Aims and intended learning outcomes

The aim of this article is to give practical advice to emergency nurses involved in caring for patients in non-clinical areas of the emergency department (ED).

After reading this article and completing the time out activities you should be able to:

- Describe the risks associated with ‘corridor care’ and the added vulnerability of patients cared for in non-clinical areas of the ED.
- Understand the different stages of patient flow and how each one may contribute to overcrowding in the ED.
- Explain where there are opportunities for nurses to enhance the safety and efficiency of patient care in an overcrowded ED.
- Apply practical solutions to minimise the risk of harm to patients cared for in non-clinical areas of the ED.

Introduction

Overcrowding in the ED is a near ubiquitous phenomenon across the developed world (Boiko et al 2021). In the UK, overcrowding in the ED has been associated with suboptimal patient outcomes, damage to staff well-being and clinical care being delivered in non-clinical areas (Boyle et al 2021). Caring for patients in physical spaces not intended for clinical use is commonly referred to as ‘corridor care’, but care in overcrowded EDs is also delivered in waiting rooms or store rooms. The fact that these spaces are not intended for patient care means that privacy, efficiency and safety have to be considered on a case-by-case basis by the individual clinicians delivering care, rather than being governed by strategic planning and procurement processes.
In an online survey of members of the Royal College of Nursing’s (RCN) Emergency Care Association, 72% of respondents (401 of 560) said they delivered care in a non-designated clinical area at least once a day, with almost all agreeing that the safety and efficacy of care were compromised (RCN 2023). The findings mirrored those of a similar survey conducted in March 2020 (RCN 2020), just before the first lockdown prompted by the coronavirus disease 2019 (COVID-19) pandemic, which indicates that corridor care is neither a new nor a pandemic-induced phenomenon.

There have been calls for action to end what has become routine in EDs nationwide (Boyle et al 2021, RCN 2023). While many of the measures necessary to resolve the situation require system-level investment and policies, the purpose of this article is to consider approaches that can be implemented at an individual and departmental level to mitigate some of the risks associated with corridor care (Tabriz et al 2020).

TIME OUT 1
Reflect on work in your ED. How often do you have to care for patients in non-clinical areas, such as corridors, waiting rooms and store rooms? What challenges does ‘corridor care’ pose in your practice?

How overcrowding occurs
Lindner and Woitok (2021) identified that the number of patients present at any one time in the ED is affected by:

- Input into the department.
- Intradepartmental flow.
- Outflow from the department.

People may decide to attend the ED because they are not aware of alternatives or because they experience difficulties accessing primary care (Whittaker et al 2016). While it is not possible at a local level to control the number of people who decide to attend the ED, how patients are streamed and triaged on arrival will affect the department’s patient population at any one time and therefore increase or decrease the likelihood of overcrowding and corridor care (Lindner and Woitok 2021).

Resuscitation areas typically have strict eligibility criteria and robust triage processes intended to safely stream low-acuity ambulatory patients to the waiting room. Overcrowding is therefore likely to have the greatest effect on majors sections and patients cared for in majors sections are most likely to experience corridor care (Yousefi and Yousefi 2020).

The movement of patients in the ED can create bottlenecks or an increased risk of losing track of patients, thereby delaying their care and ultimately their discharge (Thomas et al 2020). Many EDs use electronic patient tracking to monitor intradepartmental patient flow. However, with overcrowding, tracking may be less precise than expected. For example, patients will be easy to track if they are in a designated trolley bay in a majors section, but not if they are in a location labelled ‘corridor’.

Patient outflow from the ED has become increasingly challenging in recent years and is the most significant factor in ED overcrowding in the UK (Higgins and Boyle 2018). A loss of hospital beds, combined with the increasing number of ED attendances and inpatient admissions, has led to what the literature has called ‘boarding’. ‘Boarded’ patients are patients who have been assessed in the ED, following which it has been decided to admit them, but there is no inpatient bed available on their destination ward so they have to wait in the ED (Boudi et al 2020). The Royal College of Emergency Medicine (RCEM) (2015) supports the idea of patients being ‘boarded’ in corridors at their destination ward rather than in corridors in the ED, but this is not common practice.

A systematic review by do Nascimento Rocha et al (2021) identified that all-cause mortality increases after two hours of boarding due to reduced quality of care and increased likelihood of missed or delayed treatment. Furthermore, boarded patients require a physical space to be monitored and may not be ambulatory. They may be accommodated on ED bays or join patients who are still awaiting assessment. The subsequent mix of differentiated and non-differentiated patients in the same physical space creates challenges for ED nurses in terms of visibility and accountability.

Stages of patient flow
At each stage of patient flow – into the ED, within the ED and out of the ED – there are opportunities for nurses to mitigate the risks associated with corridor care. These opportunities can be realised through decision-making, communication and collaboration within and between teams and disciplines. Some interventions may help to ease overcrowding while others may enhance safety and efficiency by improving work practices.

Input into the department
Robust triage and streaming systems are essential to determine patients’ acuity and the most appropriate clinical area for them to receive care in an overcrowded ED. Streaming involves brief information gathering and interventions limited to basic first aid, point-of-care investigations and administration of analgesics (RCEM 2017). Patients are...
Patients streamed to a majors section and decreased cognitive function. Patients awaiting a clinical decision.

In the author’s experience, when determining whether a patient can be safely cared for in a non-clinical area, it is most appropriate to wait in a corridor on one single day had shown that some of them had time-critical conditions such as stroke, heart attack and sepsis (Cole 2017). An audit of the 24 patients who were waiting in a corridor one single day had shown that some of them had time-critical conditions such as stroke, heart attack and sepsis (Cole 2017). Using an optimal assessment tool for triage is key to prioritising patients and implementing investigations and interventions in a safer and more effective manner.

Beyond safe and appropriate triage and streaming decisions, overcrowding can be reduced by making the right practical decisions. Using the most appropriate equipment can ease patient flow through the ED and save limited physical space. If a patient requires observation – typically in a majors trolley bay – the nurse needs to consider from the outset whether a trolley or chair is the most adequate for them. An ambulatory patient who is well enough, or mobile enough, to sit in a chair will take up less space and be more easily moved through the department. In the author’s experience, it is less disruptive to allocate a patient to a chair during ambulance handover and triage than at a later stage, when it may be more difficult to convince them to ‘relinquish’ their trolley.

It is also important to consider for which patients it is most appropriate to wait in non-clinical areas. In the author’s experience, patients cared for in non-clinical areas typically fall into one of four categories:

- Patients streamed to a majors section and awaiting assessment.
- Boarded patients awaiting inpatient admission.
- Patients awaiting a clinical decision.
- Patients moved ad hoc to make space for higher-acuity patients or for patients who need privacy for an episode of care.

In the author’s experience, when determining whether a patient can be safely cared for in a non-clinical area, it is important to consider the factors listed in Box 1. Furthermore, optimal communication within and between teams, including triage and section teams, is essential to manage risks and improve safety and can be achieved by using electronic tracking, communication tools and safety huddles.

**Intradenpartmental flow**

**Team structure**

The allocation of staff across the department is not usually the responsibility of individual nurses, but defining roles within the team can be, and is an important aspect of managing overcrowding safely (Kavakli 2016). Having defined roles within the team has long been known to improve patient outcomes in resuscitation and trauma care, but this can also be the case in lower acuity care (Ford et al 2016). Patients cared for in non-clinical areas are often out of sight, and if there is no nurse specifically allocated to these patients, in the author’s experience, there will always be a risk that no one on the team feels accountable for them.

Table 1 outlines the structure of the nursing team in a majors section of a fictional ED according to two different care models. The majors section is staffed at all times by three nurses and one healthcare support worker. The section has 12 trolley bays and its surge capacity (using non-clinical areas) is 18 patients. In the task-oriented care model, one nurse is in charge of monitoring patients cared for in non-clinical areas. In the area-oriented care model, there is no nurse specifically allocated to that task.

**Tools for enhancing patient safety**

Patients cared for in ED majors sections are likely to have wide-ranging levels of acuity; older patients, for example, may be of relatively low acuity but need a physical space to lie down; patients who are usually allocated to the most appropriate physical area in the ED. Streaming may be undertaken in tandem with triage or by a dedicated streaming nurse with a view to triage further downstream. While ‘under-triaging’ can lead to treatment delays and direct patient harm, ‘over-triaging’ combined with misaligned streaming decisions can lead to disproportionate overcrowding in different parts of the ED (Hinson et al 2018).

Following the introduction of a bespoke initial assessment tool, an ED in Kent reduced mortality by half and the overall incidence of harm to patients by 70% within six months. Before the introduction of the tool, it had been observed that patients arriving in the ED would be put in a corridor without an assessment. An audit of the 24 patients who were waiting in a corridor one single day had shown that some of them had time-critical conditions such as stroke, heart attack and sepsis (Cole 2017). Using an optimal assessment tool for triage is key to prioritising patients and implementing investigations and interventions in a safer and more effective manner.

**Box 1. Factors to consider when determining whether a patient can be safely cared for in a non-clinical area**

- Level of dependence
- Level of acuity
- Physical route to resuscitation area and access to emergency equipment
- Falls risk
- Seizure risk
- Decreased cognitive function
- Risk of absconding

**TIME OUT 2**

How is your team structured and how closely does it resemble one or the other team structure described in Table 1? What are the benefits and limitations of the two care models shown in Table 1? In the area-oriented care model, how would you change staff allocation when patients outnumber the capacity of trolley bays?
ambulatory may be too unwell to sit in a chair or in a waiting room. Beyond initial triage, further assessment is therefore often required to allocate resources safely and efficiently. Furthermore, the team may comprise nurses who are not familiar with working in an ED, because staff from other clinical areas have been redeployed to the department to respond to a surge in demand or because agency staff have been called in to compensate for staff shortages. Using a structured and systematic approach will ensure that patients with the greatest need are prioritised (Cole 2017).

Patient safety huddles are a common method of improving situational awareness and identifying patients at risk of deterioration or adverse outcomes (McBeth et al 2017). They have been implemented in various hospital wards and EDs in the UK, typically at set times, but they can also be used in an ad hoc manner (White et al 2018). When confronted with an overwhelming workload, the last thing a nurse may think of is to stop what they are doing and discuss work with colleagues. However, assembling the team for a brief huddle can ensure important information is communicated and work is shared more effectively. In addition, a brief informal team huddle can reduce the length of boarding time and therefore ease overcrowding (McBeth et al 2017). Any member of the nursing team should feel free to call a safety huddle, using a non-hierarchical approach and focusing on efficiency and safety (Lamming et al 2021). This will not only help avoid missed or delayed treatment, but also alleviate concerns around accountability, strengthen team dynamics and improve staff well-being (Fitzgerald 2022).

A tool called the ED Safety Checklist was developed at Bristol Royal Infirmary to address the effects of overcrowding on patient safety in the ED, including delays in the recognition and treatment of critical conditions such as stroke, heart attack and sepsis; reliance on non-ED-trained staff and agency staff; and human errors (West of England Academic Health Science Network 2019). The ED Safety Checklist is a simple framework of medical and nursing tasks completed for every patient except those with minor complaints. It systemises the observations, tests and treatments required by patients in a time-based sequence. Following the introduction of the checklist, the ED at Bristol Royal Infirmary experienced significant improvements in the recognition of clinical deterioration and the compliance with clinical targets, particularly in patients who had had a stroke (West of England Academic Health Science Network 2019).

**TIME OUT 3**

Reflect on how patients are prioritised in the majors sections of your ED to mitigate the risks posed by overcrowding. Do you and your colleagues use a validated tool, such as safety huddles or checklists? If not, think about how you could integrate tools such as those described in the article into routine clinical practice.

**Outflow from the department**

Checklists can also be used to reduce the time ED nurses spend accompanying patients to their destination ward. Locally agreed checklist or criteria for handovers can be a way of making more effective use of ED nurses’ time (Robertson et al 2014). Traditionally, patient handover from the ED to the destination ward requires an ED nurse to accompany the patient and deliver a face-to-face handover to the receiving nurse. Provided the patient has been adequately assessed, a standardised written or electronic handover tool could be used, possibly complemented by a telephone call, and the patient could be accompanied to their destination ward by support staff, thereby freeing ED nurses’ time.

Leaving potentially unstable patients unattended in the ED to accompany a stable patient to their destination ward possibly carries a greater overall risk of harm (Schram et al 2016). Furthermore, if it is unsafe to leave the ED because there are too many unstable patients for the remaining nurses to attend to, transfer will be delayed and this will exacerbate overcrowding. There is little evidence to recommend a specific handover checklist or criteria, so a local

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**Table 1. Team structure in two different care models**

<table>
<thead>
<tr>
<th>Task-oriented care model</th>
<th>Area-oriented care model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse 1</td>
<td>Initial assessments Nurse 1 conducts initial assessment, including reviewing triage notes and taking one set of observations, and determines care plan</td>
</tr>
<tr>
<td>Nurse 2</td>
<td>Treatments Nurse 2 picks up patient notes left by doctors in box on the wall and administers treatments</td>
</tr>
<tr>
<td>Nurse 3</td>
<td>'Corridor care' and transfers Nurse 3: » Monitors patients cared for in non-clinical areas » Reviews notes of patients awaiting admission to inpatient ward or area, prepares handover notes, accompanies patients to ward/inpatient area and gives handover notes to receiving nurse</td>
</tr>
<tr>
<td>Healthcare support worker</td>
<td>» Personal care » Ongoing observations » Venepuncture and cannulation » Electrocardiography</td>
</tr>
<tr>
<td></td>
<td>» Personal care » Ongoing observations » Venepuncture and cannulation » Electrocardiography</td>
</tr>
</tbody>
</table>
agreement would be needed. The National Institute for Health and Care Excellence (NICE) (2018) has, however, published recommendations for standardised systems for intra- and interhospital patient transfers, thereby providing an overview of the evidence to consider when developing local transfer protocols.

**Equipment**

Hospital departments are stocked with equipment based on expected need. When care is being delivered beyond that capacity and in unexpected physical spaces, there may not be adequate equipment for certain tasks. In the author’s experience, for example, there can be delays caused by trying to locate a drip stand, which can be extremely frustrating for staff.

Mitchell (2023) noted that some hospital nurses are being asked to procure makeshift drip stands in the form of an adhesive hook to place on the corridor wall. While this may seem a practical solution to a challenging situation, it is important to consider the implications, in terms of professional accountability, of using untested or unauthorised equipment. If a simple wall-mounted hook poses risks to patients and healthcare professionals, the risks associated with the improper use of other medical devices cannot be overstated.

A crucial safety consideration for patients cared for in non-clinical areas is their oxygen needs. Even the large oxygen cylinders found on ED trolleys are a finite resource. If it is not possible to move the patient to a designated bay with a central oxygen supply, the nurse must be confident that the cylinder contains an adequate amount of oxygen and the patient must be moved near a secure oxygen supply as soon as possible. The National Association of Medical Device Educators & Trainers (NAMDET) has published an oxygen cylinder duration chart (namdet.org/2023/01/oxygen-cylinder-flows-and-contents-poster) that enables staff to quickly estimate how long is left in the cylinder according to its size. This can be a valuable tool when planning patient movement in the ED.

Overcrowding can lead not only to a lack of space to fit trolleys, but also a lack of trolleys themselves. In that event, ambulatory patients who require oxygen may be administered oxygen via a more portable cylinder with a smaller capacity. When formulating a plan to move these patients to a secure oxygen supply, it is important to calculate the remaining time as accurately as possible. Most portable oxygen cylinders the NHS procures are from the British Oxygen Company (BOC) and the manufacturer has developed a remaining time estimator in the form of a mobile app for many of its integral-valve cylinders (www.boconline.co.uk/en/services/healthcare-services/time-remaining-estimator-app.html). The use of such tools is supported by NHS England (2023) and allows more precise calculations of how long is left in a portable cylinder.

**Privacy and dignity**

Preserving patients’ privacy and maintaining their dignity can be particularly challenging when care is delivered in areas not designed for clinical use (Moskop et al 2019). Because conversations are less private, patients are likely to be less open and frank about their presentation and medical history, and clinicians may be equally less open and frank in their communication with patients (Stoklosa et al 2018). While altering communication approaches may help preserve privacy, important information can be missed because it is not clear what is actually being talked about. It may therefore be challenging to obtain, beyond taking observations, a comprehensive picture of patient acuity and need. The nurse may need to weigh the practicalities of moving the patient to a private area and then moving them back to a non-clinical area against the urgency of obtaining comprehensive information about their presentation and history.

Similarly, maintaining dignity is likely to be challenging in overcrowded EDs, particularly for patients who need personal care (Zamani 2019). Discussing personal care needs may be just as challenging for patients and nurses as disclosing personal medical information. Nurses need to anticipate which patients will require personal care, which can be achieved by conducting an initial needs assessment in a private area, and then prioritise the delivery of personal care in a private area as needed. For patients who are unable to communicate their needs, it may not be possible to conduct routine nursing interventions and position changes while maintaining the person’s dignity if they are being cared for in a non-clinical area. One solution is to keep one majors section bay entirely free for patients requiring exposing interventions or investigations. While this increases the number of patients cared for in non-clinical areas, it also enhances the quality of nursing care.

**TIME OUT 4**

Do you know how to calculate the time left in an oxygen cylinder according to its size? Download and study the NAMDET oxygen cylinder duration chart (namdet.org/2023/01/oxygen-cylinder-flows-and-contents-poster). If your ED uses BOC integral-valve cylinders, access and trial the BOC mobile app (www.boconline.co.uk/en/services/healthcare-services/time-remaining-estimator-app.html). Would these tools be useful to you and your colleagues?

**Would these tools be useful to you and your colleagues?**
Medicines management

Emergency presentations are often associated with pain and patients cared for in non-clinical areas may be out of view or wait a long time for definitive treatment, so pain management is an important consideration. There are many adverse consequences associated with suboptimal pain management, including increased risks of post-traumatic stress disorder and depression (Castillo et al 2017). When requesting a prescription for pain relief in an overcrowded majors section, it is important to ensure that all the necessary information has been gathered and communicated. Patients may not recall analgesia given by paramedics or may answer to the wrong name, which can lead to drug errors. Furthermore, it is important to determine the appropriateness of administering certain treatments. Patients receiving intravenous morphine or infusions containing potassium, for example, need to be closely monitored, which may be less feasible in a non-clinical area (Sur and Mohiuddin 2022, Murphy et al 2023).

Some EDs use patient group directives for certain analgesics, allowing nurses to dispense treatment for mild-to-moderate pain at triage or when patients arrive in a majors section. This is likely to improve initial pain management, but it is important to remember that boarded patients may have an ongoing need for analgesia. Depending on the length of boarding time, they may need follow-up doses of analgesics or antibiotics, for example.

In the author’s clinical experience, there are practical considerations for safe and effective medicines management in patients boarded in the ED, which are outlined in Box 2.

Special considerations

Children

There may be additional challenges in the case of children waiting in non-clinical areas of the ED with a parent of carer. It is important to consider the needs of the accompanying adult and be mindful of the safety implications if a child is left unattended, for example if the accompanying adult needs to use the toilet or make a telephone call. Developing a therapeutic relationship with the child and their parent or carer is important regardless of where the child is being cared for (Roberts et al 2015). Privacy issues may arise when determining safeguarding needs or enquiring about the provision of child and family services.

Mental health issues and cognitive issues

In an overcrowded ED, deciding where patients will be most effectively cared for based on physical acuity alone can increase the risk of patients absconding or self-harming. The risks linked to patient movement in the ED in terms of monitoring and accountability are increased in the case of patients with mental health issues and in the case of patients whose cognitive function is diminished. They may be ambulatory and medically well but nonetheless require observation to avoid absconding or self-harm (Mackway-Jones and Mackway-Jones 2020).

In the author’s experience, EDs often have an observable room designed for patients with mental health issues – an observable room typically has two doors, one of which is either locked or alarmed; it is visible from the nurses’ station and has an alarm strip rather than a single emergency call point; and it has no ligature points or trolley. With overcrowding, the capacity of the observable room is likely to be exceeded, potentially leaving vulnerable patients at risk. To reduce the risks of absconding and self-harm, it is important to communicate to all staff, including other nurses and support staff, which patients need to be observed because of the additional risks posed by the fact that they have a mental health issue or cognitive issues.

The fictional case study of Dominic illustrates the risk of patients with mental health issues absconding if they are cared for in a non-clinical area of the ED without appropriate observation (Case study 1).

Box 2. Practical considerations for safe and effective medicines management in patients boarded in the emergency department (ED)

- Anticipate patients’ medicine needs – notably for analgesics and antibiotics – at the time of the decision to admit them to hospital, to avoid missed or delayed treatment
- Check patients’ ED drug record and their inpatient prescription chart when prescribing or administering medicines to avoid duplication of doses
- Clearly record all treatments patients receive while in the ED and clearly communicate the information at handover to the destination ward to avoid the risk of exceeding maximum daily doses
- Be aware that the destination ward may use a different drug chart to the one used in the ED and clearly communicate all treatments patients have received in the ED at handover

Case study 1. Dominic

Dominic is a 20-year-old man who has been diagnosed with schizophrenia. He lives on his own and is under the care of the local community mental health team. He has a prescribed antipsychotic treatment that he does not always take. He presents to the emergency department (ED) with mixed overdose and suicidal ideation, having called an ambulance two hours after taking large amounts of paracetamol and alcohol.

At triage, Dominic is assessed as alert and systemically well but distressed, drowsy and unsteady on his feet. The triage decision is to stream him to a majors section of the ED for observation and Dominic is put on a trolley. To check Dominic’s blood levels of paracetamol, a healthcare support worker gains intravenous access, takes a blood sample and sends it to the lab. Dominic’s details are then entered onto the electronic patient management system and a porter is requested to take him to a majors section. However, all majors section trolley bays are full, so the porter leaves him in a corridor outside one of the sections. Twenty minutes later, a majors nurse comes to assess Dominic and finds the trolley empty. Dominic has left the ED with the cannula in situ.
TIME OUT 5
In Dominic’s case study, who was accountable for the patient? Consider discussing the situation described in the case study with your colleagues and think about what you could do as a team to avoid this kind of incident.

Conclusion
Reducing or ending ‘corridor care’, which has become routine in EDs, requires system-level investment and policies. However, while ‘corridor care’ is a reality, it is important to use a pragmatic approach and consider practical solutions for enhancing the safety and efficiency of patient care in overcrowded EDs. Accountability within the team, careful planning of patient movement, use of safety tools such as huddles and checklists, tactical allocation of resources and equipment and judicious medicines management are all essential to mitigate some of the clinical and professional risks associated with corridor care.

TIME OUT 6
Identify how managing care in non-clinical areas safely and efficiently applies to your practice and the requirements of your regulatory body.

TIME OUT 7
Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account.

References
Royal College of Nursing (2020) Corridor Care: Survey Results. www.rcn.org.uk/professional-development/publications/pub-009150 (Last accessed: 26 September 2023.)

Corridor care
TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. What has overcrowding in the emergency department (ED) not been associated with in the UK?
   a) Enhanced patient satisfaction
   b) Suboptimal patient outcomes
   c) Damage to staff well-being
   d) Clinical care being delivered in non-clinical areas

2. The term ‘corridor care’ is generally accepted as meaning:
   a) Care provided in physical spaces not intended for clinical use
   b) Only care provided to patients on trolleys in hospital corridors
   c) Care provided anywhere in an overcrowded hospital, including in clinical areas
   d) Care provided in the corridors of inpatient wards after patients have been transferred from the ED to their destination ward

3. Which of the following statements is false?
   a) Overcrowding in the ED is a near ubiquitous phenomenon across the developed world
   b) Corridor care is a new situation that has been created by the coronavirus disease 2019 pandemic
   c) Almost all respondents to a survey agreed that corridor care compromises the safety and efficacy of care
   d) The likelihood of corridor care is affected by how patients are streamed and triaged in the ED

4. The number of patients present at any one time in the ED is affected by:
   a) Input into the department
   b) Intradepartmental flow
   c) Outflow from the department
   d) All of the above

5. Which area of the ED is generally considered to be the most affected by overcrowding?
   a) Resuscitation areas
   b) Minors sections
   c) Observable rooms
   d) Majors sections

6. Which one of these factors needs to be considered when determining whether a patient can be cared for safely in a non-clinical area?
   a) Level of dependence
   b) Physical route to resuscitation area
   c) Risk of absconding
   d) All of the above

7. The ED Safety Checklist developed at Bristol Royal Infirmary enables clinicians to:
   a) Minimise observations, tests and treatments
   b) Outsource observations, tests and treatments
   c) Systemise observations, tests and treatments
   d) Offset observations, tests and treatments

8. Which of the following statements is true?
   a) There is no safe way to reduce the time ED nurses spend accompanying patients to their destination ward and handing them over to the receiving nurse
   b) Traditionally, handovers to the destination ward require an ED nurse to call the receiving nurse and a member of support staff to accompany the patient
   c) If patients have been assessed adequately, a standardised handover can be used and support staff can accompany them to the destination ward
   d) NICE has published a recommended handover checklist for transferring patients from the ED to the destination ward

9. A crucial safety consideration for patients cared for in non-clinical areas of the ED is:
   a) Their education needs
   b) Their oxygen needs
   c) Their personal care needs
   d) Their spiritual needs

10. In an overcrowded ED, deciding where patients will be cared for most appropriately...
    a) Should be based on physical acuity alone
    b) Should take into account factors such as mental health issues and reduced cognitive function
    c) Must be done at triage once and for all
    d) Should be primarily based on patient age

This activity has taken me __ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent Good Satisfactory Unsatisfactory Poor

As a result of this I intend to: ____________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________