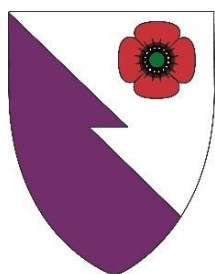


**The Royal College of Emergency Medicine**

**Quality in Emergency Care**

## **A Safer Emergency Department**

**A strategic Overview**



**May 2020**

# Overview

## Background

The Royal College of Emergency Medicine (RCEM) works to ensure high quality care for patients by setting and monitoring standards of care in emergency departments, as well as providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine. The Quality in Emergency Care Committee (QECC) is focussed on achieving a consistently high standard of care in all UK Emergency Departments.

However, please remember that RCEM is not a regulatory body.

All definitions of 'health care quality' have safety, patient centeredness, effectiveness, efficiency and timeliness as central pillars.

QECC is producing three documents to identify the areas of work the committee is focussing on: Safety in Emergency Departments, Patient experience in Emergency Departments, and Quality measurement and Standards in Emergency Medicine.

### The function of these documents

The guidance was commissioned by RCEM Council, and written by the Quality in Emergency Care committee, in recognition of the need for a strategic overview of the Royal College of Emergency Medicine approach to safety, experience and quality of care in Emergency Departments, especially in the light of the RCEM CARES campaign. [https://www.rcem.ac.uk/RCEM/Quality\\_Policy/Policy/RCEM\\_CARES/RCEM/Quality-Policy/Policy/RCEM\\_CARES.aspx](https://www.rcem.ac.uk/RCEM/Quality_Policy/Policy/RCEM_CARES/RCEM/Quality-Policy/Policy/RCEM_CARES.aspx)

This document is designed as an overview of QECC work on improving quality of care in Emergency departments. It is strategic in approach, underpinned by several processes within RCEM. The aim is to describe the relationship between the activity of RCEM and Emergency Departments in these areas.

The strategy is underpinned by practical, 'tactical' and operational advice and guidance for Emergency Departments, which RCEM has produced.

### What is in these documents?

The document contains, as relevant to safety:

- A short summary and the specific issues within Emergency Departments
- A description of QECC activity and processes
- The relationship between RCEM and Emergency Departments pertaining to safety
- A summary of the key areas of patient safety in Emergency Departments
- Signposting RCEM advice and guidance on these areas

## Scope

This guideline was produced to clarify the strategic approach of RCEM to safety in Emergency Departments (EDs). It outlines the processes within RCEM, the relationship with EDs, and highlights some of the safety interventions of value within EDs.

It does not give detailed practical and operational advice; this is described in the RCEM Safety Toolkit, and on the RCEM website.

## Introduction

### What is patient safety?

Patient safety is the prevention and reduction of errors, risks and harm that occur to patients during provision of care.

### Why is safety an issue?

Safety is an issue in healthcare due to the complexity of the systems, processes, and treatments, and because humans are central, both as patients and clinicians. To err is human.

Within healthcare, the common areas of risk are:

***Prescribing errors (including transfusion)***

***Procedural safety (safety during procedures)***

***Missed or delayed diagnosis***

***Infection control (and nosocomial infections)***

***Late identification of illness (especially sepsis, including delay to diagnosis)***

***Late identification of deterioration/lack of response to deterioration***

***Falls***

***Venous thromboembolism (VTE)***

***Risks of handover in care***

### What are the major safety concerns in Emergency Departments?

Emergency Departments are often described as VUCA environments: volatile, uncertain, complex and ambiguous. Hospitals are 'Complex Adaptive Systems', hampering effectiveness of interventions aimed at change. This serves to accentuate the conditions for safety to be compromised. **Crowding** can exacerbate the risks to safety.

All the above areas are therefore major safety concerns within Emergency Departments. However, *prescribing, procedural safety, VTE prevention, infection control, and falls prevention*, are usually managed by hospital-wide systems, so compliance and adaptation to the ED (for example VTE for limb immobilisation as well as Observation Unit, falls prevention in discharged patients) are the main issues. *Late identification of illness, missed diagnosis, and handover safety* are areas where high risk in Emergency departments exists.

There are a number of safety areas that are, while not unique to EDs, are certainly more prevalent with a higher risk in ED, these include:

Absconding of patients, especially those with concerns about capacity

Screening for (and managing) social concerns (e.g. trafficking, safeguarding, homelessness)

Drug and alcohol misuse

The effect of the ED environment on human factors (e.g. frequent changes of personnel, crowding, time pressures)

Issues related to follow up and review of patients

Certain patient groups have unique requirements:

Frequent attendees

Those in custody

Patients with frailty

Patients with mental health problems

Patients with cognitive impairment

## The Royal College and Safety

The Royal College has training and education functions- safety is a key element to these. This includes the curriculum for specialty training which has safety as a core element, as do educational activities delivered by the College.

Additionally, the College has advisory functions, both generic advice on safety (see next section) and bespoke advice available to individual departments (such as Service Reviews).

Specific safety activity undertaken the College includes:

### **Audit/National Quality Improvement Projects**

Since 2003, RCEM have devised and run a national audit programme for Emergency Departments; specific to EDs there were three audits topics each year. The reports are available on the RCEM website where the audit tools remain available for use by EDs.

In 2019, the process was changed to a Quality Improvement Methodology, supported by on-line tools to produce 'real time' data and control charts to enable EDs to undertake bespoke, individual QI projects within a national framework. Reports are available on the website. For 2020, the Quality Improvement and Audit subcommittee will refine the process and run three further National QI programmes. In the light of events in early 2020, this will include work on Infection Protection and Control (IPC).

### **Standards and guidelines**

Standards: In addition to the standards inherent in the audit/NQIP programme, and other national clinical audit standards that involve Emergency Departments (e.g. fractured neck of femur, myocardial infarction and stroke national audits), RCEM have in the past set clinical standards. There are available on the RCEM website. However, in general, relevant national standards (e.g. NICE, SIGN etc) should be followed with specific conditions or presentation. RCEM sets standards for practice in Emergency Departments and takes into account relevant national guidance (e.g. NICE, SIGN etc) as well as other expert opinion relevant to the ED setting. RCEM also issues Position Statements to clarify complex or contentious areas of practice.

Guidelines: The Best Practice Sub-committee publishes guidelines where definite evidence is not available (or is contentious or is considered to be an area of considerable concern to members / fellows), such as on pain management, investigation results management, patient advice, management of drug misuse, the alcohol toolkit, those in custody, frequent attenders etc.

### **Learning from other organisations**

RCEM has a key role in collating, reviewing and dissemination of learning from other bodies with the National Health Service; such as HealthCare Safety Investigation Board (HSIB), Coronial inquests, National Reporting and Learning Service etc. Recent and ongoing examples include working with RC of Radiology on diagnosis of Aortic Dissection (HSIB), updating antidote availability in ED advice, and investigation and follow up advice (both from Coronial inquests).

### **Providing advice and guidance to departments and clinicians through:**

#### **Safety toolkit**

This document has been produced by RCEM as a pragmatic, operational guide to improving safety in Emergency Departments.

#### **Safer Care section of RCEM Website**

This provides additional guidance and advice, expanding on the toolkit, and including safety flashes from RCEM and other organisations.

#### **Safety flashes**

These are produced monthly by the Safer Care committee, often linked to learning from other organisations, as above.

## Emergency Departments and Safety

**What departments can do to improve safety:** (See Safety toolkit for detail)

### **Develop a Safety Culture**

Establish a 'safety culture'; one that is open and encourages reporting of concerns. Measurement of the culture of safety in an ED is a good first step; RCEM have commissioned work in this area.

### **Ensure training in place for all**

Key areas of training are around human factors and non-technical skills, and mitigation of the risks. Using multidisciplinary simulation including low-fidelity in-vivo can highlight safety issues. There are specific safety skills (e.g. Root cause analysis) required for leaders and investigators, which require training.

### **Develop robust safety structures and processes**

Incident report, complaints, excellence, and error reports (both internal and external) should be used for learning (i.e. analysis and implementation of change), and this process visible to all. There should be an active, useful risk register driving this.

There should be routine audit and monitoring of issues.

### **Ensure good design of departments and processes**

Departmental design can help with safety (c.f. QI methodology such as 5S, 6Sigma). The processes within a department should enhance safety ('the right thing to do should be the easiest thing to do').

### **Areas of high value**

Developing a safety culture: Measure safety, governance meetings, safety huddles, encourage report/visible system of reporting

Procedural safety: use of checklist for invasive procedures (see RCEM IP checklist), RSI etc

Handovers; standardise and document all handovers (departmental, individual, between departments)

Regular in-vivo simulation

Robust (and rapid) results handling processes (including confirming 'afferent loop')

Visible, consistent and effective supervision and induction

Processes for embedding learning from incidents, complaints, mortality reviews

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## **Review**

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

## **Conflicts of Interest**

None

## **Disclaimers**

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

## **Research Recommendations**

Research into the effectiveness of safety intervention is suggested

## **Audit standards**

None

## **Key words for search**

Safety, Emergency Department



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