The Royal College of Emergency Medicine

The RCEM Ambulatory Emergency Care toolkit

Delivering same day emergency care from the ED

NHS Ambulatory Emergency Care Network

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Contents

Foreword

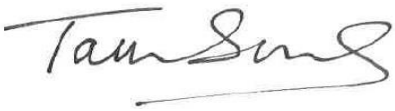
Ambulatory emergency care (AEC) activity or Same Day Emergency Care (SDEC) has been clearly demonstrated to improve flow across the acute healthcare system. It is a process that can and should be initiated at every acute interface where patients attend hospital. It requires senior decision making supported by multi-disciplinary staff, with rapid access to diagnostics and clear end point goals. Underpinning this is a focused culture of patient safety.

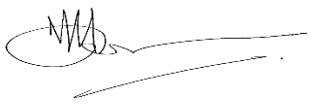
Adoption of ambulatory care strategies improves flow throughout the whole acute healthcare system and patients benefit both directly and indirectly. In order for Emergency Departments (ED) to function effectively there must be adequate outflow from the ED[1,2], this enables departments to function more effectively , leading to a reduction in morbidity and mortality as a result of ED crowding.

Emergency physicians are well placed to be at the forefront of delivering ambulatory care. They possess the correct knowledge, reasoning skills, training and judgement to manage this cohort of patients within the ED, or if more time is required in an additional short stay clinical area such as a clinical decision unit.

Importantly, we need to consider the complexity of the acute care delivery system. By reducing variation of practice and working collaboratively with colleagues in General practice, Acute Medicine, Elderly Medicine, Acute Surgery and other key specialties we can produce robust and effective clinical care pathways. It must be recognised that delivery of effective ambulatory emergency care also depends on rapid access to diagnostics and that radiology and pathology services are key specialties in enabling efficiency and effectiveness.

This toolkit has been written primarily for the Emergency Physician aiming to develop ambulatory care from the ED. It requires strong clinical leadership, regular access to senior decision makers, a clear focus on multidisciplinary team development and close collaborative working with all relevant specialty colleagues.





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Definition

Ambulatory emergency care is acute clinical care which includes investigation, treatment and rehabilitation of patients for whom, in the absence of an ambulatory emergency care service, admission to hospital would have been the default option. The requirement for and the impact of Same Day Emergency Care (SDEC) on acute care delivery has been outlined in the Long Term Plan for the NHS in England [3] .

For the purpose of this document the terms SDEC and ambulatory emergency care (AEC) are interchangeable and refer to patients presenting to hospital with ambulatory care sensitive conditions as outlined in the Directory of Ambulatory Emergency Care for Adults V6 2018 [4].

The ambulatory emergency care environment can include:

- Emergency Department (ED) based observation units
- Ambulatory emergency care units
- Frailty units
- Surgical Assessment Units
- Emergency Gynaecology Units.

In most hospitals delivery of ambulatory emergency care is an evolving process. As such it is not always reasonably practicable to have all of the ambulatory emergency care activity cohorted in one unit, due to space and access constraints amongst other reasons. In these situations it important that trusts code and record the ambulatory emergency care activity appropriately so that this activity can be recognised. This includes activity that is performed on ED clinical decision units or observation wards where some emergency patients who have ambulatory care sensitive conditions are commonly managed [5,6,7].

Scope

The scope of this document is to provide an overview of how Emergency Departments can engage with ambulatory emergency care activity, and to outline the principles of ambulatory emergency care in an ED setting.

This document does not cover how to set up an ambulatory emergency care unit or commissioning guidance. An operational handbook and commissioning guidance may be obtained via the Ambulatory Emergency Care Network.

Emergency physicians are skilled and experienced in decision making, rapid diagnosis, treatment and managing risk. This is directly aligned with the underlying concepts of ambulatory emergency care.

Same day emergency care can be successfully achieved by:

- Streamlining access to diagnostic services
- Reorganising working patterns of clinical teams to provide early senior decision making and rapid treatment
- Collaborative working with support services in the community to provide robust safety net systems and optimise integrated care
- Providing an environment that supports same day emergency care, such as the observation ward/ clinical decision unit (CDU)/ ambulatory emergency care (AEC) and early identification of suitable patients.

Many acute hospitals now have some form of ambulatory emergency care service in place. Emergency Departments should be able to refer patients to the ambulatory emergency care unit from the front door, at the point of streaming or triage as a bare minimum. Emergency physicians may wish to work alongside acute medical, surgical and other specialty colleagues in the ambulatory emergency care unit to enable development of a multi-professional clinical model to facilitate streamlined emergency care.

Principles of facilitating AEC from the ED

1. A clear process for **identifying patients suitable for transfer to the ambulatory care unit** is needed at the time of triage or streaming.

2. Emergency physicians must **work closely with specialist colleagues** to agree the case mix suitable for referral to the AECU

3. **Early streaming** to the AECU is needed within the patient journey to avoid delays

4. The **AEC environment** selected should be appropriate to meet the patients clinical need

5. All staff must be clear about the types of **patients that should NOT be streamed to the AECU**

6. A clear clinical plan as part of **a comprehensive record** must be in place to enable same day discharge, including a discharge summary sent to primary care within 24 hours.

7. **Patient information** should be available early in their journey, explaining that they are likely to receive treatment that day and not be admitted overnight. This is to manage expectations of the patient and their families.

8. **Secondary and primary care services** should be geared around patient needs and work together to provide ongoing care outside of hospital to avoid readmission

9. **Clear measures** must be adopted and monitored to assess the impact, quality and efficiency of AEC.

10. Providers must work with commissioners to agree how **AEC activity** will be recorded, reported and funded.

1. Identifying patients for AEC

Patient identification early in their journey e.g. from streaming is a key step to ensure that those most likely to benefit will be able to access same day emergency care rather than overnight admission to hospital.

Patient identification could be based on clinical suitability which can be established by using a decision tool supported by a clinical discussion. An example of a useful decision tool is the Glasgow Admission Prediction Score (GAPS)[8].

A list of ambulatory emergency care sensitive conditions may be found in the Directory of Ambulatory Emergency Care for Adults V6. This directory is not exhaustive but is useful for guidance.

2. Work closely with specialist colleagues

There are a number of clinical presentations that can be appropriately managed by ED and specialty teams within one day. There must be clarity in the allocation of these patient groups so that the response to their needs is consistent and efficient within the acute care system. Double running of ambulatory management of the same patient group in both the ED and other ambulatory areas should be avoided as this is likely to lead to unhelpful variation and waste.

Situations may arise where the same clinical condition is being treated in the ED and the AECU due to geographical or personnel constraints. In order to ensure consistency of care, local protocols should be developed. When deciding which patient groups should be allocated to which service, consideration should be given to the resources available and the effect on emergency flow.

EDs should avoid attracting additional activity to be delivered within the ED that distracts from the delivery of core ED work within the time standard. Internal professional standards should be in place to ensure a specialty response that does not disadvantage patients who are streamed from the ED to the AECU.

3. Patient Streaming

Patients who are suitable for ambulatory care may be identified at streaming or ED triage. The most appropriate ambulatory emergency service to meet the patients' needs should be selected. This can be either the ED observation unit, AEC service or other specialty ambulatory service that has the environment, staffing and equipment that are appropriate for the patient. This process should not delay patient care.

Examples of presentations that could be considered for streaming directly from ED to the AECU include:

- Low risk chest pain
- Cellulitis
- Suspected DVT
- Suspected Pyelonephritis
- Suspected pulmonary embolism

In a significant proportion of cases, patients will have their pathway initiated in the ED and then continued on an AECU or equivalent ED observation ward.
Local service agreement and collaboration are key to help decide which groups of patients are best managed in an ED observation ward, an acute medical unit or a surgical assessment area. The key feature should be to maximise the culture of delivering same day emergency care.

A significant proportion of the conditions described in the directory of ambulatory emergency care may be managed on an ED observation ward (see table 1) especially if that unit is open for extended hours or 24/7.

4. AEC environment

The practice of observational medicine is well embedded into Emergency Medicine practice. Most Emergency Departments have an observation ward attached to them. This setting is ideal to deliver some ambulatory care activity. Location of an area providing ambulatory emergency care activity close to an ED or AMU is recognised as improving the patient flow by up to 50%.

This space, unless purpose built is not usually designed as an inpatient facility and, as such is an ideal environment for ambulatory care to occur.

- To avoid the space being used as an inpatient facility the following tips can be considered: Ensure any space designated as a chair or trolley space is smaller than that required for a bed, use partial partitions, not curtains and remove curtain tracking.

- Decorate (or redecorate) the area in the style of a clinic, not a ward (for example look at Dialysis or Macmillan Units). Create a clear external unit entrance, clearly signposted avoiding any connecting thoroughfares to/from wards and wherever possible, corridors through which beds are transported

- It is recognised that each individual site is different in design and that the space needs to be designed according to local requirements.

Patients who require admission from the AECU should not return to the ED to wait for an inpatient bed to become available. Clear pathways should be developed within each unit to ensure that patients are not rebooked into ED when the AECU or the hospital is at full capacity.

Examples of ambulatory care activity that may occur on a CDU include the following:

Group	Clinical Condition
Diagnostic exclusion group	Chest pain DVT Ureteric colic Subarachnoid haemorrhage
Low risk stratification group	Upper GI bleed Pneumonia TIA Pulmonary Embolism

Group	Clinical Condition
Specific procedure group	Urinary retention Urethral Catheter related problems Suprapubic catheter problems Pneumothorax Acutely hot painful joint
Infrastructure required group e.g. therapies input, community interface	Frailty New onset diabetes Appendicular fractures not requiring immediate internal fixation Non traumatic vertebral fractures Low risk pubic rami fractures Hip pain secondary to a fall with no fracture
Short Term observation or therapy group	Overdose and poisoning Acute asthma Supraventricular Tachycardia First seizure Seizure in known epileptic Gastroenteritis Hypoglycaemia Acute abdominal pain not requiring immediate operative intervention Head injury Electrolyte disturbance Low Risk AKI

Table 1: Example ambulatory activity on CDUs

In trusts where some ambulatory emergency care activity is being managed on the observation ward, it is preferable not to replicate this in other areas of the same hospital. Conversations with clinical colleagues in other specialties and development of pathways with key stakeholders are important to enable this to happen.

Many units use advanced care practitioners who manage patients independently in the ambulatory emergency care unit. The Royal College of Emergency Medicine has developed a robust curriculum for the development of ACP's.

5. Patients that should NOT be streamed to AEC

It is important to ensure the correct patient cohort is referred to AEC. Management of patients who require admission in the ambulatory care unit results in poor patient experience and will block capacity and deny access to the service for patients who would most benefit from same day services.

The following groups should **NOT** be managed in an AEC service;

- Type 2 and Type 3 ED attenders (Minors). These patients should continue to receive their care in ED within the 4-hour standard.
- Type 1 ED patients who will breach the 4-hour standard but whose clinical care can be completed in the ED, or are awaiting ward admission.
- Clinically unstable patients.

In addition, the AEC unit is not a discharge lounge or an 'overflow' unit for other services. Sending the patients to AEC if this is not the most appropriate place for them to receive care will have a negative impact on the system. With this in mind, robust gatekeeping processes are needed to ensure that the right patients are streamed to the service.

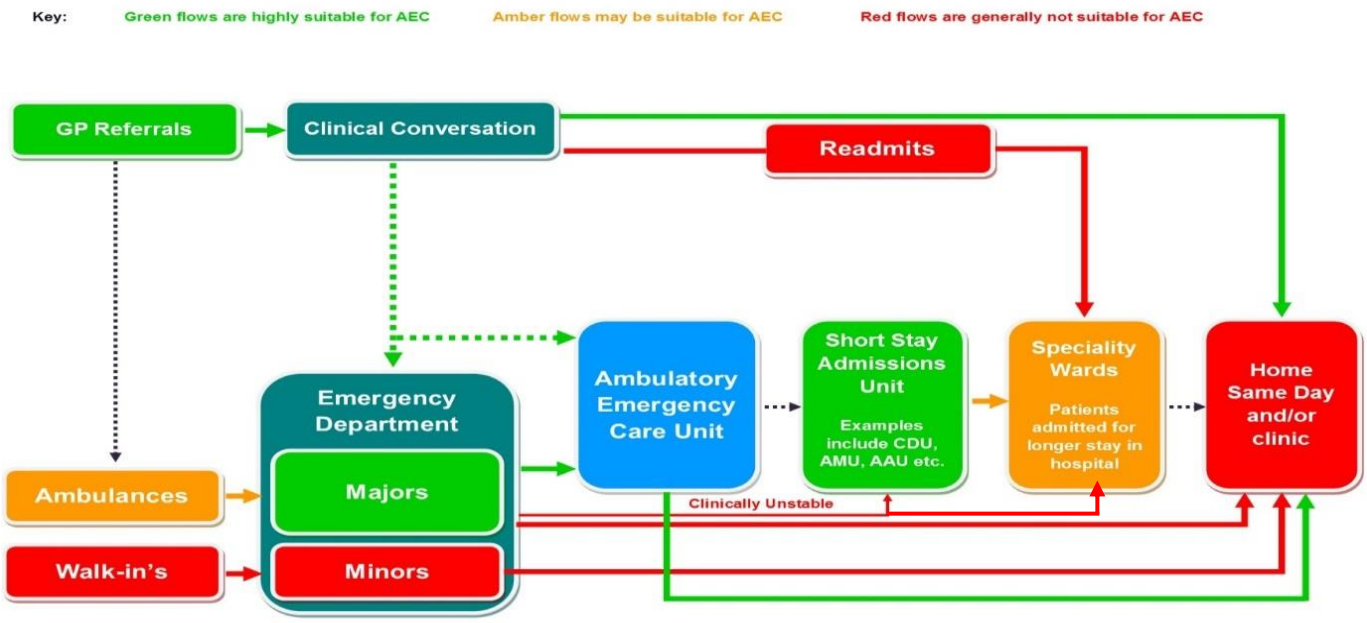

Figure 1: Patient Flow Dependencies

6. A comprehensive record must be in place

The clinical record of AEC encounters should be holistic but focussed and shared between the multidisciplinary team as a single source. Included within this should be a stratified problem list, a clear rationale for the use of AEC as the treatment modality vs admission or community care, and a plan for the care to be carried out during the index encounter as well as follow up. Wherever possible specific clinical and social capability milestones for discharge should be recorded and members of the multidisciplinary team empowered to respond to these to avoid delays, these milestones should also be communicated and agreed with the patient.

Where AEC is not deemed appropriate or becomes inappropriate during the patient journey, the reasons for this should be recorded to enable audit and review of processes. On discharge, a comprehensive summary of the record should be transferred to primary care and the patient. This should include a clear description of any follow up care and who is accountable for its provision. It is good practice that the discharge document is explained to the patient prior to departure to ensure comprehension and manage expectations.

7. Patient information

Patients should be informed early in their journey (ideally by the GP or the ED) that they are likely to receive treatment that day and are unlikely to be admitted to hospital overnight, to manage their expectations and those of their family.

8. Secondary and primary care services

Secondary and primary care services must work together to provide ongoing care outside of hospital, if required once the acute episode has been managed. AEC can be particularly valuable in the assessment and management of frail, older patients being managed with pathways supported by a multidisciplinary team with good links to services in primary care, the community and local authorities. These links can offer rapid assessment and interventions for older people, which can avoid an inpatient stay. For older people, access to these services is important to ensure safe discharge and reduce risk of readmission.

9. Clear measures

Clinical confidence in a service is based on whether or not it is delivering high-quality clinical care in terms of patient experience and clinical outcomes. Good informatics and regular reporting are key to developing an effective ambulatory emergency care service.

Metrics to consider in designing an ambulatory emergency care dashboard include:

- reduction in the number of emergency bed days used
- reduction in the number of patients admitted to hospital for <24 hours
- improved experience for patients
- improved staff experience
- improved quality of care
- improved safety
- improved patient flow
- improved ambulance turnaround
- reduction in readmissions
- reduction in incidents in emergency care.

10. AEC activity

Teams must regularly review reasons for patients being excluded from the AEC service and consider changes necessary to give these groups access to same day emergency care.

AEC activity must be recorded in an appropriate data set agreed with commissioners or funders.

AEC should have appropriate process and outcome metrics but should not be subject to the ED 4-hour standard.

A locally agreed tariff should be available for all ambulatory care activity that is carried out by the ED team. This should be the same remuneration as other ambulatory activity carried out in the trust.

The value of AEC is not in activity itself, but in reducing admissions and the number of occupied beds used by non-elective patients, thereby benefitting both patients and hospitals. As such it does not include. 'hot clinics', ED diverts and day hospital work.

ED Benefits of developing same day emergency care:

- Significant reduction in admissions via medical take
- Significant reduction in admissions via surgical take
- Enables flow in the system allowing patients who are admitted to get a bed in a timely fashion, thereby reducing ED crowding. [5]
- Development of shared learning with other clinical teams
- Opportunities to develop new skills and implement new treatments and therapies
- Diverse opportunity for research and quality improvement projects.

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Useful Links:

- Ambulatory Emergency Care Network website
- Royal College of Physicians acute care toolkits

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Acknowledgements

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Review

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

Conflicts of Interest

None

Disclaimers

RCEM 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

None

Audit standards

None

Key words for search

Ambulatory Emergency Care, Emergency Department, Same Day Emergency Care

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