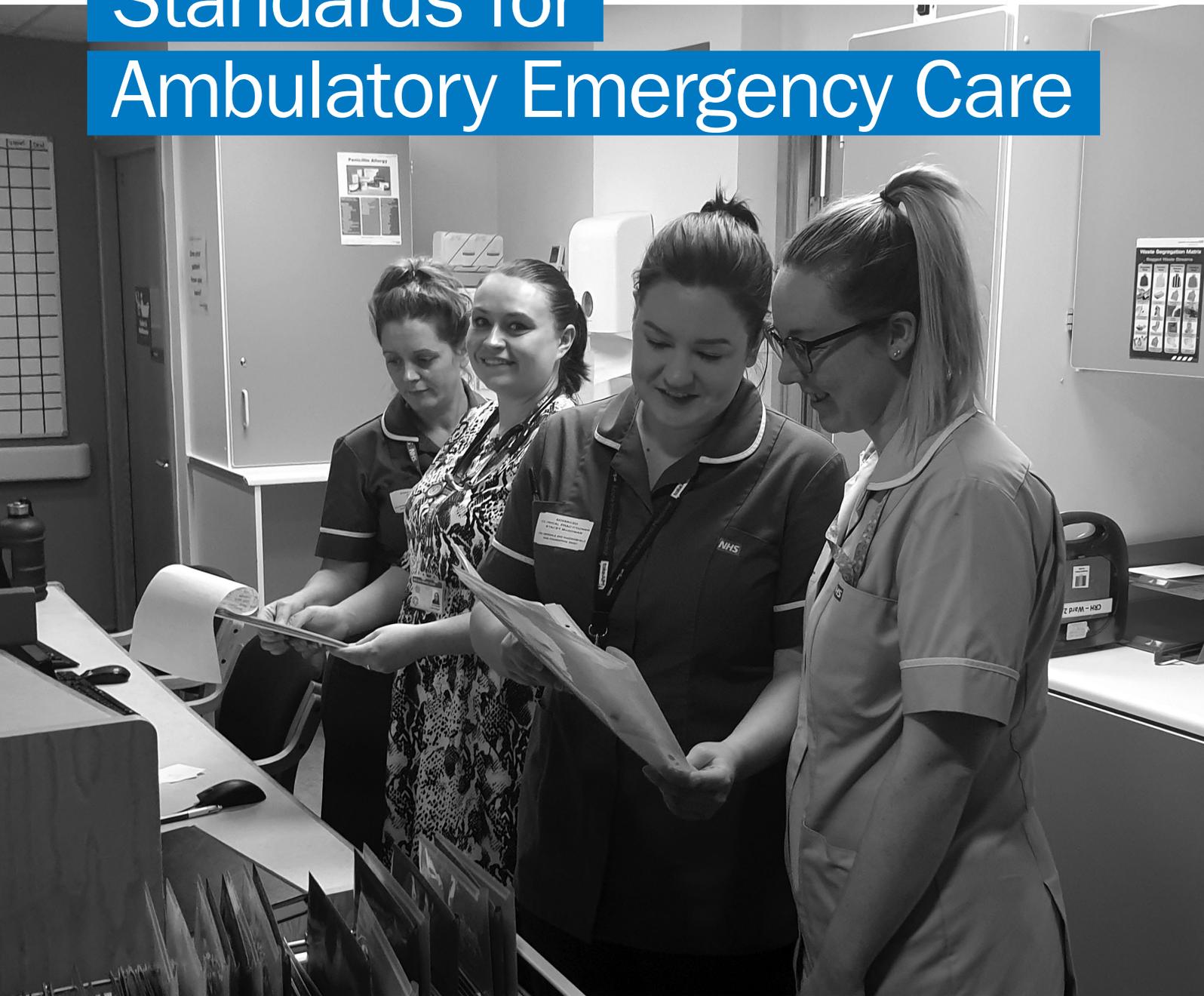


# Standards for Ambulatory Emergency Care



Report of a working group for Royal College of Physicians of Edinburgh  
and Society for Acute Medicine

Ambulatory Emergency Care (AEC) is a relatively newly described form of out-patient care for patients presenting with an acute illness that previously may have required an in-patient stay. Conditions that have been managed in this way are outlined in the AEC directory (Edition 8 May 2018). There are however no standards for delivery of such care that have been developed. The aim of the working group was to develop standards analogous to those that were developed by the West Midlands Quality Review Service and subsequently adopted by the Society for Acute Medicine.

## Suggested standards

These standards are for AEC or same day emergency care (SDEC).

- 
- 1** All units undertaking AEC should regularly survey a representative and consecutive number of patients treated in this manner. This should take the form of a short questionnaire. At least 5% of all patients should be surveyed and the total time spent in the unit for each patient calculated.

Survey results should be used by the multi-disciplinary team (MDT) in a dedicated meeting to identify possible areas for quality improvement at least every 6 months. Although more challenging, one of the surveys should take place in the winter months.

- 
- 2** Waiting times for patients in AEC should be minimised.
- Observations contributing to a NEWS2 score (National Early Warning Score version 2 - a system to standardise response to acute illness) should be obtained within 30 minutes of a patient's arrival.
  - Patients should be seen promptly and certainly within one hour by a clinician who has the capabilities to assess and investigate the patient's symptoms and signs. This clinician should have immediate access to a more senior clinical decision maker for review when the presentation proves more complex.
  - A validated risk stratification tool for specific conditions should be used to guide management including the need for investigation.

- 
- 3** A consultant physician should be available on the hospital site day and night throughout the opening times of the AEC unit to review AEC patients.

- 
- 4** A nominated clinician from the MDT should take responsibility for the overall leadership of the AEC unit to ensure there are active clinical governance and quality improvement processes and strategies.

- 
- 5** AEC unit patients should have the same access to urgent investigations as inpatients or patients attending the emergency department. In order to minimise patient waits monitoring of waiting times for diagnostics, including the generation of reports, should occur at least monthly and discussion held with relevant departments to ameliorate delays.

- 
- 6** Review of AEC performance should occur regularly using at least the metrics suggested by the AEC network (see appendix for details). Additional measures that are relevant to the local health system may also be needed to understand factors influencing performance. Results should be reviewed with the aim of quality improvement.

- 
- 7** Non-attendance of patients who have been referred to the AEC unit should be reviewed. If a patient does not attend and cannot be contacted this should be communicated with the relevant GP practice. Similarly, robust systems must be in place to ensure that patients do not get lost whilst under the care of the ambulatory unit including those in any 'virtual ward' or undergoing investigation.
-

- 
- 8** A same day discharge summary for a single episode of care should be created at the end of the AEC episode and sent to the GP and given to the patient. This should include details of investigations undertaken, any new therapies instigated and the follow up plan required and arranged. If there are multiple attendances then it is mandatory that the primary care team receives regular communication, with the mechanism and content defined locally. In either circumstance it should be clearly communicated when the AEC episode has been completed and continuing management has been transferred back to the care team in the community.
- 
- 9** Each unit should have a standard operational policy that defines the specific clinical pathways that have been developed and should also define the local arrangements that exist to ensure that the AEC unit does not become the default referral pathway for patients who would be managed more appropriately by a particular specialty or if in-patient care is required.
- 
- 10** All patient pathways should be adequately defined and resourced in association with the commissioning organisation (where applicable) to avoid duplication and provide clarity of care for specific conditions.
- 
- 11** During the period of care under the ambulatory team, patients should have clear written instructions for actions to take if they feel they are deteriorating or if they wish to discuss concerns prior to their next scheduled visit.
- 
- 12** Activity within AEC must be protected including during periods of escalation when the hospital is under pressure. Loss of this activity will undoubtedly make the acute pressures worse. AEC units should not be used for the non-acute management of long term conditions.
- 
- 13** The infrastructure and space in the AEC unit must be adequate and reviewed regularly for the throughput and the needs of patients anticipated. Waiting areas should be equipped with adequate seating, refreshment facilities, TV and toilets.
- 
- 14** All patients referred to the AEC unit should have an explanation of the service and reassurance that it can provide safe and effective care including the need for escalation of care if this is thought to be necessary.
- 
- 15** A private area must be available where all confidential conversations should be conducted.
- 

## Working group

Dr Mike Jones

Consultant in Acute Medicine, County Durham and Darlington FT  
Director of Training, Royal College of Physicians of Edinburgh  
GIRFT National Clinical Lead in Acute and General Medicine

Dr Sue Crossland

Consultant in Acute and General Medicine, Calderdale and Huddersfield FT  
Vice President, Society for Acute Medicine

Dr Mark Holland

Consultant in Acute Medicine, Salford Royal Hospital FT  
Past President, Society for Acute Medicine  
Visiting Professor, Faculty of Health and Wellbeing, University of Bolton

Prof Dan Lasserson

Professor of Ambulatory Emergency Care, University of Birmingham.  
SAMBA lead, Society for Acute Medicine

Dr Nick Scriven

Consultant in Acute and General Medicine, Calderdale and Huddersfield FT  
President, Society for Acute Medicine

Dr Hannah Skene

Consultant in Acute Medicine, Chelsea and Westminster NHS FT  
Secretary, Society for Acute Medicine

Dr Paul Sullivan

Consultant in Acute Medicine, Chelsea and Westminster NHS FT  
Quality Improvement, Lead Society for Acute Medicine  
Hon. Senior Lecturer, Healthcare Improvement, Imperial College London

## Appendix

### Possible metrics for AEC as suggested by the AEC Network.

The following metrics may be useful for anyone seeking to greater insight into the operation of existing AEC/same day emergency care (SDEC) units. Any metrics used should be presented as a return of daily data from each site.

- A** The number of new walk-in patients who presented at emergency department (ED)
- B** The number of new GP referrals that presented at ED
- C** The number of new ambulance arrivals that presented at ED
- D** The number of new ED presentations discharged same day
- E** The number of new ED presentations referred to AEC/SDEC
- F** The number of new ED presentations referred to assessment units
- G** The number of new presentations to AEC/SDEC sent home that day
- H** The number of new presentations to assessment units sent home that day
- I** The number of new presentations to AEC/SDEC admitted to a ward for an overnight stay of at least one night
- J** The number of new presentations to assessment units admitted to a ward for an overnight stay of at least one night
- K** The number of new presentations to AEC/SDEC from GP referrals
- L** An indication of whether the site generally takes GP referrals direct to AEC/SDEC or not - this is the only data item which is not a daily 'count'
- M** The number of new non-elective presentations seen and treated in AEC/SDEC
- N** The number of new non-elective presentations of patients who convert to an admission of at least one night
- O** The number of unplanned re-presentations of patients who had been managed by the AEC/SDEC unit within the previous seven days
- P** The number of new AEC/SDEC patients with a length of stay of less than two hours (maybe an indicator of potentially wasted capacity), eg inappropriate moves from ED
- Q** The number of new assessment unit presentations referred to AEC/SDEC
- R** The number of new presentations to AEC/SDEC from 999
- S** Number of patients referred to AEC/SDEC from ED more than two hours after their arrival at ED (may need audit rather than regular reporting)