

‘Better together: collaborative working between emergency medicine and critical care’: 1 year on, is this framework still relevant?

In 2021 the Royal College of Emergency Medicine and the Faculty of Intensive Care Medicine collaborated to launch the ‘Better together’ framework to improve outcomes for critically unwell patients in the resuscitation room. One year on from the launch, it remains more relevant than ever.

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The Royal College of Emergency Medicine and Faculty of Intensive Care Medicine (2018) issued a joint position statement during the winter of 2018–19. In the face of the ever-increasing challenge of complexity and demand, safety concerns were raised around the extraordinary pressures placed on both services. In July 2021, a joint strategy document resulting from this partnership was launched entitled ‘Better together: collaborative working between emergency medicine and critical care’ (Royal College of Emergency Medicine and Faculty of Intensive Care Medicine, 2021). It described a framework for improved collaborative working between the two organisations, with a clearly stated aim to improve outcomes for critically unwell patients presenting to the emergency department.

Since its launch, the pressures on the wider NHS have intensified and emergency department performance targets are now routinely missed (The King’s Fund, 2022). The impact of this pressure has been felt along the entire patient journey. Emergency department crowding, ambulance handover and response times, and consequent patient experience and outcomes demonstrate the continuing need for such a strategy document (Royal College of Emergency Medicine, 2021; Jones et al, 2022; Nuffield Trust, 2022).

A working group of dual-trained emergency medicine and intensive care physicians authored this document, with oversight and guidance from both the Royal College of Emergency Medicine and the Faculty of Intensive Care Medicine. The working group represented different types and sizes of hospitals from across the UK, including major trauma centres and trauma units. The team adopted joint Faculty of Intensive Care Medicine and Intensive Care Society Guidelines for the Provision of Intensive Care Services as the foundation for the framework (Intensive Care Society, 2019). Having reviewed the literature, the authors reached consensus in several key areas: processes, staffing and training, and equipment. Each section highlights relevant best practice standards and recommendations, in keeping with previous critical care guidelines and endorsed by the key stakeholders including the Royal College of Emergency Medicine and Faculty of Intensive Care Medicine.

Standards are the essential elements of care that must be used to identify key priorities for the resuscitation area. Recommendations are statements concerning practices that should be routine in the UK. For every emergency department in the NHS, there will be aspects of this framework that are still not met, and it was anticipated that these gaps will be used as a driver and focus for areas of development, with the ultimate aim of improving patient outcomes. The focus is very much on the patients and their families, emphasising the need for clear communication and patient-centred care.

Clinical standards

The document emphasises the need to minimise delays to definitive treatment and promote timely admission from the resuscitation room to the intensive care unit. Standards in this area are unambiguous, for example, unplanned admissions to the critical care unit must occur within 4 hours of making the decision to admit and the completion of essential

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resuscitation, including any required imaging (Intensive Care Society, 2019). The document stresses the role of senior clinicians in decisions around both the transfer of patients to the intensive care unit or onwards to tertiary care.

There are further recommendations around early prognostication and decisions to withdraw life-sustaining treatment in mechanically ventilated patients in the emergency department. The authors acknowledge that ‘decisions in the ED [emergency department] are fraught with difficulty and should be avoided, particularly in patients with a perceived devastating brain injury.’ They conclude that patients should be admitted to critical care for a period of physiological stabilisation and prognostication before end-of-life decision making. Early withdrawal of life-sustaining treatment can be justified, for example, in the presence of an advance directive or because the patient continues to deteriorate, despite escalating therapeutic measures (Harvey et al, 2018).

The importance of standardising equipment across critical care areas of the hospital for the benefit of both staff and patients is highlighted. Standardisation of equipment reduces the risk of harm to patients because staff who work between areas will be more familiar with a smaller number of devices, thereby reducing the risk of error.

An important focus of the document is on the requirement for greater governance around the care of the critically unwell patient in the resuscitation room. The need for greater scrutiny and shared learning to identify areas for improvement around the care of this group of critically unwell patients, for both the emergency department as well as the critical care team, has been highlighted.

Workforce standards

The 2020 joint guidance from the Royal College of Nursing and Royal College of Emergency Medicine on nurse staffing levels in the emergency department was incorporated into the document (Royal College of Emergency Medicine and Royal College of Nursing, 2020). A number of recommendations were made regarding the training needs of all staff working in the emergency department resuscitation area.

Research

The value of engagement with research has been emphasised, given that clinical research is the single most important way in which healthcare is improved – by identifying the best means to prevent, diagnose and treat conditions (Department of Health and Social Care et al, 2021). Evidence shows that research-active hospitals and departments have better patient outcomes (Jonker et al, 2020). Both emergency department and critical care research teams should work collaboratively to allow the recruitment of critically-ill patients to National Institute for Health and Care Research and other studies, where appropriate.

Patient participation

The views of the public were sought early in the process through a patient focus group. Their feedback has been incorporated throughout the document. The importance of timely and honest communication with families has been emphasised. Of note, the patient focus group recognised that the demands of caring for very ill patients can be great for all staff groups. They were particularly keen to stress the need to ensure adequate support for the entire team working in this environment. References to wellbeing resources from the Royal College of Nursing, the Royal College of Emergency Medicine and the Faculty of Intensive Care Medicine have been included in the document.

This strategy document was endorsed by members and fellows of both the Royal College of Emergency Medicine and the Faculty of Intensive Care Medicine following a consultation period. A number of key organisations, including the Intensive Care Society, the UK Critical Care Nursing Alliance and the Resuscitation Council UK, gave feedback, and the support of two key stakeholders – the Society of Acute Medicine and the Royal College of Nursing – was essential for the process.

Key points

- Emergency department performance targets have been missed for many years with consequent effects on crowding, which has been shown to have an adverse impact on patient outcomes.
- A collaboration between Royal College of Emergency Medicine and Faculty of Intensive Care Medicine launched the ‘Better together’ framework in 2021, with the aim of improving outcomes for critically unwell patients in the emergency department resuscitation room.
- In the absence of a strong evidence base, a consensus has been reached in a number of key areas: processes, staffing, training and equipment. Subsequent standards and recommendations have been produced.
- There is a range of stakeholder support for the framework, including that from the Royal College of Emergency Medicine and Faculty of Intensive Care Medicine; the views of the public were also included.
- The focus is very much on the patients and their families, emphasising the need for clear communication and patient-centred care at all times.

Conclusions

Waiting times of over 12 hours for admission are now commonplace and many emergency departments are seeing their highest ever numbers of attendances. The ‘Better together’ document is part of the effort to mitigate against such pressures. The need for guidance in the management of critically unwell patients in the resuscitation room remains paramount. While the overall aim is to improve the care of these patients, the focus is clear: high-quality patient experience, adequate staffing, wider system engagement and good system leadership. The first iteration of this document was published in July 2021. Further editions are anticipated as new evidence becomes available and practice inevitably changes. The framework is yet to be evaluated and will no doubt present its own challenges.

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