensure that a consultant sees all patients, and their care plans are confirmed, within 2-3 hours of admission to the ward[7] (or a *maximum* of 12 hours if admitted 'out of hours'), and sooner if the patient's clinical need requires it.
- Each patient should be discussed daily (including at weekends) with the responsible consultant[8].
- Ward managers need to be supernumerary to coordinate and drive care.

2. Maintain the momentum of care – there should be a *senior* review of every inpatient's care plan *every* day

- Every patient must have a consultant approved care plan in place within 12 hours of admission at the latest.
- Care plans must include an expected date of discharge (EDD)[9].
- EDDs should be set by the consultant in charge and only changed with her/his permission.
- Care plans must include 'criteria for discharge'[10]. Empower the multi-disciplinary team to discharge when criteria are met (particularly at weekends), rather than waiting for senior medical confirmation.
- There should be daily, early morning 'board rounds'[11] by a senior clinical decision maker (normally a consultant) to ensure that the care plan is on track[12].
- Schedule main ward rounds for the mornings, and see potential discharges first, so that beds are freed as early as possible.
- Develop 'one stop ward rounds'[13], where tasks such as writing TTOs and filling request forms are completed before the round moves onto the next patient (avoid batching work to the end of the round).

3. Get patients on the right pathways - manage patients in 'flow streams'

Emergency Department

- Establish 'protected streaming' – create separate streams for minors and majors, with dedicated staff, processes and coordination.
- Create processes to ensure that the majors stream is not halted by a full resuscitation room.
- Avoid acting as the default arrival point for referrals that do not require resuscitation or stabilisation (e.g. most GP or clinic referred patients) – these patients should by-pass ED and go directly to assessment / acute medical units or specialist beds.
- Ensure senior decision makers[14] in high volume specialties are available to attend the ED within 30 minutes of referral.
- ED should have direct admission rights using agreed protocols.

- Establish ambulatory emergency care[15] streams to avoid unnecessary overnight stays.
- Consider establishing Clinical Decision Units offering observation medicine (with LOS <12 hours) and ambulatory emergency care.

Admissions

- Stream by length of stay and care needs:

  o *Assessment capacity* should be 'sized' for patient stays of no more than 12 hours, after which patients should enter appropriate flow streams.
  o Provide *short stay capacity* for patients with an anticipated length of stay of up to two midnights (assessment and short stay capacity is usually co-located in acute medical units)[16].
  o Further streams should be to *specialist beds* (for complex speciality patients requiring >72 hour stays), beds for patients with *complex discharge* needs (e.g. the frail elderly) and *catastrophic illness* (e.g. critical care and stroke patients).
  o Ambulatory emergency care should be provided where appropriate.

- Minimise handovers between consultant teams and maximise continuity of care – a ratio of more than one handover per admission beyond ED suggests poor practice.

4. Work together systematically and predictably – implement internal professional standards

- Response standards should be agreed for *the whole pathway* and cover time to:

  o Assessment, including investigations
  o Treatment
  o Review
  o Referral
  o Discharge

- Agree and implement single assessment processes to reduce duplication.
- Simplify referral processes, rather than using them as mechanisms to 'hold back' work.
- Use metrics to measure performance and the impact of improvement initiatives.

5.   Plan and manage capacity to meet demand

- Develop an agreed escalation protocol that has input from all relevant stakeholders.
- Use a tool to predict the expected number of admissions – if anticipated admissions exceed expected bed availability, escalate early!
- Each specialty and supporting department should plan to match capacity to demand.
- Implement effective bed management, equipped with real-time information, and rigorous processes.
- Staffing rotas should be designed to match demand profiles.

6.   Manage variation in discharge planning[17]

- Minimise in-day bed swing[18] by maximising morning discharges – set targets to maximise discharges by a locally agreed 'check-out' time.
- Consistently prioritise activities associated with discharge (except where there is urgent clinical need) in order to reduce length of stay[19].
- Manage frail elderly people assertively to avoid in-hospital decompensation with associated prolonged stays.[20]
- Ensure services required for discharge are accessible at weekends.
- Avoid 'batching' in diagnostics and support services (see note 5 below).

7.   Avoid unnecessary overnight stays – implement ambulatory emergency care

- Download and study copies of the Directory of Ambulatory Emergency Care for Adults and the 'how to' guide from the NHS Institute website.
- Ensure senior clinical decision makers are available to decide on the need for admission.
- Ensure ambulatory emergency care is available for all patients who meet the criteria.
- Ensure access to timely investigations to support clinical decision making.
- Create responsive alternatives to admission:

  - Urgent clinics
  - Community based assessments
  - Community support for urgent treatment at home and in residential and nursing homes.

End notes

[1] RAT is 'Rapid Assessment and Treatment'. It is employed to manage 'majors', most usually those arriving by ambulance, or hot admissions to assessment units. A senior medical decision maker (usually an ED consultant or acute physician) will rapidly assess the patient on arrival/admission and determine what investigations and immediate treatment are needed. Due to the intensity of providing a RAT service, it should initially be piloted, taking staffing requirements and hours of operation into careful consideration. 'Door to doctor time' should be measured; best practice is a 30 minute standard.

[2] 'See and Treat' is typically used to treat patients with minor injuries and illnesses. Following registration, patients wait to be seen by a clinical decision maker (e.g. an ENP or consultant in emergency medicine) without going through any intermediate stage (such as triage). They are then seen and treated by the decision maker. It should be noted that so called 'minors' may have serious conditions that require prompt and effective treatment. See and Treat helps identify these patients early, as well as dealing with less serious conditions quickly.

[3] Triage is a process where patients are seen by a clinician (e.g. a nurse or sometimes a GP) who carries out a preliminary assessment to determine their clinical priority. Some hospitals use sophisticated assessment systems, such as 'Manchester Triage', while others use streamlined assessment tools. Triage typically takes between 2 and 10 minutes per patient, who then queue for definitive treatment. ECIST recommends that wherever possible, triage is eliminated from the pathway, as it creates additional queues and ties up clinical resources that could otherwise be used to treat patients. Evidence suggests that triage only adds value where the triaging clinician initiates diagnostics or treatment (see: *Reducing Attendances and Waits in Emergency Departments*, 2004, section 4.3.2, Cooke, M. et al).

[4] A rolling ward round (or 'continuous ward round') is where all patients are seen by a senior doctor (normally a consultant) shortly after their arrival on the ward. More traditional models, where rounds take place at set times/days, delay decision making and create workload spikes for junior doctor, nurses and supporting departments, which are not easily absorbed.

[5] 'Batching' is where jobs or events are delayed and carried out in groups/batches at a later time. While some batching is useful (e.g. elective operating lists), other batching can lead to delays to discharge (e.g. batching the writing up of TTOs until the end of a ward round or day) or care (e.g. the twice weekly ward round).

[6] Some hospitals have established 'specialty in-reach', where specialists actively visit assessment units to 'pull' appropriate patients into specialist wards or provide advice to optimise short stay episodes of care. This approach should be used with caution, as it may lead to batching or inefficient use of specialist time. Best practice is rapidly to identify patients requiring specialist care and to transfer them to specialist wards where they receive an early review by a decision making clinician.

[7] This time standard should be determined locally, as part of the process of agreeing 'internal professional standards' (see section 4). ECIST recommends the earliest possible *consultant* review of all admissions (we suggest within 2-3 hours of admission between 8am and 8pm, and a *maximum* of 12 hours if the admission is 'out-of-hours', and much sooner if the patient is not responding to treatment as expected. Out of hours, all patients should receive an early senior review, by an ST3 level doctor or equivalent, within 1 hour of admission, followed by discussion with the consultant if the patient's care plan remains undefined and/or the patient is not responding to treatment as expected). We also strongly recommend that patients are seen again the following morning by the admitting consultant. See *RCS Emergency Surgery. Standards for Unscheduled Surgical Care February RCS 2011,* and, *RCP UK Consensus Statement on Acute Medicine, November 2008,* for the minimum standards recommended by the Royal Colleges. Also see NCEPOD *Emergency Admissions: A journey in the Right Direction*? (2007)

[8] Best practice is daily 'board rounds' where the care plan of every patient is reviewed every day by a consultant to identify problems and delays in order to maintain momentum.

[9] An Expected Date of Discharge (EDD) represents a consultant's clinical decision in relation to when a patient will be clinically ready for discharge from the hospital. It should not include any allowances for non-clinical delays (an EDD missed for non-clinical reasons is sometimes expressed as EDD+1, EDD+2 etc to indicate an avoidable delay). We recommend that consultant permission is required to change an EDD, as the need to change it should only occur where recovery is not as anticipated.

[10] Ensure that consultants define and record in the notes, clinical and functional criteria necessary for each patient's discharge, and then hold multi-disciplinary team members accountable for progress against those goals daily - for example at a ward or white board round. These criteria should be realistic and allow for continuing recovery at home following discharge.

[11] A 'board round' is a rapid review of progress against the care plan, typically involving the consultant, his medical team, the ward manager and therapists (and sometimes a social worker). It is usually held by a wards 'at a glance' white board. The aim is to ensure that momentum is maintained and deteriorations identified and managed promptly.

[12] See: The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards. Aftab Ahmad, Tejpal S Purewal, Dushyant Sharma and Philip J Weston. *Clinical Medicine* 2011, Vol. 11, No 6: 524–8

[13] One stop ward rounds are where most tasks that have been identified as necessary (e.g. the writing up of TTOs or the ordering of a scan) are completed before the round moves onto the next patient. This avoids the 'batching' of tasks and consequent delays. It can be useful to use a 'COW' (computer on wheels) as an enabler. Team working is essential - leaving all the tasks to the most junior doctors is not team work. See: http://carebydesign.org/checklists/ for a useful ward round check list and other guidance.

[14] A senior decision maker is a clinician who can establish a diagnosis, define a care plan and discharge a patient without routine reference to a more senior clinician.

[15] See the NHS Institute's *The Directory of Ambulatory Emergency Care for Adults,* 2010. Ambulatory Emergency Care can be delivered by A&E consultants in a CDU (Clinical Decision Unit) and/or by physicians in acute medical units or dedicated ambulatory care units.

[16] For a more detailed discussion, see *Acute Medical Care: Report of the Acute Medicine Taskforce*, 2007 and our paper on *Unscheduled Care Pathways* at www.nhsimas.nhs.uk/what-we-can-offer/intensive-support-team/

[17] See *Ten High Impact Changes for Service Improvement and Delivery*, Change 3, Modernisation Agency, 2004 and *Ready to Go? Planning the discharge and the transfer of patients from hospital and intermediate care*, DH 2010

[18] 'In-day bed swing' is a term used to describe the fluctuation of the bed occupancy level of a hospital across a single day. Typically, hospitals become full from late morning due to the inflow of elective and emergency admissions, with occupancy easing from the later afternoon/early evening when discharges have peaked.

[19] *Simulation of patient flows in A&E and elective surgery. Discharge Priority: flows in A&E and elective surgery*, Allen A, Cooke M, Thornton S, University of Warwick

[20] Older patients with care and/or support needs (rather than acute care needs), should receive a multi-disciplinary assessment from a dedicated team within two hours of arrival in A&E, with a view to arranging suitable home based services and avoiding admission to an assessment unit. Patients who are admitted, but show signs of frailty (such as malnutrition, cognitive impairment or if they have an existing care package), should receive a geriatric assessment and case management support during their hospital stay to reduce their risk of prolonged hospital stay. See: D. Harari et al, *The older persons' assessment and liaison team* etc, 2007, www.ageing.oxfordjournals.org