In 2009, the Emergency Services Review was commissioned by the 10 strategic health authorities to undertake a review of performance and support the identification and adoption of best practice in the area of emergency care.

The Emergency Care Intensive Support Team (ECIST) established by the review, supported the implementation of this best practice by hosting events and supporting organisations.

Our Trust’s response
During Patient Safety Week last September, about 75 doctors, matrons, service managers and other clinical staff directly involved in the care of acutely sick patients, took part in a workshop at the Trust, led by ECIST.

At the end of the workshop the group developed an initial set of challenging goals centred around:
- strengthening the senior review of patients at all stages of the process
- agreeing a core set of response standards for the whole of the emergency pathway
- ensuring that the estimated date of discharge (EDD) with clinical criteria are clear, set on admission
- proactive morning discharge planning to support bed capacity that meets demand.

An implementation team was established and this newsletter will share news and progress of how we are improving the emergency care we provide to patients.

From the Chief Exec

Emergency patients make up two-thirds of hospital admissions and about 90% of our inpatient deaths, so having a safe and efficient emergency care pathway is very important.

The Emergency Care Intensive Support Team (ECIST) visits over the summer (see left) were very informative, finding some of our work “best in class” – our discharge planning with the community, for instance – but also finding areas requiring very significant improvements.

We have already started to make changes, as can be seen over the next three pages.

Providing emergency care at our best is very important, not only to me, but to the Executive Team and the Board of Directors, hence the title of this project. Dr Sean MacDonnell is the main lead, with support from the four clinical leads – see back page – and the project has a very high priority.

I would like to thank everyone involved for their commitment to further improve the quality of care that we provide.

I look forward to seeing you support these really important changes to how some of our very sickest and most vulnerable patients are treated.

Dr Gordon Coutts, Chief Executive
Showcasing good practice

Rapid Assessment and Treatment (RAT)

The introduction of a senior staff-led Rapid Assessment and Treatment (RAT) has been shown to reduce waiting times in the Emergency Department (A&E) and increase the opportunity to detect serious disorders at an early stage. It also improves patient satisfaction, avoids unnecessary hospital admissions and, from a patient safety perspective, prevents inappropriate discharges by junior doctors.

Initial assessment is a full set of observations – EPAR score (Emergency Patient at Risk), pain score and a brief history/mechanism of injury and presenting complaint – within 15 minutes of arrival of all ambulance patients. The nurse’s initial assessment is completed on all patients as they arrive on the ambulance trolley. Patients are then transferred to the rapid assessment and treatment bay. The target is for all patients to be seen by either a consultant or staff grade within 60 minutes of arrival or sooner, depending on the findings of the initial assessment.

The introduction of RAT at our Trust started last April with a working group to implement the change of practice. Now a weekly meeting takes place to evaluate data and implement service and changes to process as required. RAT ensures a plan is in place for the patient within 60 minutes of arrival and uses senior clinicians to assess and implement a prompt plan of care for all patients. The plan is then implemented, including any diagnostic requests, prescription of urgent medications and decision to refer to speciality for admission.

Analysis of our data shows the number of patients being seen within 60 minutes is more than 25% above the national standard target. There has been a significant positive impact on the quality of care, as the patient is assessed by the right healthcare professional, at the right time, in the right environment. There is a prompt referral to speciality teams including medicine, psychiatry, surgery and any other services required.

RAT has also improved the patient experience by reducing the anxiety for patients and relatives through quicker management of the patient’s acute condition. This is evidenced through patient experience feedback, plaudits and face to face interviews.

See also graph, below right.

Dr Abdul Abbas, Consultant Emergency Medicine and Helen Krysinski, Matron Emergency Department

Whiteboards promote discharge planning

Layer Marney is a 41-bed ward specialising in respiratory medicine. During the ECIST visit to the Trust – page 1 – the ward’s use of a whiteboard was highlighted as one of the Trust’s areas of best practice.

Rachel Lee has been Layer Marney ward sister for just over a year and writes: “I was delighted to hear that our whiteboard was mentioned in the ECIST visit as being comprehensive and clear in terms of which patients were ready for discharge, and what

Consultants’ presence lasts longer

In July, consultants in the Emergency Department (A&E) changed their rotas to include consultant presence until midnight, seven days a week. This, along with other changes, is showing impressive reductions in the waiting and treatment times.

From 5 December, there has been a consultant presence in Emergency Assessment Unit (EAU) until 10pm every day. Dr Peter Hawkins (pictured) is leading this important initiative and will himself work in EAU for the duration of the six month pilot.

With the earlier integration of the Short Stay ward into EAU it is anticipated this will further improve the care of emergency patients. Our surgical team is also extending their presence at night and weekends.

From the Medical Director

I have found it difficult to understand why our Trust’s Hospital Standard Mortality Ratio (HSMR) has been high and why our patient experience survey has not been as good as other trusts. The staff I work with are hugely committed and caring and as most of us live locally it is often our friends and families that we are treating. Individually, patients get excellent care.

What the Emergency Care Intensive Support Team (ECIST) – page 1 – identified is that our problem appears to be that we are not consistent in delivering the care that we can when we are “at our best”.

“This is not just about EAU and the Emergency Department (A&E)”

We need to improve the organisation’s process for treating emergency patients.

When people come to hospital as an emergency, they are uniquely vulnerable and deserve prompt, safe and effective care, every time. This is not just about Emergency Assessment Unit (EAU) and the Emergency Department (A&E). If patients are getting the right treatment at the right time on the ward there will be fewer delays and their whole experience will improve. As a consequence there will be less pressure on the frontline areas, fewer outliers on the wards, a daily review by a senior clinician, and everyone, including the patient, clear about the treatment and discharge plan. A less stressful environment for all.

Emergency Care At Our Best is a large project and is likely to affect all staff groups at some stage. It can be difficult to get information to all staff, hence this newsletter.

Dr Sean MacDonnell, Medical Director
stage other patients were at in their pathway. The status at a glance boards by the ward control had already been set up as part of the Productive Ward roll out. The daily board rounds have really evolved from there. Every patient is reviewed at 9.00am by key members of the medical, nursing, pharmacy and therapy teams. It is consultant-led and is an ideal way to identify problems and delays to the patients care pathway.

“The layout of the board has evolved from just having the basic patient details to now having a number of key points covering discharge planning and patient safety information such as VTE and nutritional assessment.

“The board round is attended by myself with support from all the nurses. It has had a number of benefits including sick patients being prioritised and reviewed, social care issues being picked up early, timely physiotherapy referrals and the patient’s plans are up-to-date.

“It has also helped the site team at a glance with bed management and most importantly the length of a patients stay has gone down.

“...and as anyone involved signing up to its benefits and is now a key part of the ward’s routine.

“As with anything there is always room to improve and I am keen to push for the columns of the Estimated Date of Discharge (EDD) and the TTO ordering of all patients to be fully completed as early in their pathway as possible.”

Rachel Lee, Ward Sister, Layer Marney

Changes to the Hospital at Night medical handover

Handover is a high-risk activity for doctors, where it is crucial that there are fail-safes to ensure that problems are always identified.

Dr William Thomas writes: “Since autumn 2011, junior doctors, along with consultant gastroenterologist Dr Ian Gooding and Dr David Gannon, Consultant Acute Physician (Diabetologist), have been leading the development of a new night-time medical handover at Colchester General Hospital.

“The old-style meeting was replaced to try and improve patient safety, staff education and communication among the night medical staff. It was felt the old-style meeting needed modernising and revitalising whilst building on the positive aspects we already knew existed.

“The new meeting brings together doctors, nurses, outreach staff and night technicians and has a set agenda and format, giving structure and an opportunity for all members of the staff to contribute. This has led to the new handover and a forum where registrars will be able to discuss handover and other issues on a two-monthly basis.”

The new system has allowed sick patients to be handed over safely and also stop acutely unwell patients slipping through the net.

It brings the Trust up-to-date with the latest guidance from the Royal College of Physicians. In future, it may well be enhanced by consultant presence at the meeting on a nightly basis.

“The meeting takes place in the handover room by Trust Offices in the Main Block at Colchester General Hospital and has the feel of a boardroom-type meeting,” said Dr Thomas. “One medical registrar said that Colchester had a much better handover system than other hospitals they’d worked at and liked the teamwork from the multidisciplinary team that attend.”

It is hoped that after an audit of our practice and feedback from staff, the Trust can present the meeting as a way of improving patient safety in hospitals at night.

Dr William Thomas, CMT2 doctor

How are we doing?

Rapid Assessment and Treatment

The graph shows the 95th percentile of times from arrival at A&E to full initial assessment for patients brought in by emergency ambulance (i.e. the time below which 95% of attendances within the month were assessed).

Target: <= 15 mins

It shows how the introduction of the Rapid Assessment and Treatment (RAT) – see above left – has seen a sharp decrease in the assessment waiting time.

Source: Qlikview
For the last year, as part of the Trust’s work on patient safety, a group of senior clinicians and executive directors have been holding weekly mortality reviews on a Friday at 7.30am. The group – which includes the chief executive – along with multidisciplinary team members, review a 10 per cent random selection of patients who have died in our hospitals. Consultants, ward sisters and matrons tell the group about individual patients and their journey through the Trust. The meetings are positive and challenging, teaching us much about the systems we operate. A more strategic overview of mortality data is taken by the mortality review group, which looks reviews our data and uses this to drive improvement in our care.

This work has helped us understand the impact our emergency care processes have on our patients. We have seen examples of excellent care and have also seen problems. We have drawn attention to these issues in grand rounds, by written updates to staff and through the introduction of the SBAR communication tool – see above right.

The mortality review group and patient safety committees recognised that the Trust needed to focus on reforming the emergency process to improve our care. Research data supports this approach: delays to admission have been shown to be independently adversely related to mortality outcome.

Through these groups, we invited the Emergency Care Intensive Support Team (ECIST) to visit – page 1 – and help us improve the emergency pathway. The team visited us several times over the summer and many of you came to the meeting in September when we committed to transforming the emergency pathway. This is a major piece of work and will deliver lasting improvement if we get it right. ECIST are continuing to support us to help us deliver emergency care, at our best.

Dr Gillian Urwin (pictured)
Associate Medical Director Patient Safety

About the ECRIT
The aim of the ECRIT is to promote efficient, safe effective care every time for patients from the Emergency Department, through assessment areas and wards, to the point of discharge or transfer to another unit. The project is therefore not just focused on the Emergency Department – it covers the whole hospital. The project is being supported by a number of clinician-led groups, each focusing on an area of the emergency care pathway. Their aim is to develop models of care that ensure all our emergency patients get the right care, at the right time, wherever they are.

Over the coming months we will showcase work already in progress and changes being carried out by the four ECRIT groups.

What do you think? Let us know!

For more information about the project, please contact:
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