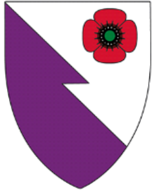

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RCEM Position Statement

COVID-19: Resetting Emergency Department Care

6 May 2020

Executive Summary

COVID-19 has brought significant disruption to the way medical care is delivered across all areas of clinical practice. As we move from a pandemic to an endemic state, delivery of care must adapt to ensure this – and similar diseases – can be managed safely within our Emergency Departments. This position statement makes recommendations about how care in Emergency Departments in the UK needs to be transformed.

The recommendations support these five fundamental aims:

1. Emergency Departments must not become reservoirs of nosocomial (hospital or healthcare acquired) infection for patients
2. Emergency Departments must not become crowded ever again
3. Hospitals must not become crowded again
4. Emergency care must be designed to look after vulnerable patients safely
5. Emergency Departments must be safe workplaces for staff.

These five fundamental aims and associated recommendations are designed so that we can minimise the harms of nosocomial infection and continue to provide the best possible care for patients in our Emergency Departments.

If we do not do this, people will die of avoidable nosocomial infections.

The Emergency Medicine response to COVID-19: much done, more to do.

The coronavirus pandemic has brought suffering and damage to many lives across the world and will continue to challenge national health systems for years to come. The NHS response has been phenomenal; demonstrating an ability to optimise the delivery of patient care that puts patient safety first. As we move from a pandemic to an endemic state, delivery of care must also change to ensure this – and similar diseases – can be managed safely, alongside regular Emergency Care, within our Emergency Departments and wider healthcare systems.

Past disruptions to healthcare delivery have put increased pressure on Emergency Departments as they are perceived to be 'safe places' by the public and other parts of the system, and therefore the default option for all healthcare needs. This has contributed to unsustainable overcrowding and corridor care in Emergency Departments.

The SARS-CoV-2 virus causing COVID-19 is not unique in its method of spread, and this pandemic has highlighted the critical importance of high-quality infection prevention and control. We must learn from this response and make changes to our future operations. As we progress beyond the peak of this outbreak, we must take action now to ensure patient safety is never jeopardised again through poor infection control, design, physical crowding, inadequate staff protection, and corridor care. We cannot treat ill and injured people in an environment that does not allow adequate social distancing.

Attendances at Emergency Departments fell during the first two months of the pandemic. Possible reasons for this include changes in disease patterns or behaviour, patients being treated by alternative pathways, or anxiety over presenting to hospitals. This is not fully understood yet but there appears little or no evidence of patients being able to access 'alternative pathways'. The extent to which patient behaviour was influenced by each of these is uncertain, but we know that most of the decline has been in lower acuity groups and the rate of presentation of seriously ill patients has fallen by a lesser amount. It is important to consolidate alternative routes of access for lower acuity patients, whilst maintaining access for those who need the services of Emergency Departments and hospitals. This would both ensure the best possible outcomes and lower nosocomial infection risk for patients and staff.

The response of the public in complying with the social isolation imposed by lockdown has been impressive and effective. The pandemic has driven use of NHS 111 and other advice lines in a way that had previously not been realised. Ambulance services have focused heavily on prioritisation and need for conveyance. Primary care and other services have undergone a paradigm shift in how consultations are conducted, and community work is undertaken. There has been a transformation in the way that many specialties have delivered care to their most vulnerable patients to minimise their risk of nosocomial infection, by increasing the use of telemedicine and remote consultations. This needs to continue. Major changes have been made to the way patients are cared for throughout the system to effectively respond to the pandemic. Some of these changes are welcome – many are overdue – such as increased use of virtual fracture

clinics, telemedicine, and careful consideration around the value of hospital admissions and end of life care. Many such changes have been implemented at pace and the normal safeguards to ensure they work as intended may be missing. In these cases, it is important to consider the changes carefully and adapt where necessary. It is also important that the public, who pay for and use these services, are meaningfully consulted as to how Emergency Departments need to change.

Emergency Departments have been extensively reconfigured into streams to separate patients more likely to have COVID-19 from those less likely; in many cases this has involved changed or increased footprints. Many departments have also operated different rotas and introduced new processes, and traditional inpatient team involvement at the "front door" has increased, with improved access to face-to-face specialist opinions and radiology.

Hospital occupancy has fallen due to a combination of fewer "medically fit" patients remaining in hospital, acceptance of different admission and discharge thresholds, improvements in pathways within hospitals, and reductions in elective surgery. This illustrates that delayed transfers of care and the resulting exit block is not an insoluble problem, and can be fixed where there is a political, financial, managerial and clinical will. Patient flow has improved, and many Emergency Departments are less crowded as result of all of these changes.

RCEM welcomes signs of recovery from the first wave of the pandemic but cautions that we are at the beginning of a long period of necessary transformation. Failing to appreciate this risks minimising the significant pre-pandemic problems in urgent and emergency care. There is also a concerning risk that subsequent waves may coincide with a seasonal flu epidemic, creating more pressure.

There is a moral imperative to ensure our Emergency Departments never become crowded again. If we are crowded, we cannot protect patients and staff. Crowding has long been associated with avoidable mortality, and COVID-19 reinforces and multiplies this risk. Emergency Departments will need to continue to operate in segregated streams, with an absolute focus on minimising nosocomial infections. There will be a 'nosocomial dividend' from implementing these recommendations, with reduced infections to staff and patients and improved safety and quality of care. This will also need to be the case within the whole system, and the challenge that this represents cannot be underestimated. The whole health system must adapt and change.

Emergency Departments should return to their original core purpose: the rapid assessment and emergency stabilisation of seriously ill and injured patients. They can no longer be used to pick up the pieces where community, 'out of hours', or specialist care has struggled to cope. This will need leadership and active support at national, regional and local level, together with changes in behaviour from both the public, this will only be possible if patients have 24/7 access to high quality services they can trust.

Recommendations to ensure patient safety and high-quality emergency care

1. Improved infection control

- Patients who come through 'blue light' 999 or self-present with time critical illnesses will need to be assumed to have a contagious infection until more information can be gathered, so that their treatment is not delayed. This may mean an end to the waiting room as we know it.
- Staff will need appropriate levels of Personal Protective Equipment (PPE) to manage this unknown risk. Nosocomial outbreaks affecting healthcare workers and vulnerable patients in our Emergency Departments must be unacceptable.
- Triage processes need to routinely consider infection control, leading to reduced hospital acquired infections (HAI) for patients and staff.
- Tests with rapid turnaround of results should be readily available to ensure patients are nursed in appropriate areas of the hospital if admitted.
- Clinical staff will need levels of PPE appropriate to the risks of working with undifferentiated patients.
- The combination of segregated departments and reduced productivity will require flexible staffing reconfiguration.
- PPE, rigid visitor policies and social distancing can seem dehumanising and are distressing for both patients and staff. We need to be mindful of this. Taking a history, examining a patient and organising tests are more time consuming now, and individual productivity will inevitably decline.
- Emergency Departments should establish their maximum occupancy for each area that allows adequate social distancing. It is invariably impossible for patients to maintain a safe distance if they are waiting on a trolley in a corridor.
- Hospital bed occupancy must be maintained at a level that promotes good infection control.

2. Reducing crowding and improving safety

Critical illness and injury

- All ambulance services should have the technology to provide an electronic record to the receiving hospital with clinical details of the patient. Many ambulance services already have this, but it should be a matter of routine. This allows better planning of where time critical patients are seen to meet their needs.

Non-time critical presentations

- Non-time critical patients should either be referred by GPs, Urgent Treatment Centres, or NHS 111 or devolved nation equivalents, or have undergone 999 screening. NHS 111, and their equivalents, has been used as the principal patient-facing service in this pandemic and should continue in this role. These patients should have specific care needs that can only be provided by the Emergency Department. We support enhanced clinical telephone triage services to help patients access the right health care they require in the safest place for it to be provided. NHS 111 or equivalents needs to have both the

capacity and clinical capability to direct patients to the best care for their needs.
- NHS 111 and equivalents, needs to be better integrated with clinical systems, so that there is shared learning and governance.
- Transfer to, or advice to attend, hospital should be of clear benefit to the patient and should only occur if the patient requires expertise, diagnostics, technology or treatment available in the hospital that cannot be provided elsewhere.
- Clinicians from all spheres of practice will need to become more involved in the urgent and emergency care pathway so that patients can receive early specialist opinions when the patient needs it, and be moved on to the most appropriate facility more rapidly for definitive care.
- There is a need for the acceleration of programs aiming to deliver same day emergency care (SDEC) so that there are appropriate alternatives. This will both reduce admissions and improve access to the right care for patients from the outset of their clinical journey and reduce infection risk.
- Patients should be discharged as soon as they are medically fit therefore the positive reduction in the numbers of patients stranded in hospital must be maintained and the situation as was must never be allowed to occur again.

3. Patients already under the care of specialist teams

- Patients under active speciality care who present with a problem relating to that speciality should be managed through their existing specialist teams. This might include patients with post-operative problems, or complications of their disease or its treatment. Attendance at the emergency department for just advice from specialty teams should not occur.

4. Physical Emergency Department redesign

- The COVID-19 pandemic has demonstrated how flexible and nimble Emergency Medicine teams can be, but there is now a need to consolidate their efforts into sustainable long-term solutions. In some cases, this will mean continuing with current adaptations, while others will need physical redesign and rebuild to keep patients and staff safe.
- Emergency Departments need to remain segregated to reduce the risk of nosocomial infections from COVID-19 and other infections. This includes resuscitation facilities where the risks are highest because of aerosolisation.
- Emergency Departments need to have enough side rooms to protect patients who are at high risk of dying from nosocomial infection.

5. **Using COVID-19 testing for best care**
    - We need timely testing and pathways that allow admitted patients to wait safely until we know whether they have COVID-19 or other infectious diseases or not. This has radical implications for the capacity and functional design of our hospitals.
    - Patients must leave the Emergency Department as soon as they are clinically 'ready to progress' and not be delayed awaiting the outcome of COVID-19 screening swabs.

6. **Metrics to support reduced crowding**
    - RCEM recommends that NHS England and their equivalents in the devolved nations review and implement metrics that reduce crowding and promote good quality care for time critical conditions.
    - RCEM has collaborated on the Clinical Review of Standards led by NHS England and the work was paused due to the current exceptional circumstances. There is a clear need to implement an intervention that reduces crowding and allows us to protect our patients from nosocomial infection. RCEM is supportive of the aims of Clinical Review of Standards but recommends that this now includes markers that identify the need for isolation and the maximum occupancy of an Emergency Department.