

The Royal College of Emergency Medicine

## Best Practice Guideline

### Screening in the Emergency Department



February 2024

## Summary of recommendations

1. Screening information should be obtained after triage / initial assessment process and should not interfere with timely access to care. Initial triage processes should limit the focus and content of questions to information pertinent to the patient's condition to determine the priority in which patients should be seen and allow a limited risk assessment should they decide to leave without being seen.
2. Screening should only occur if there is sufficient capacity such that the primary role of the ED and key quality metrics are largely unaffected.
3. The benefit gained by the individual from the screening should outweigh any harms, for example from over diagnosis, overtreatment, false positives, false reassurance, uncertain findings, and complications.
4. There should be agreed evidence-based policies covering which individuals should be offered interventions and the appropriate intervention to be offered.
5. Any screening process that is developed must minimise the burden placed on ED clinical staff and there must be clear governance processes in place, particularly with regards to who has the responsibility for follow-up after screening and dealing with the impact of 'false positive' screening.
6. When considering implementing screening processes, prioritisation should be given to those conditions which frequently present symptomatically to the ED and that are amenable to intervention within the resources of the ED.
7. Screening processes should be developed which are implementable within the ED workflow and that minimize impact on patients and ED staff.
8. Local disease prevalence and risk factors should be central to deciding whether to implement a screening programme.
9. Screening interventions should be sustainable both in terms of ED resources (staff time etc.) and the wider costs and benefits to the healthcare system as a whole.
10. Involve patients in the implementation of any screening programme / initiative.
11. There are clear benefits to embedding screening into electronic health records, however caution must be exercised when considering mandating any form of screening.
12. The use of screening measures as performance metrics is generally discouraged.

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## Scope

Children and adults attending emergency departments. The term 'screening' is used in a very broad sense in this document covering the whole spectrum, from specific conditions which have a recommendation from the National Screening Council to opportunistic case findings. Screening may refer to a specific test or the process of questioning.

## Reason for development

Emergency department (ED) patients are being targeted with increased frequency for screening initiatives, some of which are unrelated to the patient's reason for attending (opportunistic). ED staff are coming under increasing pressure to implement 'screening' initiatives. The aim of this guidance is to provide recommendations to EDs when considering implementing a screening initiative.

## Introduction

The primary role of the emergency department is to assess and treat acute illness and injury, other areas of the healthcare system exist whose core function encompasses screening e.g. General Practice. It also needs to be recognised that an ED attendance may represent a unique opportunity to engage with underserved patient groups (e.g. homeless) either by virtue of their presenting illness / injury or merely their presence in a healthcare setting. Evidence is emerging that screening for conditions unrelated to the ED attendance may also be effective. It is therefore clear that a 'tension' exists between the primary role of an ED and the opportunities to improve population in a wider setting, for which it is not currently directly funded.

Triage / initial assessment is a rapid evaluation of patient acuity to establish the order and/or location where the patient should be seen. The current standard in England is that no patient attending an emergency department should wait more than 15 minutes for their initial assessment. The routine inclusion of general (unfocussed) screening questions in the initial triage process creates a preventable delay in caring for patients and can potentially lead to harm.

There is a clear distinction between screening patients with certain types of presentations for associated conditions which may not be disclosed without direct questioning, and 'opportunistic' screening where the patient is found to have a risk factor or condition as a consequence of routine activity or specific screening activity by the ED. For example, a patient attending the emergency department with a facial fracture, it would not be unreasonable to ask questions regarding Interpersonal violence (IPV) or alcohol use; weighing the patient and measuring their height to calculate the patient's body mass index (which will not have any impact on ED management) to establish whether the patient is obese would be considered 'opportunistic'.

There is a real risk that the use of screening measures as performance metrics can lead to unintended consequences e.g. the over prescription of antibiotics. The denominator of the screening measure is especially important, it is rarely justifiable to have 'all ED attenders' as a denominator, rather a specific focussed patient group who are likely to be more relevant.

Examples of ED screening includes (not exhaustive):

Mandatory: Homelessness, Paediatric safeguarding.

Non-mandatory: Alcohol, Drugs, Tobacco use, Hypertension, Chlamydia, HIV, Delirium, Intimate Partner Violence, Syphilis, Viral Hepatitis, Obesity, Diabetes, Clinical Frailty Score.

The implementation of a screening initiative is unlikely to be cost neutral when ED staff time is factored in, and departments should be mindful of both sustainability and the cost of the initiative. A screening initiative that takes as little as 30 seconds to administer from start to finish at first may seem to be a 'minor' addition; however, if applied to three quarters of all ED attenders over year, for a department seeing 80,000 patients this would equate to an additional 500 hours of extra work or 50 extra 10-hour shifts.

## Recommendations

Screening information should be obtained after triage / initial assessment process and should not interfere with timely access to care. Initial triage processes should limit the focus and content of questions to information pertinent to the patient's presenting condition to determine the priority in which patients should be seen and allow a limited risk assessment should they decide to leave without being seen.

Screening should only occur if there is sufficient capacity such that the primary role of the ED and key quality metrics are largely unaffected. Screening should only be implemented when there is evidence of benefit.

The benefit gained by the individual from the screening should outweigh any harms, for example from over diagnosis, overtreatment, false positives, false reassurance, uncertain findings, and complications.

There should be agreed evidence-based policies covering which individuals should be offered interventions and the appropriate intervention to be offered. If there are no interventions or clear outcomes to an ED screening process, the necessity of the screening taking place in the ED should be questioned. ED screening processes which impact ED patient management should be prioritised over those where the screening process impacts non-ED management.

Any screening process that is developed must minimise the burden placed on ED clinical staff and there must be clear governance processes in place, particularly with regards to who has the responsibility for follow-up after screening and dealing with the impact of 'false positive' screening. Setting up a screening initiative is likely to require significant input from senior ED staff and this should be recognised as an additional role, as well as the need for any on-going oversight of the initiative. Screening processes should be developed which are implementable within the existing ED workflow and that minimize impact on patients and ED staff. The assumption should be that screening should only be implemented in the ED if new resources (i.e. funding for extra staff) are available in order to undertake the screening. This is the only way to avoid negatively impacting upon existing clinical care which is already under high levels of pressure.

When considering implementing screening initiatives prioritisation should be given to those conditions which frequently present symptomatically to the ED and that are amenable to intervention within the resources of the ED. An example of this would be injuries related to alcohol use and the delivery of brief alcohol interventions by specialist alcohol teams already working in the ED. Local disease prevalence and risk factors should be central to deciding whether to implement a screening programme, these will naturally vary between EDs. Individual EDs have the expert knowledge of their own local population and are best placed to determine the likely impact of implementing a particular screening programme.

Screening interventions should be sustainable both in terms of ED resource (staff time etc.) and the wider costs and benefits to the healthcare system as a whole. Patients or patient representative groups should be involved in the implementation of any screening programme / initiative.

There are clear benefits to embedding screening into electronic health records, however caution must be exercised when considering mandating any form of screening. The use of screening measures as performance metrics is generally discouraged, there is a significant risk that the desired effect of the screening process will be subverted by the need to comply with a target (Goodhart Law).

EDs operating opportunistic screening programmes which go beyond direct questioning (face to face or electronic) and lead to additional investigations (e.g. blood or urine tests) should ensure the relevant GMC guidance on consent is followed and that patients are aware which additional tests are being requested for the purpose of screening. Clear processes need to be in place which ensure staff are able to follow and document that they are acting within GMC best practice guidance.

# About this document

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## Acknowledgements

RCEM QECC

## Review

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

## Conflicts of Interest

None.

## Disclaimers

RCEM 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

None.

## Audit Standards

There should be a documentation and audit system in place within a system of clinical governance.

## Key words for search

Emergency department, screening, consent, opt out

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# **Appendix 1**

## **Methodology**

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

## **Evidence Levels**

1. Evidence from at least one systematic review of multiple well designed randomised control trials.
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting.
3. Evidence from well-designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies.
4. Evidence from well-designed nonexperimental studies from more than one centre or research group.
5. Opinions, respected authority, clinical evidence, descriptive studies, or consensus reports.



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