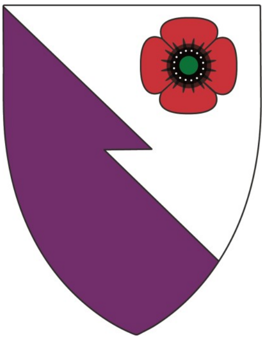


The Royal College of Emergency Medicine

COVID19: Resetting Emergency Care

Operational FAQs for clinical leaders

June 2020

In May 2020, RCEM published a position statement 'Resetting Emergency Care' in the COVID-19 era. This made some radical proposals about how Urgent and Emergency Care needs to be reorganised.

Who is responsible for the safety of patients and staff in our EDs?

Ultimately, safety for patients and staff in an organisation lies with the board of that organisation (or equivalent). The organisation itself will be responsible in law for its actions.

If somebody is harmed as of a breach of duty, the organisation will be liable to pay damages and will likely be able to draw on one of the schemes operated by NHS Resolution.

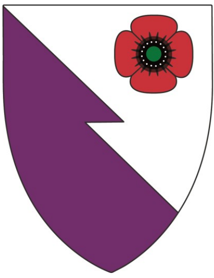
However, there are other forms of responsibility. Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013), employers and other people in charge of premises are required to report and keep records of injuries. Covid-19 is not one of the diseases specifically identified, but any disease attributable to exposure to a biological agent is.

Breach of the RIDDOR or any failure to provide a safe system for work may give rise to a criminal liability of the employer.

Departmental leaders are responsible for ensuring that the department is doing everything it can to deliver safe and effective care whilst maintaining a duty of care to staff. This includes escalating concerns where appropriate.

Clinical leaders such as consultants and senior nurses hold a professional responsibility for ensuring the safety of their patients and staff in the department, working within resources available to them. This includes an obligation to escalate concerns where appropriate.

Individual staff members maintain their normal professional responsibility to patients, but also have individual employment rights under health and safety legislation.



How do I define the maximum occupancy of my ED?

This is best thought of in terms of how many safe places in each area there are to fit patients, accompanying persons AND staff once current social distancing and IPC measures are in place. Count the number of designated trolley spaces, spaces previously designated as suitable for patients being treated in an ambulatory fashion, and waiting area spaces. Ultimately your limits will be governed by:

- Resus occupancy
- Trolley space occupancy
- Ambulatory space occupancy
- Total occupancy including all waiting area spaces (may be the same as the last one)
- This may need to be expressed for adults and children, as well as overall.

Is it OK for patients to wait in what were previously traditional waiting rooms whilst undergoing ambulatory treatment?

Yes. It may be appropriate to use former waiting rooms, with appropriate social distancing, to support ambulatory management. This means that to maintain safe social distancing, alternative arrangements for patients waiting to be seen may need to be made.

Is it OK to redirect patients to other services?

Yes. RCEM initial assessment guidance does allow for this providing the process is well governed and based on adequate clinical assessment. It is important to recognise that this can be uncomfortable for both patients and clinicians, and we need to be sensitive to this

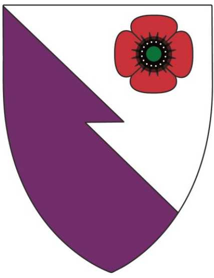
What if the ED is full? Should we decline to offload ambulances?

RCEM believes is that it is important to offload ambulances when it is safe and possible to do so. Holding patients in ambulances is not fair or ethically right, especially if there are patients ready to leave the ED. Declining to offload ambulances is therefore a last resort.

RCEM also believes that we cannot safely look after patients, protect them from viruses such as COVID, and protect staff if departments are crowded, i.e. above maximum occupancy. Crowding is always unacceptable and dangerous for patients. It is even more unthinkable to accept that this may happen predictably (such as out of hours, or at weekends, or over bank holidays). These two absolutes mean that our departments must have sufficient capacity to meet demand, and constant flow out. If this is not acquired, we will not be able to keep our patients and staff safe.

If your ED is predicted to reach maximum safe occupancy, then your operational site and executive teams need to create a reliable flow out of the department so that patients can still flow in. This will require more determined prioritisation and proactive management of unscheduled care flow, and more effective escalation than has ever happened before. It will also require engagement of clinical teams and support services, and rapid innovation within organisations. Your organisation must have a clear escalation plan that works effectively. Experience during the first stages of the COVID pandemic has shown that this is possible where there is good organisational leadership, removal of barriers, and collaborative working.

Examples of escalation plans are available in the [RCEM local guidelines] section.



Should EDs be responsible for holding areas pre-ED if these are used?

RCEM does not support the use of holding areas Pre-ED. Where holding areas are used to support ambulance offloading in the presence of a department at full occupancy, this reflects organisational failure. It is therefore an organisational responsibility to find a safe solution using all available resources. It is unlikely that EDs are resourced to safely manage holding areas.

If your organisation chooses this route, EDs should always seek to help identify and safely offload patients with time-critical clinical needs first.

Should EDs be responsible for patients who have completed their ED care?

Patients should not be held in the ED once they are ready to progress, particularly whilst they wait for testing for infectious diseases. Trusts must have areas available to accept patients whose infectious status is unknown, cared for in a way that keeps both patients and staff safe from nosocomial infection. Ideally, these would simply be regular assessment areas kept free by flow into inpatient beds, or normal inpatient wards.

The extensive use of holding areas post-ED, unless they are assessment areas, represents organisational and systemic failure. RCEM does not support that EDs should be responsible for such areas, as these patients have completed their ED care. It is therefore the responsibility of operational management teams to find a well-defined and safe alternative, with agreed managerial and clinical oversight.

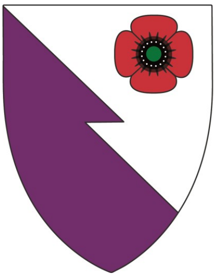
What should we be doing for shielded patients?

There is likely more than 2 million patients in the UK who should be shielded. In addition, elderly patients are more vulnerable than other groups and this group should also be strongly protected.

- Specialities should develop pathways for their shielded patients that mean they avoid coming through the ED whenever possible.
- Shielded patients should ideally be heralded (advance warning).
- Shielded patients should be placed in a side room whenever possible.
- Shielded patients are not exempt from standard geographical stratification into high or lower risk COVID pathways (e.g. Red or Green EDs).
- Departments should be working in a way that is safe for all patients, not just the identified shielded ones.

What should we be doing for staff at higher risk of developing COVID-19?

RCEM supports sensible national guidance. The basics of which include involvement of your local occupational health team, risk assessment for individual staff, assigning higher risk staff to roles where there is a lower risk of exposure to COVID, rigorous attention to rules around testing, social distancing, PPE, and working with infected patients. Finally, we should not be allowing departments to become crowded, as this will increase risk to all staff, including higher risk staff.



How do we keep our cleaners, catering staff, porters and receptionists safe?

Firstly, talk with them and ask them about their particular concerns. Ensure they are included in departmental communication. Work with them to understand their roles and working practices. Ensure they are all appropriately trained in IPC.

Special measures, which we have been moving away from (such as barriers in reception areas) may need to be employed.

It is easy to forget that as health care professionals, we are well informed about this disease and its health and operational implications. It is our responsibility to ensure that our wider teams are also appropriately included and informed.

What can organisations reasonably expect from EDs to support flow?

ED teams are responsible for using the resources available to them to provide timely and effective emergency care. Our responsibility includes early prioritisation, differentiation and decision making, institution of treatment and accurate speciality referral, and preparing the patient for safe discharge or onward care. We are also responsible for working with our clinical and managerial colleagues to develop the best clinical pathways possible.

What is reasonable to expect our organisations to do to support flow through ED?

It is reasonable to expect our organisations to prioritise patient and staff safety. This applies to all areas, all patients, and all staff.

- ED patients are equally important to consider than any other group, and in many cases may be more vulnerable.
- ED staff are equally important to receive professional respect and safe working environments. They are also at higher risk because they deal with sick, undifferentiated patients with unknown infectious disease statuses.

It is therefore reasonable to expect organisations to do everything they can to support flow through the ED. This includes ensuring that EDs are appropriately supported, configured and staffed, and that there is access to investigations and specialist support to enable rapid decision making. Alternatives to admission need to be available. Hospital processes need to be working over extended hours and across the working week and previous acceptance of delays for such simple things as TTAs, transport, porting and for more complex things such as investigations, specialist input, or procedures should no longer be accepted.

What can we reasonably expect from other inpatient teams?

RCEM recognises that the current situation has impacted specialist teams in variable ways and that many of our colleagues are now concerned about elective as well as non-elective care. It is, however, reasonable to expect that specialities should look after their own patients when they develop complications of their disease or treatments, and that they continue to introduce systems to ensure that these patients are not coming to EDs as the default option, particularly out of hours and on weekends.

Access to Same Day Emergency Care and specialist opinions across extended hours, and throughout the week is of tremendous value to patients and can avoid or shorten admissions. RCEM recommends that organisations maximise the potential for SDEC.

Facilitation of streaming and fast-track care for some patient groups is well established in many departments and should be the norm in all.

Agreement and application of simple internal professional standards is a simple measure and should be enforced.

If we are running higher-risk and lower-risk ED tracks, is it reasonable for EDs to be staffing both?

Our speciality is about the evaluation and treatment of undifferentiated patients, and we need to be involved where undifferentiated patients are being seen. It is becoming clear, however, that expecting EDs to carry the sole responsibility for staffing multiple clinical areas is not always possible, as normal volumes of activity will return. Co-working with physicians is proving successful in many places, and providing mixed nursing and multi-professional teams has worked in many organisations in order for skills to be shared.

If we have changed or are changing working patterns to support new configurations, what are the College's Job Planning recommendations?

RCEM produced guidance during the first peak of COVID and our sustainability guidance applies. EDs have been at the sharp end of the first stage and will continue to be so. Working must therefore be sustainable. Emergency rotas should be stepped down as soon as possible to more sustainable patterns, with restoration of normal quality improvement, professional development, teaching and research activity for all groups of staff. RCEM would recommend consultation with industrial organisations around apparently temporary changes to job plans, to avoid any situations where the desire of emergency physicians and teams to step up to support our patients might be interpreted as sustainable long-term change.

Relevant links

COVID-19: Resetting Emergency Care

Sustainable senior doctor working patterns during the COVID-19 pandemic

RCEM crowding guidance

RCEM initial assessment guidance

UK government guidance on COVID-19 including guidance on risk assessment for healthcare workers and IPC guidance

NHS England Infection Prevention and Control Board Assurance Framework