



# The Royal College of Emergency Medicine

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## QUALITY IN EMERGENCY CARE COMMITTEE STANDARD

### Consultant Sign-Off (June 2016)

#### Introduction

Over the past 40 years the Emergency Department (ED) has become the "front door" of the acute hospital, responsible for the management of 14 million patients every year in England alone. Some of the sickest patients in the hospital will be found in the ED, and the level of clinical risk is very high because ED clinicians are required to make critical decisions under conditions of considerable uncertainty with limited information, limited resources and limited time. Published research indicates that consultant-delivered care reduces waiting times and length of stay, improves clinical outcomes and ensures that patients are only admitted to hospital if there is no reasonable alternative (Wyatt et al, 1999; Thornton & Hazell, 2008; Geelhoed et al, 2008; White et al, 2010). A review of national incident reporting systems in England has informed this.

The ED is an excellent training area for junior doctors, because they are required to see a large number of acutely ill and injured patients and make important clinical decisions. This provides effective training, but it also has the effect of matching very inexperienced staff with very sick patients, creating high levels of clinical risk. In addition, nurse practitioners increasingly work within EDs, as do professional groups not fully trained in EM (e.g. General Practitioners). In response, EM consultants have put in place systems to support their teams and manage risk. However, very few EDs have enough Consultant Emergency Physicians to deliver a consistent 24/7 presence. Despite this there is an increasing expectation that care will be delivered and supervised by fully-trained consultant medical staff.

RCEM advocates progressive EM consultant expansion in order to improve the quality and timeliness of care, and enhance the support provided to junior doctors and other practitioners working within the ED. RCEM believes that it is now appropriate to specify particular high-risk patient groups who should be reviewed by a consultant in EM before they are discharged from the ED. This is an initial step towards RCEM's longer-term aim that an EM consultant be involved in the care of every ED patient.

#### The Standard

The following patient groups should be reviewed by a consultant in EM prior to discharge (i.e. discharge home or to their usual place of residence) from the ED. If, due to insufficient numbers of consultant staff, an EM consultant is not immediately available on the "shop floor" of the ED, then review may be carried out by a senior trainee in EM (ST4 or above), or by a staff grade or similar substantive career grade doctor with sufficient ED experience to be designated to undertake this role by the EM consultant medical staff.

Review by a senior trainee or similarly experienced doctor is considered an interim measure pending a move towards extended EM consultant shop floor presence. EDs are encouraged to work towards this standard in association with their employing Trust.

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## The Patient Groups

- Atraumatic chest pain in patients aged 30 years and over
- Fever in children under 1 year of age
- Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge
- Abdominal pain in patients aged 70 years and over

There are many other presentations that carry important risk (e.g. headache), and individual departments may wish to add these and other conditions locally when staffing allows.

Junior doctors should have formulated a clear diagnosis or differential diagnosis and documented their proposed action plan prior to seeking EM consultant sign-off. The consultant review should be recorded in the patient's clinical notes, and should normally include the patient being seen and reviewed in person by the EM consultant. If the consultant is unable to make a contemporaneous note in the patient's ED record they should countersign the notes at the next opportunity, making a record of the date and time that this occurs.

## Further Comment

These patient groups have been selected on the basis that they are important ED presentations with a risk of life-threatening disease that may not be immediately appreciated by less experienced staff.

It is accepted that some EDs, particularly those with lower numbers of EM consultants, will find it challenging to adopt this standard. However its purpose is to promote improved risk management by reducing the possibility of catastrophic clinical error, whilst at the same time supporting the case for an expansion in EM consultant numbers. Where it is not feasible to immediately implement this standard RCEM recommends that EDs have in place a plan to both address the clinical risk and work towards achievement of the standard, through an increase in EM consultant numbers.

Feedback on this standard and its implications is welcomed by RCEM, and it will be formally reviewed during 2020. The standard forms the basis of a national clinical audit, which is reauditing in 2016/17.

## References

1. Geelhoed GC, Geelhoed EA. Positive impact of increased number of emergency consultants. *Arch Dis Child* 2008;93:62-64.
2. Thornton V, Hazell W. Junior doctor strike model of care: Reduced access block and predominant Fellow of the Australasian College for Emergency Medicine staffing improve emergency department performance. *Emergency Medicine Australasia* 2008;20:425-30.
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4. Wyatt JP, Henry J, Beard D. The association between seniority of Accident and Emergency doctor and outcome following trauma. *Injury* 1999;30(3):165-168.

*Revised standard prepared by Adrian Boyle, on behalf of the Quality in Emergency Care Committee, June 2016.*

*Original standard prepared by Jonathan Benger, on behalf of the Clinical Effectiveness Committee, December 2010*