Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS Improvement

Rapid Improvement Guide to:

Making internal professional standards work for you ('the way we do things here…')

The working relationships between people in an organisation are more powerful, positively or negatively, than a bookcase full of policies, procedures and escalation flow charts. The way professional staff work together can make or break the flows required to achieve safe, effective and timely emergency care. This is particularly noticeable with junior doctors on short term or locum contracts, rotating rapidly through a variety of jobs where the culture and learned 'way we do things here' can markedly differ from the values an organisation espouses.

Internal professional standards are a clear, unambiguous description of the values and behaviours expected in an organisation. They are most powerful when they are centred on patient care, are written and agreed by the clinical leaders and openly supported by the executive team. An example from an acute Trust is included in this guide, which was developed and agreed by all of the Clinical Directors and Heads of Nursing. While some of the principles can be generalised, the real power comes from clinicians developing a local set of standards that is owned by the organisation.

However, this alone is not enough. Professional standards need to be translated into professional behaviours. These principles need to be discussed and promoted at every induction, describing 'the way we do things here'. Individual Consultants and Senior Nurses need to demonstrate in their routine, daily interactions with their teams, that the internal professional standards form part of their core behaviours. Role modelling and reinforcement will make the standards stick and can make your internal professional standards become 'the way we do things here, all day, every day'.

Ten principles for effective emergency care

1. An emergency department (ED) decision making clinician will see new patients on or as close to arrival as possible in the ED.

2. The ED team will not admit a patient likely to be able to go home just to avoid a breach of the emergency care standard.

3. Specialities will have arrangements in place for sufficiently experienced staff to assess emergency patients within 30 minutes of referral and must not insist on ED based investigations that do not contribute to the immediate management of the patient.

4. Patients referred from primary care (or any other clinical service) should be routed directly for specialty assessment via the operations centre. If this does not occur and the patient attends the ED, the patient will be transferred to the specialty considered most appropriate by the ED team unless immediate medical intervention is required.

5. Patients will only be sent to the ED as a result of advice by speciality teams if immediate clinical intervention is required, as all other patients should normally be seen in the designated assessment areas. In this situation, the ED team will continue to provide clinical support to patients within the resuscitation area, and then refer to the most appropriate specialty for on-going management of the current clinical problem.

6. Transfer patients from Critical Care will take priority in in-patient bed allocation over and above any other calls for that available bed.

7. No speciality doctor will refuse a request to assess any ED patient. If subsequently it is considered that an alternative speciality would provide more appropriate care, it is the responsibility of the first speciality (and not the ED team) to arrange the transfer. The ED team will continue to provide clinical support to patients within the resuscitation area.

8. The ED team will highlight any patient recently discharged from an inpatient admission or under current investigation or treatment for assessment by the suitable specialty. This should help the speciality team to avoid unnecessary admissions.

9. If there is a failure for different specialties to agree on accepting a patient, the ED consultants have the authority to admit any patient to any level one bed in the speciality that they consider best able to meet that patient's clinical needs.