Extended Emergency Medicine Ambulatory Care (EEMAC) in OUH Emergency Department

Standard Operating Procedure

Version History

Date	Version	Author(s)	Edits
08.05.2025	DRAFT v1	[redacted]	
02.06.2026	DRAFT v2		Terminology updated from ED SDEC / EM SDEC to EEMAC throughout. SOP refreshed to reflect 2026 decisions, communication & new national guidance

References

Royal College of Emergency Medicine (2026) *Extended Emergency Medicine Ambulatory Care (EEMAC)*. RCEM Guideline, February 2026

NHS England (2026) *The Model Emergency Department: high performing urgent and emergency care pathways*. Published 9 February 2026.

Royal College of Emergency Medicine (2025) *Initial Assessment*. RCEM Service Design and Delivery Guidance.

NHS England (2022) *Guidance for emergency departments: initial assessment*. Published 12 August 2022.

Glossary of terms and references found at end of document

Contents

Standard Operating Procedure

Purpose

Extended Emergency Medicine Ambulatory Care (EEMAC) is an Emergency Medicine-led ambulatory care model providing assessment, investigation, treatment and observation for selected adult emergency patients who require extended diagnostics, senior clinical decision-making, treatment or observation, but who are expected to be discharged safely on the same day. Care will usually be completed within 8 hours of arrival to the Emergency Department, with total pathway times exceeding 12 hours expected to be exceptional.

EEMAC supports the delivery of same-day emergency care within the Emergency Department footprint, improving patient flow, enabling greater value-added clinical activity at the ambulatory front door, and enhancing patient experience in line with Royal College of Emergency Medicine (RCEM) and NHS England guidance.

This SOP defines:

- The scope of EEMAC
- Patient eligibility
- Clinical governance arrangements
- Standards of care
- Responsibilities of staff working within EEMAC

Operational processes are described in the appendices

EEMAC Principles and Model of Care

EEMAC is a 24-hour Emergency Medicine-led ambulatory care service located within and led by the Emergency Department.

Core Principles

- EEMAC provides assessment, investigation, treatment and observation for selected emergency patients who require ongoing Emergency Department care.
- Patients managed within EEMAC remain under Emergency Medicine clinical responsibility unless formally accepted and transferred to another specialty.
- EEMAC is not a triage streaming destination and should only be used following initial assessment and initiation of care
- Transfer to EEMAC must be based on clinical need and anticipated patient benefit, rather than operational pressures or performance targets.

- Patients should not be transferred to EEMAC where there is a clear requirement for inpatient admission or specialty-led Same Day Emergency Care (SDEC) at the point of assessment. EEMAC remains an appropriate setting for patients whose ultimate disposition is uncertain and may include subsequent transfer to specialty or inpatient care following further investigation, observation or senior clinical review.
- EEMAC is not an appropriate clinical area for low acuity patients who could be managed via a UCC or UTC.
- Patients managed within EEMAC should have equitable access to diagnostics, specialty advice, treatment and admission pathways available elsewhere within the Emergency Department.
- The majority of patients managed within EEMAC are expected to complete their care and be discharged on the day of attendance.

Patient Characteristics

Patients transferred to EEMAC will typically:

- Have completed an initial Emergency Department assessment and had care initiated.
- Require ongoing investigation, treatment, observation or senior clinical decision-making beyond that typically deliverable during the initial phase of Emergency Department care.
- Remain clinically stable and suitable for ambulatory management.
- Be able to be managed safely within a recliner-based or ambulatory care environment.
- Be anticipated to achieve same-day discharge in most cases.

Care is delivered using recliner-based seating, waiting areas and ambulatory treatment spaces, with access to the same diagnostic, specialty and operational resources available to other Emergency Department patients.

Patient Eligibility

Inclusion Criteria

Patients may be managed within EEMAC when they:

- Are aged 16 years or over
- Require ongoing diagnostics, treatment, observation or senior review
- Are clinically stable and suitable for ambulatory care
- Are anticipated to be discharged on the same day

- Would benefit from ongoing Emergency Department management rather than specialty SDEC or inpatient admission

Exclusion Criteria

Patients should not be managed in EEMAC if they:

- Require resuscitation, close monitoring or trolley-based care
- Require inpatient admission at the point of assessment
- Are more appropriately managed through a specialty-led pathway or low acuity UCC or UTC pathway
- Have significant behavioural disturbance, intoxication or mental health needs requiring enhanced observation
- Have no ongoing diagnostic or treatment requirement

Electronic activity and data recording

Due to current local system limitations, EEMAC activity is temporarily recorded as inpatient SDEC activity. Activity will be recorded as ECDS Type 5 when system functionality allows, in common with all other SDEC activity.

Operational Standards & KPIs

Access Standards

Standard	Target	Source
Initial assessment	<15 minutes	RCEM initial assessment
Secondary Assessment	<30 minutes	NHSE
Transfer to EEMAC	<90 minutes, appropriate patients only	Local operational policy

Outcome standards

Standard	Target	Source
Same-day Discharge	>80%	RCEM EEMAC
Admission rate (inpatient or SDEC)	5-15%	NHSE / RCEM EEMAC
Total pathway duration	80% <8hours	RCEM EEMAC
>12 hour total stay	Exceptional & triggers review	RCEM EEMAC

Care Standards

Patients in EEMAC must have:

- Access to appropriate facilities, comfort, food and drink
- Information provided on journey and care pathways
- Documented observations appropriate to clinical need
- Named responsible clinician
- Real-time documentation
- Timely analgesia and regular medication administration
- Discharge documentation completed before departure
- Appropriate escalation arrangements
- Equal priority access to diagnostics, admission and specialty input as patients within the main ED

Clinical Governance and Responsibility

Consultant Oversight

Overall responsibility for EEMAC lies with the Emergency Department Consultant in Charge.

A designated consultant provides operational oversight of EEMAC and ambulatory assessment processes, including consultant-led board rounds at least twice daily.

Senior Decision Maker

A senior decision maker (ST3+ or equivalent) is allocated to EEMAC at all times and, under consultant supervision, is responsible for:

- Patient review and decision-making
- Flow management
- Documentation including discharge letters
- Escalation of concerns
- Supervision of junior staff

Nursing Responsibilities

The EEMAC nursing team is responsible for:

- Direct patient care

- Observation monitoring
- Medication administration
- Environment and equipment checks
- Supporting patient flow
- Completion of nursing discharge processes & ensuring safe discharge

Administrative Responsibilities

Administrative staff support:

- Patient tracking
- Transfers within EPR
- Admission and discharge processes
- Maintenance of operational systems and facilities

Operational Responsibilities

Operational team support:

- Outward flow from EEMAC with allocation of inpatient beds or speciality SDEC capacity
- Escalation procedures when at capacity

Escalation and Safety

Clinical Deterioration

- Patients who deteriorate within EEMAC should receive immediate assessment and stabilisation.
- Patients requiring higher levels of monitoring, intervention or inpatient care should be transferred to the most appropriate clinical area without delay.

Detailed deterioration procedures are provided in Appendix 3.

Capacity Escalation

- EEMAC capacity is determined by available staffing, estate and operational safety.
- The Nurse in Charge retains authority to limit admissions to EEMAC when safe operation cannot be maintained.

Detailed escalation triggers and actions are provided in Appendix 4.

Governance and Audit

EEMAC performance will be reviewed through:

- KPI monitoring
- Incident reporting and review
- Patient feedback
- Audit against RCEM and NHSE standards
- Quality improvement initiatives
- Regular departmental meetings with EEMAC focus

EEMAC will remain under remit of ED Clinical Governance structure. Named nursing and clinician leads will support this process.

The SOP should undergo formal review every two years or sooner following significant service change.

APPENDIX 1 – EEMAC PATIENT FLOW PROCEDURE

Purpose

This appendix describes the operational process for identifying, transferring and managing patients within EEMAC.

Identification of Suitable Patients

Potential EEMAC patients may be identified during:

- Ambulatory Assessment
- Ambulance Assessment
- ED Majors (where clinically appropriate)

Patients must meet EEMAC inclusion criteria and not meet any exclusion criteria.

Transfer to EEMAC must be based on clinical need and anticipated benefit to the patient, rather than departmental performance targets or bed pressures.

Prior to Transfer to EEMAC

Before transfer, patients should have:

- Initial assessment completed
- Secondary nursing assessment completed
- Initial investigations commenced where appropriate
- Urgent treatments initiated
- Senior clinical review undertaken where required
- A documented working diagnosis or investigation plan

The transferring clinician remains responsible for the patient until transfer is accepted and completed.

Transfer to EEMAC

Patients should normally transfer within 90 minutes of arrival to the Emergency Department.

Patients should:

- Be clinically stable
- Be able to sit in a chair or recliner environment
- Have an identified investigation or treatment plan
- Have an anticipated same-day discharge outcome
- Not be more suitable for a specialty specific pathway

The EEMAC team will ensure the patient is transferred to the correct EPR location and allocated an appropriate responsible clinician.

Clinical Management within EEMAC

Patients within EEMAC may receive:

- Ongoing diagnostics and investigation review
- Treatment and therapeutic interventions
- Observation and reassessment
- Senior clinical decision-making
- Allied Health Professional input
- Specialty advice and review where required

Patients remain under Emergency Medicine clinical responsibility unless formally transferred to another specialty.

Discharge from EEMAC

Discharge should occur as soon as clinically appropriate.

Prior to discharge:

- Results must be reviewed, endorsed and acted upon
- Follow-up arrangements completed
- Medication requirements addressed
- Discharge documentation completed
- Patient information provided
- Safe discharge considered including removal of IV cannula

The majority of patients should complete their care on the day of attendance.

Admission or Specialty Transfer

Patients requiring inpatient admission or specialty-led care should be referred and transferred according to existing hospital processes.

Clinical responsibility remains with Emergency Medicine until formal acceptance and transfer has occurred.

APPENDIX 2 – EEMAC OPERATIONAL STANDARDS

Hours of Operation

EEMAC operates as a 24-hour Emergency Medicine service.

Staffing Standards

Minimum staffing should include:

- Allocated nursing staff 24/7
- Administrative support at peak times
- A designated senior decision maker (ST3+ or equivalent) available at all times
- Consultant oversight through the Emergency Department consultant structure

Staffing should be reviewed dynamically to ensure safe care across both EEMAC and the wider Emergency Department.

Board Rounds

Consultant-led board rounds should occur twice daily:

- 08:00
- 16:00

Additional senior reviews may be undertaken according to operational demand and patient need.

Monitoring Standards

Patients should receive:

- Observations appropriate to clinical condition
- Minimum four-hourly observations unless an alternative frequency is documented
- Escalation of abnormal observations according to hospital policy

Medication Standards

Patients should receive:

- Time-critical medications
- Regular medications where clinically appropriate
- Analgesia in accordance with RCEM standards and documented pain assessment

Documentation Standards

All patients must have:

- A named responsible clinician
- A documented management plan
- Appropriate observation records
- Real-time clinical documentation

Patient Experience Standards

The EEMAC environment should maintain:

- Patient dignity and privacy
- Access to food and drink
- Access to toilet facilities
- Clear communication regarding ongoing care and expected timelines

Length of Stay Standards

The service should aim for:

- Greater than 80% same-day discharge
- 80% of patients completing their pathway within 8 hours (ED plus EEMAC LoS)
- Very limited numbers of patients remaining within the pathway beyond 12 hours

Patients approaching 12 hours total pathway duration should undergo senior review and documented disposition planning.

APPENDIX 3 – CLINICAL DETERIORATION PROCEDURE

Purpose

To ensure safe recognition and management of patients who deteriorate while receiving care within EEMAC.

Recognition

Any member of staff identifying deterioration should immediately initiate escalation.

Examples include:

- Physiological deterioration
- NEWS escalation
- New chest pain or ECG changes
- Altered conscious level
- Seizure activity
- Acute behavioural disturbance
- Any clinician concern regarding patient safety

Immediate Response

The EEMAC team should:

- Attend the patient immediately
- Initiate assessment and treatment
- Request additional clinical support
- Escalate according to Emergency Department emergency response procedures

Available emergency systems include:

- EEMAC emergency alarm system
- Security response system
- Emergency Department senior clinician support

Clinical Decision

Following initial assessment, the senior clinician should determine whether the patient can:

- Continue treatment safely within EEMAC with aimed discharge disposition
- Require transfer to ED Majors
- Require transfer to Resuscitation

- Require direct inpatient admission

Transfer to Higher Acuity Area

Where higher levels of monitoring or intervention are required:

- The receiving clinical area should be identified
- Clinical handover completed
- Transfer documented
- Continuous patient supervision maintained throughout transfer

EPR Process

Where a patient returns to the Emergency Department from an EEMAC encounter:

- Existing documentation must be preserved
- EPR processes should follow current OUH documentation guidance (appendix 5)
- A discharge summary from the EEMAC encounter should be completed where required

Governance

All significant deterioration events should be reviewed through normal departmental governance processes.

APPENDIX 4 – EEMAC CAPACITY AND ESCALATION PROCEDURE

Purpose

To ensure safe operation of EEMAC during periods of increased demand, reduced flow or staffing pressures.

Principles

EEMAC capacity is determined by:

- Available clinical staffing
- Nursing staffing levels
- Estate limitations
- Ability to provide safe patient care
- Overall Emergency Department operational pressures

The Nurse in Charge (NiC) retains authority to limit or suspend admissions to EEMAC where safe operation cannot be maintained.

Patient safety takes precedence over flow targets at all times.

Operational Capacity

The operational capacity of EEMAC will be agreed by the Nurse in Charge in conjunction with the EEMAC clinical team and may vary according to staffing and departmental pressures.

Patients identified as suitable for EEMAC may remain within other Emergency Department waiting areas until capacity becomes available.

Escalation Triggers

Level 1 Escalation

Trigger:

- 85% capacity within EEMAC without anticipated imminent discharge
- Significant delays in patient progression
- Concerns regarding clinical workload or flow

Actions:

- Inform Nurse in Charge (NiC)
- Inform Consultant in Charge (CiC)
- Inform Operational Team

- Undertake senior review of EEMAC board and patient plans
- Prioritise discharge decision-making
- Consider temporary redeployment of clinical staff
- Consider transfer of appropriate patients to specialty pathways or inpatient areas where clinically indicated
- Consider environmental measures to improve flow and patient safety

Level 2 Escalation

Trigger:

- 100% capacity within EEMAC and not able to safely accept further patients
- Area assessed as operationally unsafe by clinical leadership
- Inability to provide timely clinical review

Actions:

- Inform Nurse in Charge (NiC)
- Inform Consultant in Charge (CiC)
- Inform Operational Team
- Suspend further transfers into EEMAC
- Manage suitable patients within alternative Emergency Department areas until flow improves
- Review staffing and capacity requirements urgently

Delayed Clinical Review

Trigger:

- EEMAC patients waiting more than 2 hours for clinician review

Actions:

- Escalate to EEMAC senior clinician or Consultant in Charge
- Review clinician allocation
- Reprioritise workload where necessary
- Undertake senior review of patient cohort and pending investigations

Recovery

Once patient flow and staffing return to safe operational levels:

- Transfers into EEMAC may recommence
- Escalation status should be stood down

- Any significant operational concerns should be discussed through departmental governance processes

APPENDIX 5 – EPR AND DOCUMENTATION PROCEDURE

Purpose

To ensure consistent electronic documentation, patient tracking and activity recording for patients managed within EEMAC.

Patient Tracking

All patients managed within EEMAC must:

- Be assigned to the correct EPR location
- Have a named responsible clinician
- Have an active documented management plan
- Remain visible on departmental tracking systems throughout their attendance
- The EEMAC team is responsible for ensuring patient locations remain accurate and updated in real time.

Clinical Documentation Standards

Clinical documentation should:

- Be completed contemporaneously
- Clearly document assessment findings
- Record investigation results and actions
- Document clinical decision-making
- Record escalation and handover discussions
- Include discharge or admission decisions

Documentation standards within EEMAC are equivalent to those expected elsewhere within the Emergency Department.

Activity Recording

EEMAC activity should be recorded in accordance with current NHS England and Emergency Care Data Set (ECDS) guidance.

At the time of writing, EEMAC activity is recorded as inpatient SDEC activity. Activity should be recorded at ECDS Type 5 when OUH systems allow.

Any future national coding changes should be adopted in accordance with Trust guidance.

Discharge Documentation

Prior to discharge:

- A discharge summary must be completed
- Investigation results must be reviewed and actioned
- Follow-up arrangements must be documented
- Safe discharge and removal of IV cannula
- Patient advice and safety-netting information must be provided
- Prescribed medications and TTOs must be completed where required

Discharge documentation should normally be completed before the patient leaves the department.

Electronic Discharge Process

Admin or nursing staff should ensure:

- All discharge documentation is complete
- Medication requirements have been addressed
- Follow-up arrangements are documented
- Electronic discharge processes are completed in accordance with local practice

Patients should not be electronically discharged until all required documentation has been completed.

Transfer to Inpatient or Specialty Care

Where a patient requires admission or transfer:

- Clinical handover must be documented
- Accepting specialty details must be recorded
- Transfer decisions must be clearly documented
- Clinical responsibility must be explicit at all stages

Patients Returning to the Emergency Department

Where a patient deteriorates within EEMAC and requires transfer to ED Majors or Resuscitation:

- Patient safety remains the immediate priority
- Existing documentation must be preserved
- EPR processes should follow current OUH guidance for movement between encounters: Currently this involves discharging and readmitting the patient in order to not lose recorded information.
- A discharge summary from the EEMAC encounter should be completed where required

Audit Requirements

The following may be monitored through governance and data tracking processes:

- Completion of discharge summaries
- Dispostion: Proportion of onward admission verses discharge
- Patients choosing to leave prior to assessment
- Patient length of stay
- Quality of clinical records

Audit findings should be reviewed through established Emergency Department governance structures.

Glossary of Terms and Acronyms

AHP – Allied Health Professional

CiC – Consultant in Charge

CT – Computed Tomography

CXR – Chest X-ray

EAU – Emergency Assessment Unit

ECDS – Emergency Care Data Set

ED – Emergency Department

EEMAC – Extended Emergency Medicine Ambulatory Care

EM – Emergency Medicine

EPR – Electronic Patient Record

LoS – Length of Stay

MDT – Multidisciplinary Team

MRI – Magnetic Resonance Imaging

NEWS – National Early Warning Score

NHSE – NHS England

NiC – Nurse in Charge

OUH – Oxford University Hospitals NHS Foundation Trust

RCEM – Royal College of Emergency Medicine

SDEC – Same Day Emergency Care

SDM – Senior Decision Maker

ST3+ – Specialty Trainee Year 3 or above (or equivalent senior clinician)

TTO – To Take Out (discharge medication)

VTE – Venous Thromboembolism

Definitions

Ambulatory Care – Assessment, investigation, treatment and observation delivered without the need for inpatient admission or trolley-based care.

EEMAC – An Emergency Medicine-led ambulatory care model providing same-day assessment, investigation, treatment and observation for selected emergency patients who require extended diagnostics, treatment, observation or senior decision-making but are expected to complete their care without inpatient admission.

Initial Assessment – The early clinical assessment undertaken following arrival to the Emergency Department to identify acuity, initiate investigations and treatment, and determine the most appropriate care pathway.

Length of Stay (LoS) – The total time a patient spends within a defined healthcare pathway. Within EEMAC reporting, this will normally refer to the total pathway time from arrival in the Emergency Department until discharge from EEMAC or transfer to an inpatient or specialty service.

Same-Day Discharge – Discharge from hospital on the day of attendance without requiring an overnight inpatient stay.

Senior Decision Maker (SDM) – A clinician with sufficient training and experience to make independent clinical decisions regarding investigation, treatment, disposition and escalation of care. Within EEMAC this is typically an ST3+ clinician, Associate Specialist, Specialty Doctor or Consultant.

Specialty SDEC – A specialty-led Same Day Emergency Care service operating outside the Emergency Department, for example Acute Medicine, Surgery, ENT or Gynaecology SDEC pathways.

Total Pathway Time – The time from patient arrival in the Emergency Department until discharge from EEMAC or transfer to an inpatient or specialty service.

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Redaction Summary

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Redaction 1.1

Comment: Personal Data

Exemptions/exceptions:

- S.40 - Personal Information