Care Quality Commission
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Via email

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Dear Chief Executive

Safety and quality of emergency care

When services are under pressure, CQC's priority is to ensure that people using services remain safe. We want to ensure that our monitoring and inspections are helpful to trusts. While we accept it may be necessary to take action where we see unsafe care, this letter highlights some of the positive action which a number of trusts are successfully taking.

In order to understand and identify good practice, we recently brought together 34 senior clinicians and nursing staff from 16 trusts that have a good or outstanding rating for their urgent and emergency care services. Key areas where patients could be at risk were identified and the advice from these clinical staff from successful departments will help us define our approach in the future.

We recognise rising demand pressures are not simply related to the winter period and are an issue for the whole hospital and local health economy, not just the emergency department.

In the near future we will publish detailed outcomes from the event, with examples of what has worked well for some trusts so that others can learn from and adapt to their own circumstances. We will share these with you and your clinical teams. In the meantime we thought it was important to share with you the following key themes that emerged from this work.

Ambulance arrivals

Any patient physically on the hospital site should be regarded as under the care of the emergency department and should be booked into the department without delay; the clock should start ticking at that point. Patients should not wait in ambulances and should not be delayed being booked into the department, as there should be no 'two tier' system whereby patients who arrive independently are booked in on arrival.

First clinical assessment

Patients needing urgent care should be consistently identified in a timely way. First clinical assessment of all patients attending the emergency department should again be undertaken without delay and should give the department confidence that they know whether each patient has a serious problem or not.

Use of inappropriate physical spaces

Patients should receive safe and effective care in an environment that allows for their privacy and dignity to be protected. This means for example, that they are always in sight of clinical staff, and that there are sufficient numbers of clinical staff in that area to care for them. We do not endorse the use of inappropriate areas, such as a corridor, for patient care. Where a department does use such an area, there should be a plan to address this, so that the practice does not become routine. Our view on the use of inappropriate areas extends to other areas of the hospital.

Specialist referrals

There should be no undue delay to patients being seen by the appropriate specialist team once they have been referred. Once referred, the patient should remain under the specialist team's care and should not be referred back to the emergency department. It is not acceptable for patients to be held for prolonged periods in the emergency department waiting for specialist assessment.

Escalation

There should be a consistent and effective trust-wide escalation process that enables an adequate and safe response to unexpected surges in demand. It is the responsibility of trusts as a whole, and potentially the wider health system, to deal with these surges, not just the emergency department.

Deteriorating patients

Emergency departments need a consistent, effective and audited system for identifying patients whose condition is deteriorating. This may be by means of early warning scores, a safety checklist – which have been found to be effective in some trusts – or by another method suited to local circumstances.

Patient outcomes

Information about effectiveness of people's care and treatment should be routinely collected, monitored, and used to drive quality improvement. Trusts should consider incorporating the Royal College of Emergency Medicine and other relevant clinical standards into their patient outcome monitoring systems.

Staff

Effective and consistent clinical leadership is essential for both patient safety and staff well-being. Staff are working under great pressure in most emergency departments and poor leadership and culture can add to the difficulties they face. Emergency departments with good and empathic leadership that recognises the importance of staff well-being will be better able to meet the workforce challenges that exist throughout the system.

For many acute trusts their greatest risks to patient safety are likely to be in their emergency departments. These risks will be increased when the department is working under pressure. It is essential that trust boards are aware of the safety of their emergency departments. It is important that boards recognise that solutions related to safety incidents lie in ensuring the whole hospital has an effective response to pressures within emergency departments.

The issues we have outlined here are those identified as most important to clinicians from good and outstanding departments. When we inspect emergency departments we will assess their performance in line with our published assessment framework; however, recognising the pressures that services are facing, we will focus on key elements of safety which we have outlined above. The core service framework for the inspection of urgent and emergency care services can be found on our website. Trust boards should review their own processes and policies to ensure the safety of their emergency departments including all the key areas outlined above.

Yours sincerely

Professor Ted Baker
Chief Inspector of Hospitals