The Royal College of Emergency Medicine

Best Practice Guideline

Patient Care in the ED

Royal College *of* Emergency Medicine

November 2021

Introduction

This guideline has been developed to help medical and nursing staff within Emergency Department (EDs) provide better care for their patients.

Emergency Departments should aim to provide a safe, committed, compassionate and caring service. This guideline provides a checklist of care initiatives directed at improving patient experience and the quality of care given to patient, covering the following themes:

- The patient environment
- The Patient pathway through the ED
    - Arrival
    - Early Assessment
    - Assessment and diagnosis
    - Continuing and ongoing care
    - Discharge
- Care for specific patient groups
    - Care of the elderly patient
    - Care of children
    - Care of patients with complex requirements
- Departmental and staff requirements
    - The ED team
    - Education about care
    - Measuring care and leadership

Standards within this document are graded as either 'Fundamental' or 'Developmental'. Fundamental standards are those which every ED should routinely achieve. Developmental standards are those which departments should be working towards. Achieving these standards requires commitment and support. Emergency Departments are encouraged to regularly analyse their practice using this document. These standards should be regularly audited, and departments assess compliance with the standards. Where a standard cannot be met, this should be escalated to those who can take appropriate action.

Reason for development

The culture of focusing on national targets and financial balance, whilst neglecting acceptable standards of care was exposed in the 2013 Francis report of the Mid Staffordshire NHS Trust Public Inquiry[1]. The Royal College of Emergency Medicine (RCEM) recognises such occurrences are not isolated to one organisation or one department [2].
The first recommendation of the Francis report is that "*all staff should contribute to a safe, committed, compassionate and caring service*".
The National Advisory Group on the Safety of Patients in England 2013 [3] issued as its first guiding principle: "*place the quality (and safety) of patient care above all other aims for the NHS*".
This document should be read in conjunction with the following RCEM documents:

Quality in Emergency Care: Defining and measuring the quality of care in EDs
Patient Experience in Emergency Departments: A strategic Overview
A Safe Emergency Department: A strategic Overview
Emergency Department Standards: A strategic Overview

The patient environment			
Item	***Standard***		***Points to consider***
1	Are all areas of the ED clean and well lit?	☐ F	Including the waiting room, reception front entrance and its surroundings?
2	Is the physical condition of the ED in good order?	☐ F	Broken or stained ceiling tiles for example, may give a poor impression to patients lying on trolleys: "*if they care for the building like this, how will they care for me?"*
3	Is the signage and information for the patients sufficient to enable easy navigation to, through and from the Emergency Department?	☐ F	The ED can be disorientating. Has it been made easy to locate and understand the 'pathway' through the department? Reducing violence and aggression in A&E https://www.designcouncil.org.uk/what-we-do/social-innovation/reducing-violence-and-aggression-ae
4	Do clinical areas enable patients to retain dignity and privacy, including facility to register with privacy?	☐ F	Can sensitive questions be overheard by other patients and staff? This includes clinical discussion and handover. Including securable and separated (i.e. solid walls/door, no curtains) cubicle for those with specific dignity needs (e.g. intimate examination and conditions, religious observance, end of life care)
5	Do all toilet facilities in the ED clearly display a completed daily cleaning log?	☐ F	A minimum of twice daily cleaning is advised.
6	Are waiting areas furnished with: ☐ Reading material ☐ A television ☐ WiFi access ☐ Information regarding process ☐ An updated waiting time ☐ Refreshments	 ☐ D ☐ F ☐ F ☐ D ☐ D ☐ D	 A number of EDs have a charity book stall. ** see standard 66. A news channel on silent with line feed perhaps? Is this made clear to all appropriate age groups including teenagers? What can the patient expect: triage, nurse practitioner or doctor assessment, care, the four hour target etc. See RCEM Best Practice Guidelines: giving information to patients in the Emergency Department. This will require active planning for patients who may need to be 'NBM'.
7	Are relatives and carers catered for? ☐ Is there sufficient cubicle seating for patients' relatives and carers? ☐ Can patient and relatives communicate? ☐ Are bereaved relatives cared for sensitively?	☐ F ☐ D	Are patients told that they can use their phones? Are patient's wishes regarding contacting and giving information to relatives/carers established and met? Is there a bank of phone chargers available for patient use? Are refreshments available and offered regularly? Are bereaved relatives routinely offered a follow up appointment with a senior ED physician? Are doctors clear which patient deaths require reporting to the coroner / procurator fiscal ?

			See End of Life Toolkit: http://www.rcem.ac.uk/docs/RCEM%20Guidance/RCEM_End_of_Life_Care_Toolkit_December_2020_v2.pdf
8	Is there a message for recumbent patients on the ceiling tiles in the Resus room?	☐ D	E.g.: "You are in the Emergency department at Standard Hospital"
9	Is there a dedicated psychiatric assessment room that conforms to PLAN [4] standards.	☐ F	
10	In the case of a dying or recently deceased patient, is the relevant clinical area ☐ Quiet ☐ Private ☐ Sensitively designed ☐ Readily identifiable as such to approaching staff?	☐ F ☐ D	Consider hanging laminated symbol (e.g. butterfly), indicating the need for staff to keep noise level and language appropriate. Some rooms for bereaved relatives are designed with adjacent room for the deceased.
11	Is patient feedback sought and acted upon? Are patients' comments (positive and negative) shared with staff?	☐ F	Consider a monthly care newsletter. Friends and family surveys. Gathering and disseminating feedback from Care rounds. [5] Many departments have Lay Representatives/Patient Voice Representatives at departmental meetings. Is there a nominated ED (senior medical) patient champion?

Patient pathway through the ED Arrival			
Item	***Standard***		***Points to consider***
12	Are patients, arriving by any means, warmly greeted by a named person?	☐ F	For those EDs running Rapid Assessment and Triage, is the "meet and greet" incorporated within. [6] Are patients offered water at triage or at Paramedic handover/ RAT? (When appropriate, c.f. after discussion if concerns regarding stroke). #CallMe - addressing patients with their preferred name and not assuming that they are most comfortable using their formal birth forename.
13	Do staff introduce themselves by name, as well as identify their role and position? Do staff identify the rationale for the interaction?	☐ F ☐ F	This includes both verbal and physical (e.g. badges) identification. i.e. Explaining why the staff are speaking with the patient, and what they are going to do.
14	Are the processes, and patient journey explained clearly	☐ F	In a variety of formats including written and electronically available formats, audio-visual displays, posters etc.
15	Are patients clearly told how to access staff when they have needs or concerns? Is this access facilitated by the department, to make it as easy as possible?	☐ F	Are patients on trolleys routinely told how to use a call bell that is within reach? Are there posters explaining how to inform staff of concerns, or patient requirements? Consider how easy this is for patients? Has it been 'road tested' by staff (e.g. 'mystery shopper').
Patient pathway through the ED Early assessment			
Item	***Standard***		***Points to consider***
16	Do nursing staff at patient entrances have easy and timely access to a senior doctor for treating sick patients as well as prescribing analgesia for severe pain	☐ F	
17	Are patients routinely given *forecasts*[5]? Is the process of care explained clearly?	☐ F	*"You're likely to have broken your hip….and will need surgery tomorrow…they'll have you up and moving the very next day"* or *"we'll have a proper look at you, get you (another) ECG, some blood tests and an X-ray and then assess what you are like on your feet…you can expect this to take a couple of hours."*
18	Is there a process for identification of time critical conditions that is: Early Effective	☐ F	e.g. Trauma, Sepsis, Stroke, MI Consider processes for rapid identification of deteriorating patient, and the application in ED (i.e. Use of NEWS scoring etc) Is escalation of concerns by staff easy and appropriate? See RCEM document on *Quality in Emergency Care: Defining and measuring the quality of care in EDs*
19	Is there a process for rapid treatment of time critical conditions that is:	☐ F	Consider processes for rapid management of specific conditions e.g. Trauma, Sepsis, Stroke, MI

	Early Effective		See RCEM document on *Quality in Emergency Care: Defining and measuring the quality of care in EDs* *Note: CRS standards* *National audit standards: e.g. NICE Head Injury, TARN*
20	Is there a process for early treatment of symptoms?	☐ F	i.e. Pain, withdrawal symptoms, vertigo/dizziness, N&V, urinary catheterisation in urinary retention
21	Are patient expectations and previous decisions, as well as bespoke care needs established early	☐ F ☐ D	e.g. nominative preferences, LPA requirements, contact with NoK, etc. Do staff routinely establish what patients want from the visit? Do staff routinely establish if any bespoke care needs? (e.g. dietary requirements, language requirements, religious needs etc) Electronic access to DNAR / RESPECT decisions
22	Is there a process for initiation of investigations which is : Early Appropriate	☐ F	Is there appropriate use of care sets and point of care tests (e.g. early use of VBGs, early ECG) Early senior review to request specific tests (e.g. CT, specific tests that are part of pathway-but often overused [e.g. D-Dimer, HsTn]) (note: risk and costs of over investigation). Consideration of RCEM Guidance on Reducing redundant activity in the acute setting
Patient pathway through the ED Assessment and diagnosis			
Item	***Standard***		***Points to consider***
23	Are there regular reviews of the patient, including comfort and clinical needs?	☐ F	Are there regular checks on: • Patient comfort (see Comfort and Care rounds) • Clinical status (to identify 'the deteriorating patient') • Patient symptoms (including the effectiveness of treatments) Is there action based on these check and is it documented? Hourly Safety Checklist (https://onlinelibrary.wiley.com/doi/10.1111/jocn.15184)
24	Are patients given regular updates to forecasts	☐ D	Is new information communicated to patient (and relatives) in a timely fashion? e.g. results of tests, completion of stage of treatment, movement within department, and through the process of care.
Patient pathway through the ED Discharge			
Item	***Standard***		***Points to consider***
25	Does discharge planning: ☐ Include bespoke written and verbal advice ☐ Include check of social and welfare concerns ☐ Pragmatic considerations (e.g. how is the patient getting home) ☐ Including communication of	☐ F	See 'Giving information to patients' guideline from RCEM. Is there a system of assuring and documenting these? Does the discharge advice include: • 'Safety netting' Advice about when to return as emergency, concerning signs and symptoms • Fitness to drive and fitness to work advice • Diagnosis and any uncertainty surrounding this (note not all patients will have a specific diagnosis following an ED visit) • Symptom management and treatment • Contact details of ED for concerns Is there a discharge checklist that is used by all staff?

	this to carers, relatives, healthcare providers, custody staff (where appropriate)		
26	Ensure follow up arrangements and prescriptions provided and clear if needed	☐ F	It is better for patients not to have to return for medications (see RCEM advice on Emergency Department Out of Hours Discharge Medications). Similarly, it is preferable that appointments are arranged prior to discharge. Where not possible, clarity regarding time-frames and processes must be clear (and robust).
27	Are systems for review of results and communication of these to patients effective?	☐ F	See RCEM guidance on Management of Investigation Results in the Emergency Department. This system should include unexpected results (e.g. 'missed factures', addendums to results, and delayed results (e.g. microbiological culture results) Systems for communication of these findings to the patient in a timely and sensitive fashion should be in place. This should include follow up for 'incidental findings' (e.g. lung nodule, adrenal adenomas) and repeat/further investigations suggestions (e.g. repeat 6-week CXR/CT chest)
Continuing care			
Item	***Standard***		***Points to consider***
28	Is comfort rounding routine?	☐ F	Are pillows routinely offered to those patients who will be admitted?
29	Is there a trolley round offering food, drink, toiletries etc?	☐ D	Does the ED have volunteers? Minimally on a daily basis.
30	Is there a clearly displayed up to date information regarding taxis, bus timetables, bus stop locations, car parking, cash points, shops and refreshments etc?	☐ D	
32	Is written information provided for patients, and carers for those returning to care institutions?	☐ F	Incorporating appropriate details such as diagnosis, management, new/ altered medications, ED contact details, next of kin informed (yes/no) and recommended action in case of further episodes.
33	Is there easy access to translation services, including British Sign Language?	☐ D	Do staff know otherwise know how to access a translation service? Is there an up to date staff foreign language speakers list? Are information leaflets available in other languages?
34	Does the ED follow the advice contained within the RCEM documents regarding of Mental Health Act, consent, capacity, and restraint in the Emergency department?	☐ F	See RCEM Guidance webpage.

Care of the elderly patient			
Item	***Standard***		***Points to consider***
35	Is dementia friendly training mandatory and up to date among all ED staff including receptionists, cleaners and security?	☐ F	
36	Is dementia care of a high standard?	☐ D	Has the department been examined and responded to a report by a dementia friendly group e.g. the Alzheimer's Society? Is there a care package for dementia? Are such patients given a dementia wristband? Are the departmental toilets dementia friendly? Are directions to them, and return to ED clearly signposted? Does the ED provide an appropriate number of dementia friendly cubicles? See Airedale NHS Foundation Trust's A dementia friendly ED.
37	Is a skin vulnerability assessment performed on arrival for all frail, elderly patients? Are those with vulnerable skin promptly places on mattress toppers (that enable imaging) or a bed or airwave?	☐ F	
38	Is screening for cognitive impairment routine?	☐ D	
39	Is screening for risk of Falls routine? Is there a falls prevention policy specific to ED?	☐ F	
40	Are the delirious offered distraction therapy?	☐ D	E.g. A twiddlemuff or dementia dolls http://www.emexeter.co.uk/care.html
41	Does the ED follow the advice contained in the following RCEM documents? ☐ End of life care for adults in the ED ☐ Quality care for older people with urgent and emergency care needs. ☐ Dignity in dementia.	☐ D	See RCEM Guidance webpage. https://www.bgs.org.uk/resources/resource-series/silver-book-ii
Care of children			
Item	***Standard***		***Points to consider***

42	Is there demonstrable evidence of the safeguarding of children? ☐ Is there evidence that all staff are trained to the levels set out in the document opposite? ☐ Are staff aware to whom to escalate? ☐ Do staff know who the Trust safeguarding lead is?	☐ F	For reference *Safeguarding Children and Young People: roles and competencies for health care staff*. https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies
43	Are facilities available for distraction of distressed children? Do a facilities meet the RCPCH standards for Emergency Care	☐ F ☐ D	E.g. computer tablets, a starlight distraction box (www.starlight.org.uk<http://www.starlight.org.uk/), DVDs etc. Facing the Future: Standards for children in emergency care settings https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings Some of these standards will be aspirational in a few departments.
44	Is care instituted as soon as possible? ☐ Are all children offered appropriate and prompt analgesia? ☐ Are the parents/ relatives/carers/ all young children with vomiting and diarrhoea +/- dehydration encouraged to start oral rehydration therapy on arrival?	☐ F	RCEM Management of Pain in Children. Are there multi-disciplinary processes to reduce admission (e.g. as per BOAST Paediatric Forearm Fracture audit standards: https://www.boa.ac.uk/resources/boast-early-management-of-the-paediatric-forearm-fracture.html)
Care of patients with complex requirements			
Item	***Standard***		***Points to consider***
45	Does the department have access to learning disability health care staff and is there evidence that the service is used?	☐ F	How do staff know how to access LD staff? Are expectations around the service for staff, patients and providers clear?
46	What evidence is there demonstrating ED compliance with the following RCEM Quality in Emergency Care Best Practice Guidelines: ☐ The Patient who Absconds ☐ ED patients in Police Custody	☐ F ☐ F	See RCEM Guidance webpage.

	☐ Caring for adult patients suspected of having concealed drugs ☐ Information sharing to reduce Community Violence ☐ Management of Adult Patients who enter ED after Sexual Assault and/or Rape ☐ Mental Capacity Act in Emergency Medicine practice ☐ Management of Acute Behavioural Disturbance ☐ Management of Domestic Abuse ☐ Chaperones in the ED ☐ Alcohol toolkit ☐ Frequent attenders in the ED ☐ Giving information to patients ☐ Drug Misuse in the ED ☐ Homelessness and Inclusion Health	☐ F ☐ F ☐ F ☐ F ☐ F ☐ F ☐ F ☐ F ☐ F	Management of Suspected Internal Drug Trafficker (SIDT See also RCEM Mental Health Toolkit Does the ED have a domestic violence champion? Are Independent Domestic Violence Advocates available? Including teenagers Patients identified as 'very high frequency attenders' (e.g. 30 or more attendances per year) should have a multidisciplinary meeting and case management; including social care and primary care, with a review of the bespoke management plan.

The ED team			
Item	***Standard***		***Points to consider***
47	Do all staff feel valued? Does the department meet the RCN staffing ratios/ requirements including those for children's nurses?	☐ F	Are there frequent shared examples of positive feedback, either at handover or in writing (or both). Consider care awards in recognition of achievement. Are staff thanked for their efforts by the lead clinician or senior nurse on completion of post? Is there regular effective feedback to staff? Do you regularly and explicitly celebrate excellence in care and within the ED team? e.g. 'GREATix' Is there support for those involved in stressful situations? See RCEM Guidance & Resources webpage.

48	Is there a joint regular scheduled combined medical and nursing handover?	☐ F	Effective team working requires collaboration between medical and nursing teams. Joint handovers facilitates this.
49	Are senior doctors approachable and available?	☐ F	"Be approachable and available for the Juniors" See RCEM Non-technical Skills - Top 10 Tips. Are the processes for contacting and involving senior staff clear?
50	Are staff routinely able to take breaks?	☐ F	Tired staff are less likely to come across as caring and they are more likely to make clinical errors.
51	Are staff from other specialties engaging in clinical work in the ED supported?	☐ F	Are they welcomed, helped in finding the patient, equipment, paperwork/software interfaces and told who to report to on closure? Have they received correspondence outlining these aspects?
52	Is staff wellbeing managed?	☐ F	Is there an active wellbeing champion in the ED? Is there resilience training (or equivalent)? Is there ongoing activity/projects to support wellbeing? Are systems in place to prevent, identify, support and rehabilitate staff burn out?
53	Is the equipment in the department easy to locate, clearly organised and labelled?	☐ F	Repeated searches for essential equipment lowers morale. Is the department re-stocked daily? Delays in locating equipment can affect patient care. Consider the use of trollies/packs for frequent activity and procedures (FICB, epistaxis management, PVB care, vascular access etc.).
54	Is there an effective process to report and respond to problems IT, estates and equipment?	☐ D	Poor IT support can harm patients and demoralise clinical staff. Staff and patients should be able to identify and report issues with the patient environment. Are reported issues resolved quickly? Is there a Nominated IT / Informatics lead? (To champion the use of technology and information within the ED to improve patient care and efficiency as well as promoting data quality and access for clinicians)
Education about care			
Item	***Standard***		***Points to consider***
55	Have all staff had training in, and deliver: ☐ Customer care ☐ Compassionate care Is it clear to all staff that the NHS mission is to provide a safe, committed, compassionate and caring service?	☐ D ☐ D	Many Trusts have a policy of Value Based Recruitment and training in value based communication. As per RCEM's Francis Report Recommendations: a checklist for Emergency Departments. Consider offering a welcome letter outlining this to all new members of the team.
56	Is "care" embedded within ED induction for all staff? Does it form a part of ongoing teaching and handovers?	☐ F	Consider using clinical scenarios to discuss the care of patients and their relatives/ carers.

57	Are staff encouraged to report concerns regarding care? Do they know the procedure to follow when they do not believe their concerns have been listened to?	☐ F	Raise concerns in line with local policy, which may be in keeping with escalation below: • Incident Reporting • Line Manager/Clinical Director • Chief Medical Officer/Chief Nursing Officer/Responsible Officer for the organisation • Freedom to Speak up Guardian/Chief Executive
58	Are staff aware of how to respond to patients or relatives who wish to complain?	☐ F	
59	Are registered staff aware of their statutory obligation to observe a duty of candour where a patient has come to harm or death as a result of clinical error?	☐ F	

Measuring care and leadership			
Item	***Standard***		***Points to consider***
60	Has the ED made measurable improvements in response to their CQC reports, RCEM and local audit, and patient feedback? Are standards related to patient care improved through audit and quality improvement? Is there engagement with national benchmarking projects to promote service development and excellence?	☐ D ☐ D ☐ D	Such as comfort care metrics. *See RCEM Quality in Emergency Care: Defining and measuring the quality of care in EDs* e.g. NHS Benchmarking, GIRFT EM
61	Has the ED inspected the CQC Patient First and RCEM crowding guideline/ toolkit in anticipation and in response to exit block?	☐ F	RCEM Francis Report Recommendations – A Checklist for EDs See also Patient First https://www.cqc.org.uk/publications/themes-care/project-reset-emergency-medicine-patient-first
62	Does the department have leads for: ☐ Care ☐ Other significant groups e.g. adolescents, patients with dementia, frequent attenders etc	☐ D	How is the activity and effectiveness of these leads measured?
63	Does the department have an understanding of the population it serves, and tailored its services accordingly?	☐ D	Is there an understanding of the need to provide specific services in departments with high levels of potentially vulnerable patients groups (e.g. homeless, migrant workers, alcoholics).

			Does the ED have access to services which reflect the need of the community it serves e.g. HIV screening, frailty, assault in-reach services.
64	Can you demonstrate that patients are happy with the care provided, and staff are proud of the care provided.	☐ D ☐ F ☐ D	Is the department engaging with the patients about care standards? **Does the department regularly seek and review patient feedback and patient experience measures?** *See RCEM Quality in Emergency Care: Defining and measuring the quality of care in EDs, and Patient Experience in Emergency Departments: A strategic Overview*
65	Has the department embedded 'Safety' into the structures, processes and culture of the department?	☐ F ☐ F	See the RCEM 'Safety Toolkit' and the 'A Safe Emergency Department: A strategic Overview' documents. Is there a departmental risk register? A clear policy exists with regards clinical responsibility for patients referred to or seen by specialty teams but who remain in the ED.
66	Does the department follow Infection Prevention and Control guidelines? Can the Department demonstrate this?	☐ F	Infection Control and Prevention procedures are in place and understood by staff. Points to consider: regular hand hygiene audits, staff compliance mandatory IPC training, ability to isolate potentially infectious patients (e.g. MERs-CoV, SARS),Policy for isolation of patient with potentially highly infection diseases (e.g. MERS-CoV), RCM guidance: Emergency Department Infection Prevention and Control (IPC) during the Coronavirus Pandemic Some of the guidance in this document may require modification in relation to infection control and prevention measures during the Coronavirus pandemic e.g. reading material in the waiting room.

Authors

First published in July 2017, authors: Gavin Lloyd, Adam Reuben, Caroline Dowse, Simon Smith.

Revised and updated in May 2021 by Gavin Lloyd, Adam Reuben, Caroline Dowse, Katherine Henderson, Simon Smith, James France

Acknowledgements

July 2017:

Adrian Boyle

Katherine Henderson

Glynn Barnett

May 2021:

Adrian Boyle

Glynn Barnett

Ian Higginson

James France

Review

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

Conflicts of Interest

None

Disclaimers

The College 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

Research recommendations are described in the linked document: *Quality in Emergency Care: Defining and measuring the quality of care in EDs*

Audit standards

Audit standards are described in the linked document: *Quality in Emergency Care: Defining and measuring the quality of care in EDs*

It is anticipated that Emergency Departments will use this document to benchmark themselves and use these ‘standards’ to audit themselves. Feedback to RCEM on the usefulness of this document, and use of the standards in improving patient care is welcomed.

Key words for search

Patient care, Emergency Department

References

1. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013. https://www.gov.uk/government/publications/reportof-the-mid-staffordshire-nhs-foundation-trustpublic-inquiry (accessed 28 March 2017)
2. Robinson S, Brown R. The Francis Report: a call to arms. Emerg Med J 2013;30;783
3. Berwick D. A promise to learn – a commitment to act. Improving the Safety of Patients in England 2013. https://www.gov.uk/government/publications/berwick-review-intopatient-safety (accessed 28 March 2017)
4. Psychiatric Liaison Accreditation Network (Royal College of Psychiatrists). PLAN Standards. Available at: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/liaisonpsychiatry/plan.aspx (accessed June 2017)
5. Lloyd G. Care rounds: hot patient feedback enabling team care education. Br J Hosp Med 2016;77:262
6. Lloyd G, Reuben A. Improved emergency department patient care via rapid assessment and triage. Br J Hosp Med 2017;**78**:500

The Royal College of Emergency Medicine

7-9 Breams Buildings

London

EC4A 1DT

Tel: +44 (0)20 7400 1999

Fax: +44 (0)20 7067 1267

www.rcem.ac.uk

Incorporated by Royal Charter, 2008

Registered Charity number 1122689

Excellence in Emergency Care