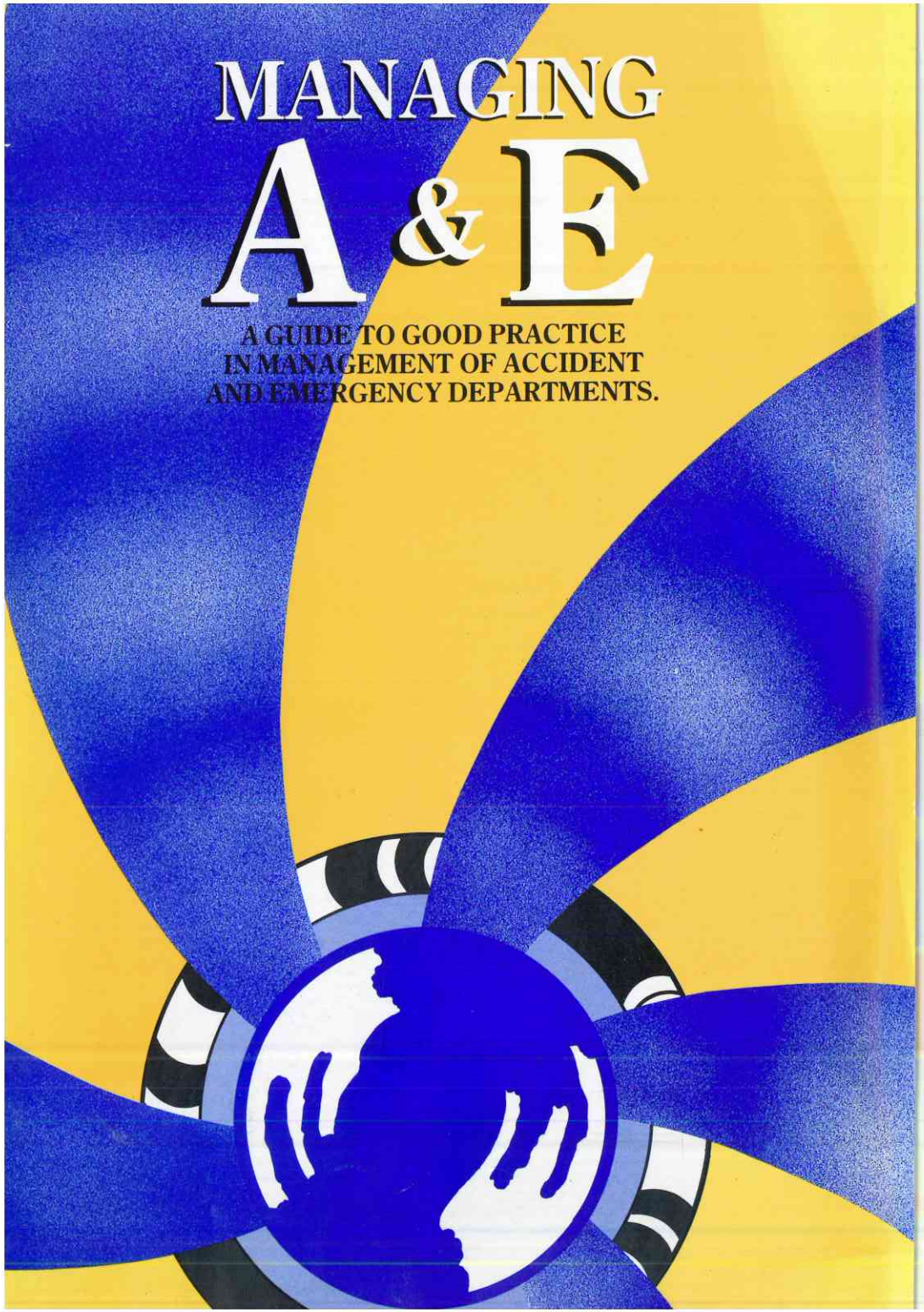
MANAGING A&E

A GUIDE TO GOOD PRACTICE IN MANAGEMENT OF ACCIDENT AND EMERGENCY DEPARTMENTS.



ACCIDENT AND EMERGENCY SERVICES

"My doctor doesn't work Saturdays"

"No one explained why we had to wait so long"

"If you miss the first sign on entering and go on to the main car park, getting to the right place is difficult..... at night and in a panic the signposting to the accident department is useless"

"During the whole process I was in a lot of pain but I had to keep waiting for different things – couldn't the process have been speeded up?"

INTRODUCTION

It is in the very nature of Accident and Emergency services that patients enter unannounced and unscheduled, in varying states of anxiety, hoping to be seen, diagnosed and treated all in a short space of time.

It is not surprising, therefore, that Accident and Emergency (A & E) is seen by many people as the "shop window" of hospital services.

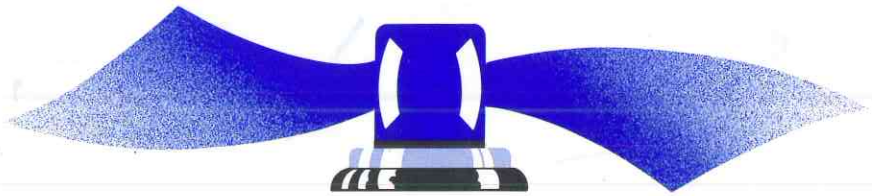
A high quality Accident and Emergency service places unique demands on its staff, buildings and managers. Not least is the unpredictable load and nature of the work: there is no such thing as a typical day, month or year for an Accident and Emergency Department.

This booklet is an attempt to help staff tackle these special demands and to meet some of the criticisms from consumers that A & E resources do not always meet their needs.

The Department of Health says: ***"Accident and Emergency Departments provide a service (at major units on a 24 hour, seven days a week basis) primarily for the reception, assessment, examination and treatment of patients who have been involved in an accident or have sustained an injury or who have an acute surgical or medical emergency"***. In England and Wales new attendances at A & E Departments increased by over 50 percent between 1959 and 1971 (DHSS, 1974). This increase in demand is largely an urban problem.

Only about 20 percent of patients attending A & E Departments are seriously ill or suffering from major injuries, 80 percent have conditions ranging from minor wounds, abscesses, septic hands and minor eye injuries and some have undiagnosed medical conditions, which may or may not turn out to be serious.

About 30 percent of people attending A & E Departments are patients returning for follow-up visits. Predicting the number of first-time attendances is difficult and can be affected by many different issues, such as whether the hospital is in a rural or an urban setting. Each A & E Department must decide what its role is and what its priorities are for providing a high quality service that meets the demands of its customers. This booklet will help in deciding those priorities and in improving the service provided.



Of course, the first priority has to be a high quality, technically excellent service.

Those who pass through A & E are among the most vulnerable people entering hospital, and it is vital that confidentiality is protected at all stages.

Consideration should be given to the provision of counselling services both for comfort and for providing information. Staff should have training in bereavement counselling techniques and there should be clear procedures for handling patients' property, death and complaints. Arrangements should also be set up for liaison with other outside counselling organisations which can offer a wider range of services. Extreme care has to be taken over patients' belongings, for even small items can be of immense importance both to patients and relatives.

Consideration has also to be given to the needs of casualties who have additional problems. For example, are there guidelines for dealing with:

- children,
- deaf patients,
- partially sighted and blind patients,
- the disabled,
- wheelchair patients,
- psychiatric patients,
- drug abusers,
- patients who need to be treated in isolation,
- ethnic minorities,
- drunken people and alcoholics,
- victims of violence.

Success in these issues comes down to good communication and good management.

"I didn't think that my GP could cope with my son's injury"
"I don't live here so I haven't got a doctor"

When the NHS was set up in 1948, it was thought that general practitioners would be the first point of contact for people with non-urgent, minor illnesses – leaving hospitals free to care for actual emergencies, sudden illnesses and accidents only.

Yet study after study has shown that around three quarters of patients attending Accident and Emergency Departments have not contacted their family doctor first. Some A & E Departments may consider this as appropriate and will need to cope with the additional work load that treating these patients will involve.

☛ Patients may be unwilling to contact their GP out of hours. This may be because they 'do not want to disturb them' or because they are unavailable.

Some practices may be difficult to contact out of hours and, if they are using deputising services, these may be over-stretched and have poor response times to a request for help from the patient.

☛ Some GPs may discourage patients with minor injuries from turning up. But what seems minor to a professional may seem much more traumatic to the patient.

If attempts need to be made to persuade more patients to contact their GPs first, consider:

☛ If there are one or two practices in the A & E department's catchment area who are recurrent "offenders" in terms of inappropriate referrals, out-of-hours referrals and unavailability of the 'on-call' doctor at night or weekends, this may be discussed by the A & E consultant with the practices and if necessary, via the Family Practitioner Committee.

☛ Some hospitals could mount through the press and with leaflets and posters, campaigns to educate the public on when and how to use A & E and GP services.

☛ Whether the public need to be told about the respective roles of the Accident and Emergency Department and the General Practitioner. This information should be provided by health authorities and the family doctors.

☛ There should be a clear system for collaboration between the health authority and family practitioner committee about how information campaigns need to be run and any changes that might need to be made in service provision.

☛ GPs should be encouraged to include on their practice information cards full details of how to contact the emergency doctor out of hours. These cards could also include references to the fact that when on holiday or staying with relatives, patients are quite entitled to see a local family doctor.

☛ Practices should make it as easy as possible for patients to contact the duty doctor and not be referred via a series of answering machines.

☛ All information provided about how to use Accident and Emergency departments, and family doctor services should be made available in additional languages as appropriate to the district.

The numbers of people who actually attend A & E departments are an important factor in their workloads. The departments may want to look at how patients could be referred back to GPs, or the practice nurse, for follow up treatment where necessary.

If Accident and Emergency Departments include Fracture Clinics, managers might reconsider whether this is the best arrangement.

Fracture Clinics can add to the workload, causing traffic problems with crutches, wheelchairs etc.

ORGANISING THE DEPARTMENT

All hospital A & E departments need to be well organised, properly staffed and efficiently managed. The most important aspects of ensuring that the A & E department operates as smoothly as possible are that:

- ☛ there are enough staff
- ☛ they are being properly deployed
- ☛ they are available at the right time.

Staffing levels need to be geared to the peaks and troughs of workloads as far as possible.

Managers may want to look in detail at when these peaks occur. They may also wish to review staffing levels for nursing, medical and clerical manpower if this has not been done recently.

Work study staff from the regional health authority could be called in to help look at whether staffing levels are adequate and efficient.

☛ The arrangements for consultant cover in the department may need to be reviewed. Increasingly, it is now usual to have a designated Consultant in Accident and Emergency rather than arrangements such as combining this with the post of Consultant Orthopaedic Surgeon. Accident and Emergency Consultants are now recognised specialties and the medical Royal Colleges, when assessing the suitability for recognition of the hospital for junior medical staff training, are putting greater emphasis on the need to identify a Consultant to ensure adequate training.

When reviewing workload patterns, managers should consider whether or not the staff are being used not only efficiently, but flexibly as well.
Asking these questions may help:

CLERICAL STAFFING

Should there be 24-hour clerical cover for A & E? Or should the Department use clerical cover on a "catch up" basis the next morning, or operate a twilight shift to cover busy periods, such as after pub closing on Fridays and Saturdays?

Are there additional duties that staff can do if full night cover is chosen?

PORTERING STAFF

Can adequate levels of service best be achieved by having Departmental porters, a pool or a mixture of both?

X-RAY STAFF

Should the Department look at flexible staffing rotas to cover early evenings and/or adequate resident stand-by/ on-call cover?

Do GPs know the appropriate times to refer patients?

NURSING STAFF

Obviously nurses are vital in the provision of high quality A & E services. What are the precise roles in the A & E department and should a Triage nurse and/or nurse practitioner be introduced?

A Triage nurse assesses patients and streams them into those who are seriously ill, those who do not require immediate treatment and those who could sit and wait if necessary. The introduction of a Triage nurse is not universally accepted, particularly among senior medical practitioners in some A & E departments, but the principle of Triage is already performed informally by ambulance and reception staff. If Triage nursing is to be introduced it should be carried out by an experienced member of the A & E departmental nursing staff.

A & E is one of the most appropriate of all areas in the hospital to encourage the extended role of the nurse.

Managers, therefore, might also consider the introduction of the nurse practitioner. This is a senior nurse who can provide immediate minor treatment for patients. The introduction of a nurse practitioner will involve the consultant, the unit manager, and possibly the health authority, in agreeing to accept vicarious liability for the nurse acting in this extended role.

Managers should look at the arrangements for admitting patients. Major problems can be caused by the A & E department acting as a sort of "holding bay" until the specialist doctor comes to agree admission. One solution is to have accident beds for holding patients, prior to admission or for observation until it has been decided whether the patient can be safely discharged.

To leave patients waiting on trolleys, often in corridors, is upsetting and uncomfortable for the patients and prevents proper observation. It also means that there is a greater chance of the patient developing pressure sores.

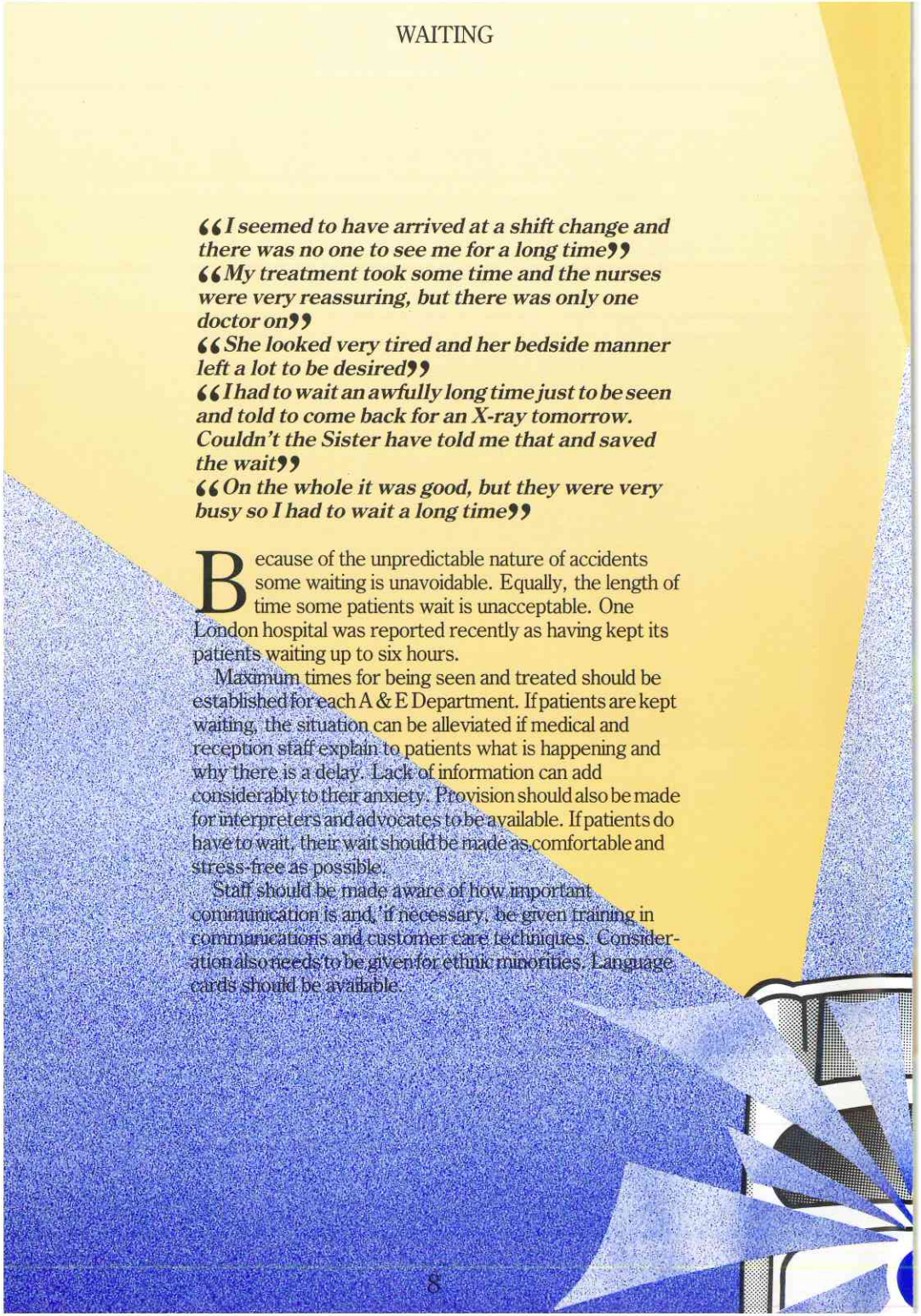
Some departments have dedicated A & E beds, available 24 hours a day. Others use A & E beds prior to admitting patients to a ward the next day. This can cause problems if the beds are also used as day care beds.

"I seemed to have arrived at a shift change and there was no one to see me for a long time"
"My treatment took some time and the nurses were very reassuring, but there was only one doctor on"
"She looked very tired and her bedside manner left a lot to be desired"
"I had to wait an awfully long time just to be seen and told to come back for an X-ray tomorrow. Couldn't the Sister have told me that and saved the wait"
"On the whole it was good, but they were very busy so I had to wait a long time"

Because of the unpredictable nature of accidents some waiting is unavoidable. Equally, the length of time some patients wait is unacceptable. One London hospital was reported recently as having kept its patients waiting up to six hours.

Maximum times for being seen and treated should be established for each A & E Department. If patients are kept waiting, the situation can be alleviated if medical and reception staff explain to patients what is happening and why there is a delay. Lack of information can add considerably to their anxiety. Provision should also be made for interpreters and advocates to be available. If patients do have to wait, their wait should be made as comfortable and stress-free as possible.

Staff should be made aware of how important communication is and, if necessary, be given training in communications and customer care techniques. Consideration also needs to be given for ethnic minorities. Language cards should be available.



"I was looking for "casualty" so I got lost. There was no receptionist at the main desk"
"Alternative car parking is difficult to locate for a first time user"
"There are too many signs"
"The waiting area was too small and in need of brightening up"
"I didn't see any toys available. Other patients entertained my child"
"The chairs were uncomfortable, particularly with my bad leg"
"The drinks from the machine tasted horrible"
"I was embarrassed to tell the receptionist what had happened, because everyone else could hear"
"Cubicles are only separated by curtains and I could hear what was going on next door"

A good environment is vital. Not only does it contribute to the overall impression of the hospital that patients take away with them, but it can play a major part in reducing stress and making a wait more bearable.

The environment is both human and physical and starts from the moment patients are in the care of the NHS.

It is irritating and sometimes upsetting for patients arriving at A & E departments to find no parking spaces available. They are often difficult to find and usually some way away from the departments. These difficulties are made worse if staff are using the car parks close to A & E.

Procedures for dealing with records and documentation, all need to be clear and regularly monitored. Confidentiality is of the utmost importance.

☛ Reception, medical and nursing staff all need to be briefed on the level of information that may be released to the police.

☛ Staff should look at the type of record cards used by the Accident and Emergency Department. These cards could have a duplicate copy which may be sent to the family doctor, given to the patients to take to their doctor, or in cases such as "travelling people", these records could be given to the patient to hold.

☛ An Accident and Emergency Register has to be kept and the Department must keep an "At Risk" register for cases suspected of child abuse. There should be a procedure for updating the register.

☛ The system should be adequate for checking, for example, whether or not a patient has attended before, and therefore has a record at the hospital.

☛ The Department could have a special form to send back with the patient to local authority sheltered Part III accommodation or private nursing homes. This form could explain the treatment and medication given since elderly patients may be confused or disorientated.

☛ Departmental managers should ensure that staff are clear about handling paper work.

SECURITY

Accident and Emergency department staff can be very vulnerable to attack.

Staff should not be expected to work on their own, particularly at night; a balance has to be struck between receiving patients in a friendly way and protecting staff from attack.

Health authorities should make sure steps are taken to protect staff from attack and that there is support if attacks do take place.

- The use of security guards, closed circuit TV, panic buttons and alarms should all be evaluated.
- Managers and senior police officers, including those from the traffic division, should meet regularly and agree procedures for dealing with incidents in the A & E department, and policies for dealing with other areas of mutual concern.
- Some departments may be able to set aside a room for the police.

Good communication is vital at all stages. Even a minor injury or sudden, unexplained illness can be frightening.

Family doctors referring patients to the A & E department, should make it clear to them why this is necessary.

Ambulance staff should communicate with the patients about what is happening and why. If possible, whoever is taking the patient to hospital should try to make sure they have the basics: shoes, coat and small change. Patients once they arrive should be told of any delays that are likely to occur and why. Good communications between the hospital and ambulance staff are most important. Relatives should be kept informed of what is happening. Patients should be given adequate information about their condition and treatment. Many patients find it hard enough to ask doctors for information, without the extra strain of a sudden accident or illness.

There should be provision for communication with people from different ethnic backgrounds, including interpreters and language cards.

Consideration should also be given to those suffering from sensory deprivation such as deafness or blindness.

Patients should be told what is happening to them. For example, that they are going to be taken for an X-Ray, that they are being admitted etc.

But staff to staff communications are equally important. For example, are staff clear about the procedures that need to be followed?

Are staff clear about the procedures for dealing with patients' records, patients' property, death and complaints?

Is there a clearly defined procedure for handling telephone calls? For example, who should give advice to anxious relatives or prospective patients, and what is the relevant amount of information? If there are to be changes in the way the Accident and Emergency Department is run, is everyone consulted and informed? For example, if Triage is to be introduced, the ambulance service needs to be consulted. It may affect where the patient is delivered and who is informed.

Are there clearly laid down procedures for liaison with other agencies such as local authorities, social services and housing departments, voluntary organisations and Family Practitioner Committees?

Are there good channels of communication between the Department and local family doctors? The smooth running of the department is dependent on the co-operation and understanding of local GPs.

There should be guidance for the use of volunteers within the A & E department.

Many patients attending A & E departments find their own way there.

However, of course, many will arrive by ambulance. Few people realise just how costly an emergency ambulance call can be. On average, each call will cost between £90 and £100. About 25% of all ambulance calls are for cases of sudden illness in a person's home, maybe when a doctor is unavailable.

Additional pressure is put on ambulance services because of continuing reduction in the availability of public transport, particularly in rural areas.

It is easy to believe that most people have their own cars these days. This is simply not so.

Family doctors may like to include information on their practice information cards about what patients should do in case of sudden illness at home.

There must be clearly defined systems for making sure that patients and their relatives can leave the Department as soon as they are able. For example, can they use a free 'taxi telephone'? Is there an area where the taxis can wait for passengers without causing traffic problems, and enabling people to find their cabs easily? Are patients and relatives told about how they will be getting home? For example, is an ambulance going to be available, or will they have to find their own way back?

Is there information available on bus and other forms of public transport, times, routes etc?

Are there maps available?

Are there systems for regular liaison with the public transport authorities to see if transport problems for patients can be eased?

WHAT CAN YOU DO?

The bottom line has to be that your hospital or unit is providing a high quality service to all those who need it.

1. As far as possible an estimate should be made as to when departments are likely to be most in demand. Staffing levels should be adjusted accordingly.
2. Twenty-four hour reception and portering cover should be evaluated to make sure that nursing staff are not used to cover gaps.
3. The number of medical staff should be regularly reviewed and kept up to complement.
4. A Triage and a nurse practitioner system should be evaluated.
5. The security of all staff is important and whenever possible you should avoid people working alone.
6. The introduction of shift working should be considered whenever delays and inconvenience are caused by speciality services being unavailable outside normal hours. GPs should be urged not to send non-urgent cases to hospital after 5pm, if, for example, radiographers do not work after 5pm.
7. All staff, but particularly medical staff should make a greater effort to ensure that patients are made to feel as easy as possible during care. This should include giving the patients information about their condition and treatment, and including families and carers if appropriate.
8. More education is often needed about the roles of the family doctor and A & E departments.
9. Signposting must be clear and unambiguous.
10. Waiting areas should be as comfortable as possible.
11. Do you involve voluntary bodies, consumer groups, such as Community Health Councils, in monitoring the quality of care in your Department?

Managing A & E has been produced by the Institute of Health Services Management and the Association of Community Health Councils for England and Wales.

Copies should be made available to members of health authorities and CHC's, managers, medical staff, and all staff who work in Accident and Emergency departments.

This booklet is published by the IHSM, 75 Portland Place, London W1N 4AN.
Tel: 01-580 5041

Price per copy: £1.99

ISBN 0901003611

THE INSTITUTE OF HEALTH SERVICES MANAGEMENT

Association of Community Health Councils for England and Wales