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RCEM Position Statement on Clinically Ready to Proceed Metric

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Scope and reason for development

The concept of Clinically Ready to Proceed has been proposed as a metric in the Clinical Review of Standards. RCEM is cautiously supportive of this metric and we have identified the need to standardise the definition. This position statement is intended to provide useful information for managers and senior clinicians who are implementing the revised metrics in the Clinical Review of Standards in England.

Intent

The metric Clinically Ready to Proceed is part of a number of standards that identify problems in patient flow that result in Emergency Department (ED) crowding. This particular metric should provide useful information about the interface between the ED and areas of the hospital that provide further care. This is a clinical standard, and as such, must be recorded by a clinician, though this can be delegated.

Operational Definition

NHS England has defined this in the data dictionary as:

"*An Emergency Care Clinically Ready to Proceed Timestamp is the first date and time that the care professional, authorised to discharge the patient from the Emergency Care Department, makes a clinical decision that the patient no longer requires ongoing care in the Emergency Care Department*."

The patient can be declared ready to proceed if they are being: admitted or transferred to another department or clinical service area outside the ED, transferred to another health care provider for continuation of care, discharged from the ED. The time from this time stamp to eventual leaving the ED should be less than 60 minutes. Although this is recorded for all patients, included discharged patients, it should only be externally reported for patients who are being admitted to an inpatient bed.

Clinical considerations

This must be owned by Emergency Medicine clinical staff, as they are usually best placed to decide that a patient has had appropriate care. It is difficult to cover all scenarios, but appropriate care would include:

1. Adequate analgesia for severe and moderate pain.
2. Time critical treatments, such as antibiotics for sepsis.

3. Treatments that should best be performed before the patient leaves the ED, such as urgent joint reduction, plastering and wound care.
4. Investigations that are likely to change urgent treatment or disposition.
5. Identification of the most appropriate responsible inpatient specialty.

The following actions should not be considered reasons to delay recording of Clinically Ready to Proceed.

1. Inpatient specialty clerking.
2. Bed availability.
3. Waiting for agreement between two specialties about responsibility for ongoing care.
4. Waiting for investigation results that don't influence urgent treatment or disposition.