



Royal College
of Nursing

2020 | International Year
of the Nurse and Midwife

Corridor Care

Survey Results

EMERGENCY CARE ASSOCIATION SURVEY



This publication contains information, advice and guidance to help members of the RCN but it is equally relevant for other non-medically qualified registered health care professionals such as Allied Health Professionals etc. It is intended for use within the UK but readers are advised that practices may vary in each country of the UK.

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Methodology

The RCN conducted an online survey of members of the RCN's Emergency Care Association (ECA) working in England exploring respondent's experiences of corridor care. The ECA represents RCN members working in emergency care.

The link to this survey was emailed to all members working in England and publicised on the forum's social media accounts. The survey was open from Tuesday 14 January 2020 until Monday 27 January 2020. The majority of questions were closed qualitative with three supplementary open-text questions. We included a range of testimonials on the impact of corridor care both on patients, and on nurses. These reflect a balance of views on the main themes emerging from the survey, these were reviewed to remove any identifiable features.

In total, 1,174 ECA members responded to the survey. This signifies a 16.5% response rate from our sample (7,106 ECA members work in England) and demonstrates a representative view of Emergency Care Association members working in England. Statistically this sample provides a 95% confidence level in the results, with a 2.6% margin of error.

Summary of findings

- 73% of respondents provide care to patients in a non-designated clinical area at least once a day. A further 16% do the same at least once a week.
- 90% said the frequency of providing care in non-designated clinical environments has increased since last winter.
- 69% work in a hospital where nursing staff are deployed specifically to look after patients in non-designated clinical areas such as corridors.
- The use of the term ‘corridor nursing’ is being normalised, with 49% of respondents saying it is formally used in their workplace. An additional 40% say it is used informally.
- Respondents told us care being provided in non-clinical areas had the following impact on patients and their relatives:
 - * 90% said clinical practice becomes physically more difficult, for example, trying to provide intravenous medication
 - * 93% said it is difficult to monitor patients
 - * 90% said patient safety is compromised
 - * 95% said patient confidentiality is compromised
 - * 95% said patients’ dignity is compromised
 - * 85% said patients’ distress is increased
 - * 95% said patients’ privacy is compromised
 - * 90% said relatives become distressed.

Please see Appendix 1 for a selection of free-text responses to this question.

We also asked respondents what impact providing care in non-clinical areas had on themselves or other staff:

- 92% of respondents feel worried that patients may be receiving unsafe care
- 88% feel stressed providing care in these circumstances
- 84% told us it takes them longer than usual to provide the care they need to.

Please see Appendix 2 for a selection of free-text responses to this question

Finally, we asked respondents whether their emergency department had undertaken any initiatives to improve patient care this winter:

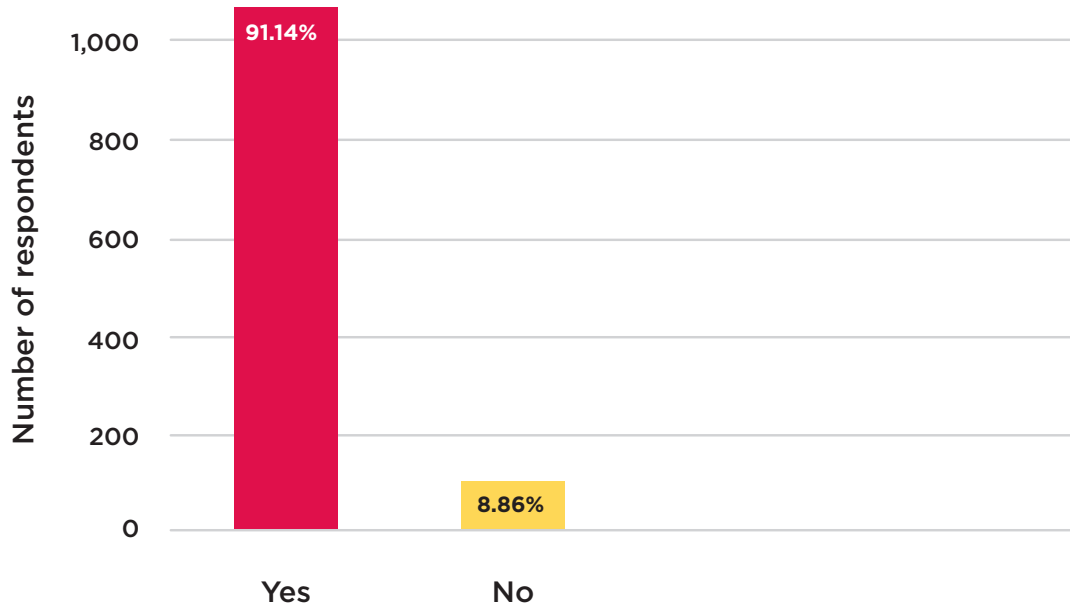
- 61% told us they had.

Please see Appendix 3 for a selection of free-text responses to this question.

Survey results

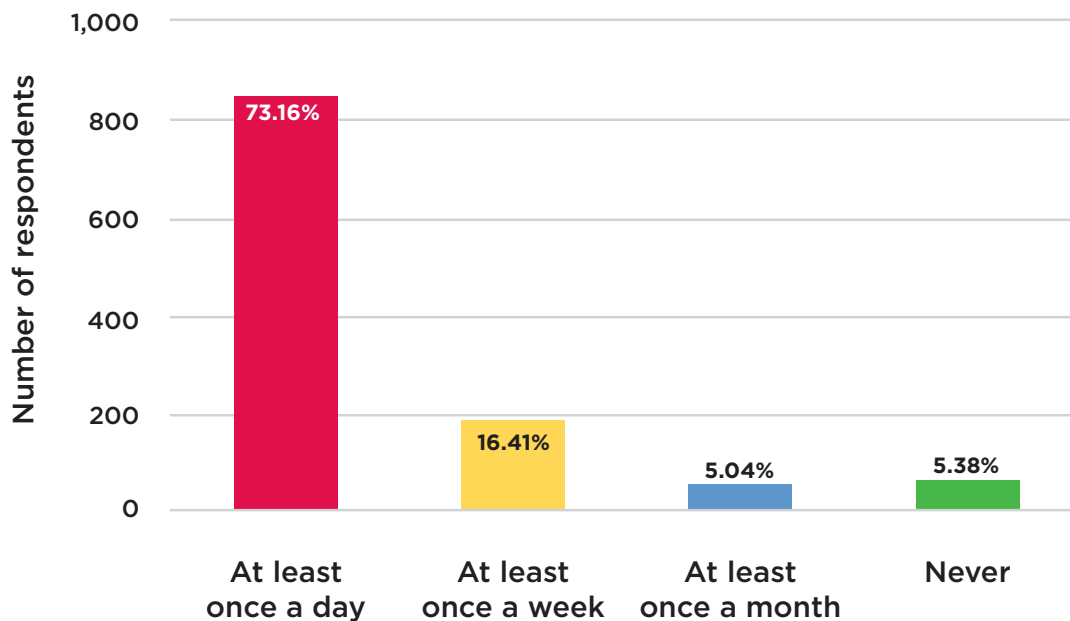
Question 1

Do you regularly work in an emergency department?



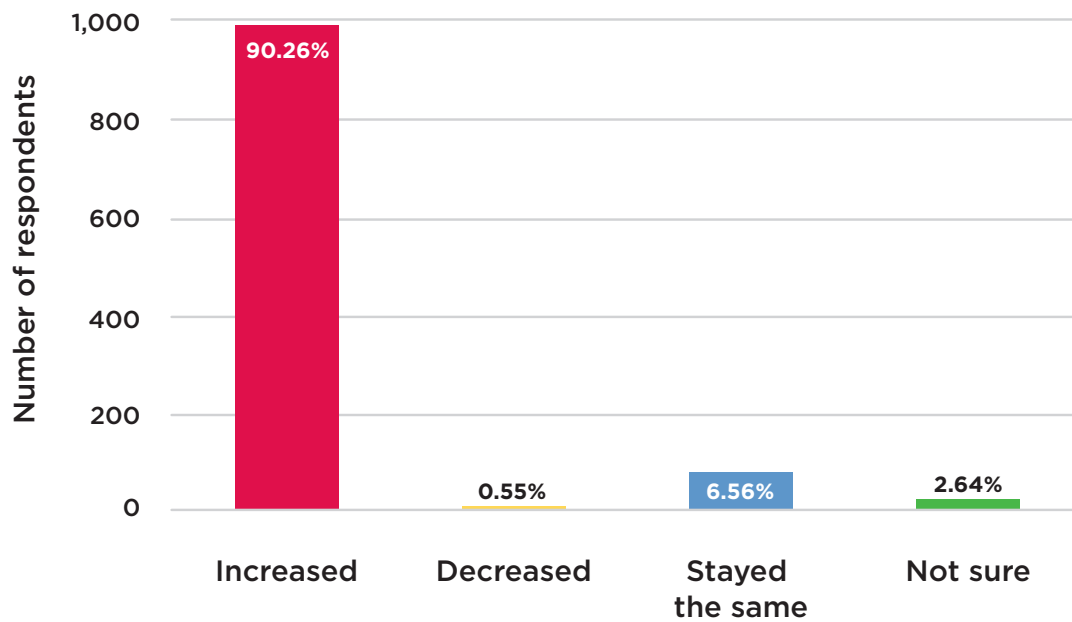
Question 2

In the last six months have you had to provide care to patients in a non-designated clinical area such as a corridor, waiting room or storeroom?



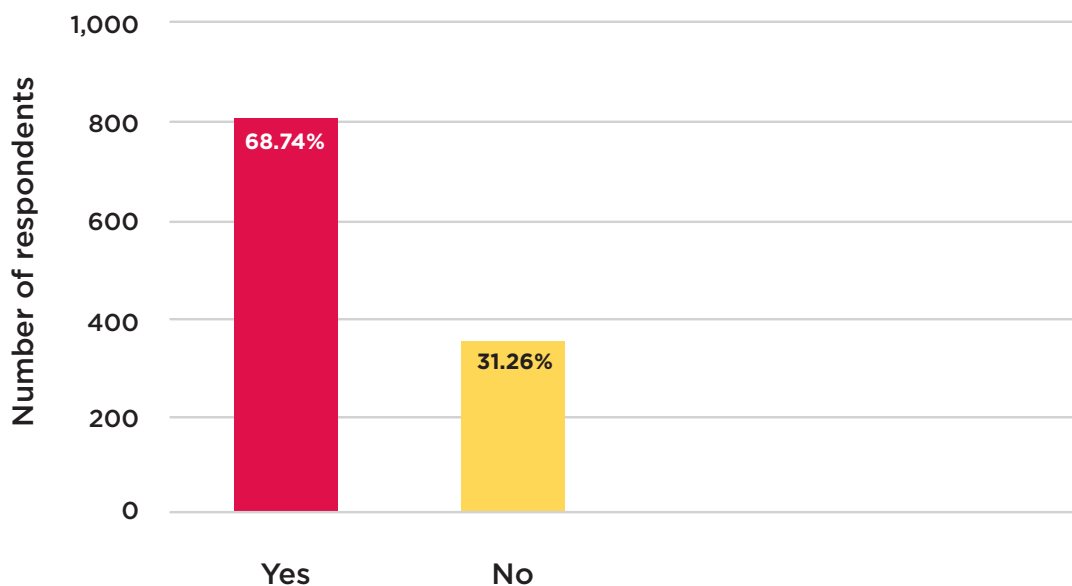
Question 3

Since last winter, has the frequency of providing care in non-designated clinical environments:



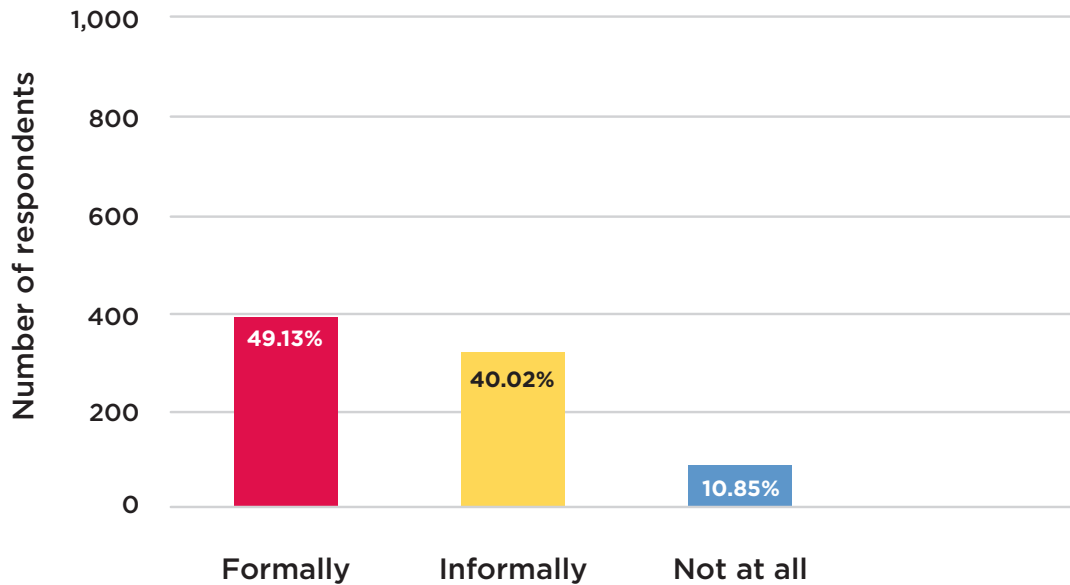
Question 4

As far as you know, does your hospital deploy any nursing staff specifically to look after patients in non-designated clinical areas such as corridors?



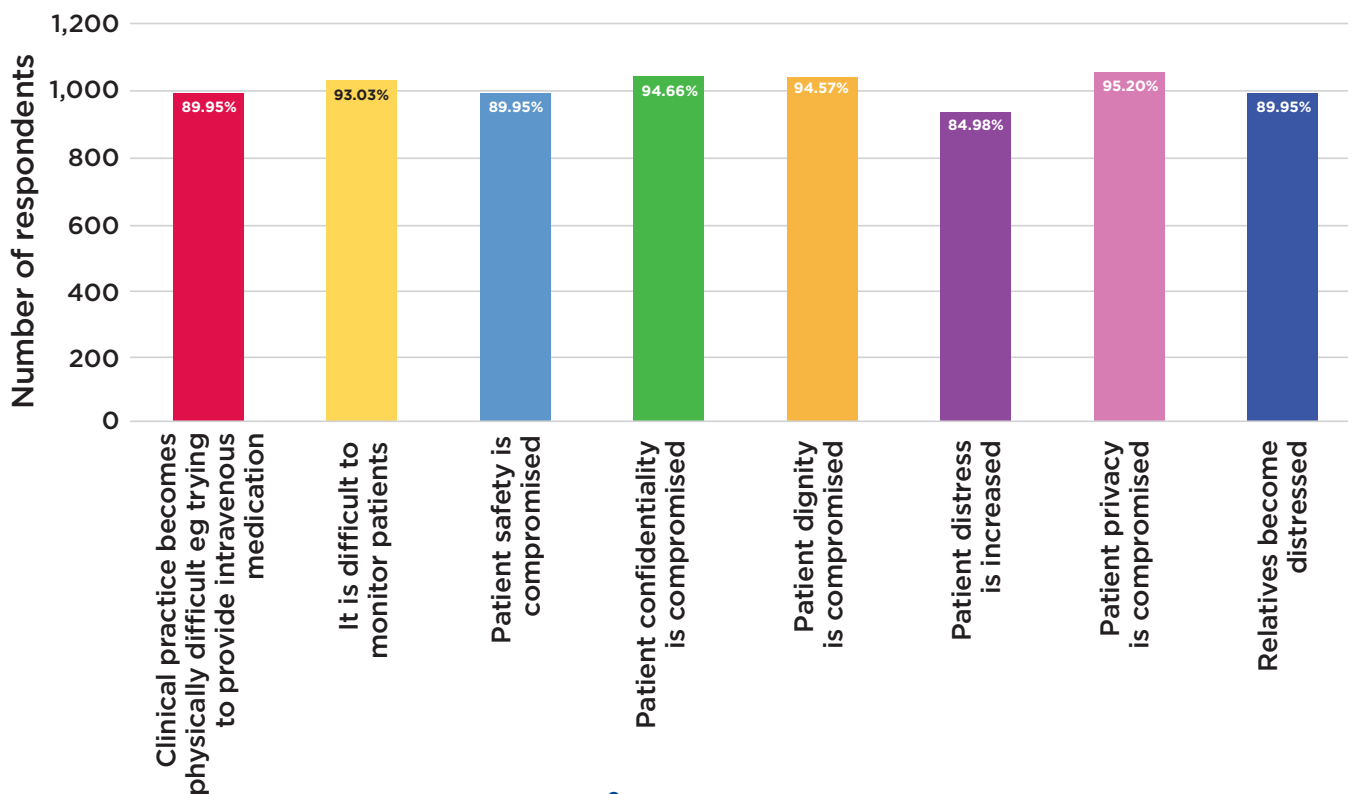
Question 5

Is the term 'corridor nursing' used?



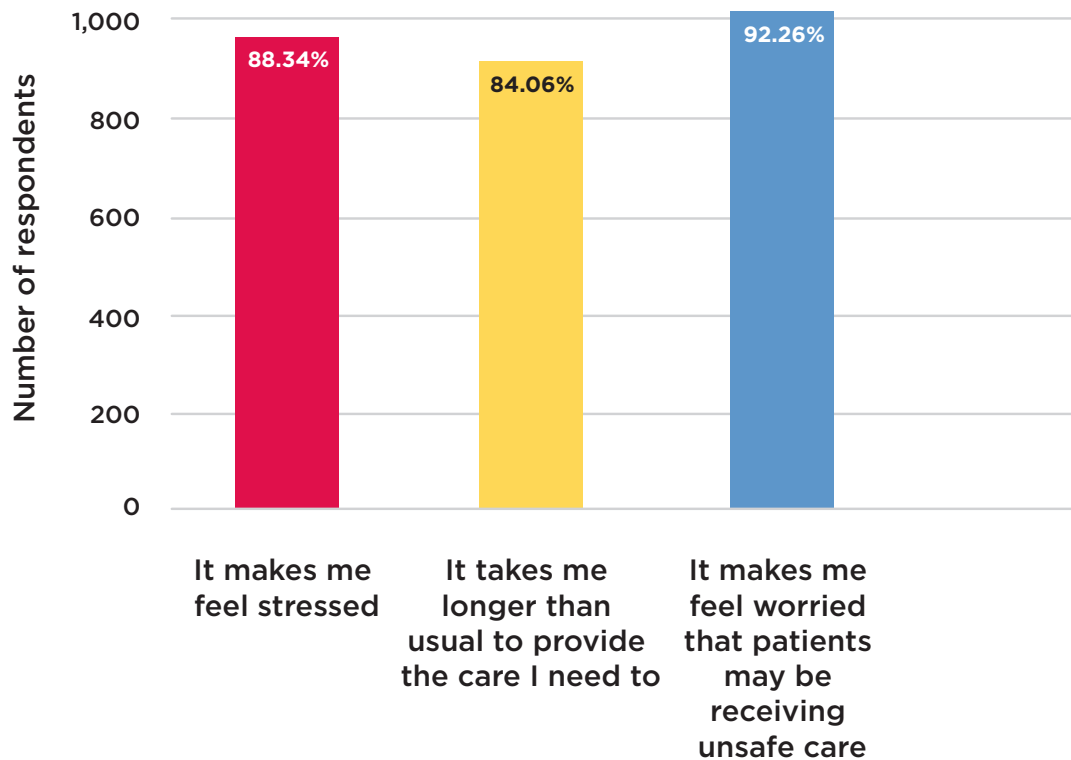
Question 6

Please tell us if you have observed any of the following impacts on patients of having care provided in non-designated clinical areas.



Question 7

Please tell us of any impact on yourself or other staff of providing care in these circumstances.



Question 8

For free-text responses to this question, please refer to Appendix 3.

Appendix 1

Representative sample of free-text responses to Question 6 on how providing care in non-designated clinical areas impacts on patients

1. I have worked as an agency nurse in over 30 hospitals and have been allocated to the corridor or the 'queue' in at least half. Most recently in my own job we allocated a 'Queue Nurse' every shift and had criteria for their responsibilities documented. One hospital gave me the ambulance bay as an allocated area and offered me a hi-vis fleece for safety. Corridor nursing is a routine and daily occurrence.
2. Someone fell in the store cupboard that we use to house medical patients as the nurse and the HCA were otherwise occupied. There are no call bells or emergency bells in there. It is not safe but we can't complain as the chief exec has apparently said we have to use the space.
3. Patients unable to mobilise crying because they need the toilet but there isn't a space to take them to, having to dodge passing corridor "traffic" beds, trolleys etc while giving medication or doing assessments, unable to get ECGs (particularly on ladies) in a timely manner, trying to take histories in crowded inappropriate areas.
4. In the department I work in it is not uncommon to have up to 20 patients on the corridor at anyone time. The responsible nurse, the "ambulance triage nurse" is expected to then provide all aspects of nursing care. All whilst trying to ensure that they meet targets for offloading the next wave of ambulances already pulling up. We have funding for a senior support worker (band 3) who can assist with venepuncture, cannulation etc. While this is happening there are patients being seen by clinicians being added to the corridor of patients as there are no cubicles who require treatments, medicines. If we are fortunate to have enough staff a band 5 will often be deployed as the corridor nurse but this still leaves a 10:1 ratio.
These patients are often very poorly & kept on the corridor for hours laying on A&E trollies. The nurse to patient ratio and corridor care is unsafe, undignified and unacceptable.
5. Cardiac arrest on corridor during winter pressures. Patients observed having seizure on corridor - no cubicle to move them to.
Very dangerous for all involved and only a matter of time until a nurse loses her pin due to corridor nursing!
6. We don't have a corridor that trolleys can fit down otherwise we would use it. We have chairs in corridors where IV meds, dressings are done.
7. Nebulisers are delayed and not given by some staff as no plug sockets available to corridor patients.
IV fluid pumps time out no call bell for proper patient dignity.
8. When I witnessed elderly patients being assisted onto bed pans while on ambulance trolleys (surrounded by paramedics, other patients on trolleys, and relatives) all squashed in a freezing corridor... I realised that I can no longer preserve or protect my patient's dignity, and that I am failing them as a nurse. Dignity is the first thing that the patient's are stripped of when in a queue in a dark cold corridor, closely followed by safety. I have had to cannulate and take blood from patients with absolutely no privacy or confidentiality. Patients who are needle phobic have no where else to look when the

patients in front are bled one after another, which must increase patients' anxieties. Then when it is their turn, they are humiliated while everyone around listens to me or my colleagues trying to reassure them, and they try to hold back tears while they face their fear in front of a busy loud audience.

Furthermore, how safe is it to have sharps and potential blood contamination in such close proximity to staff and members of the public (many of which are violent and abusive). I often have to manoeuvre myself out of my colleagues' way while in the middle of taking blood samples as they are trying to get urgent blood gas readings from the machine that is in the corridor that patients are squashed into.

The corridor that is blocked full with patients on trolleys is the same corridor and only access that ambulances have to transfer patients into our resus department. I have had to help herd patients on trolleys into a human shoal while paramedics fight through with a patient having CPR.

It is a matter of time before an innocent life is lost, or a nurse is taken to court for failing to provide (impossible) care.

9. It's an unsafe practice. It's appallingly. A&E depts in England look like A&E depts in third world countries. Clinical observations are being missed. Privacy and dignity have gone. Time critical medications are being missed.
It's a fire hazard all this patients on the corridor. Blocking fire doors.
10. There are significant infection control issues with corridor nursing. Patients being cannulated etc and relatives/others.
Walking up and down coughing and sneezing, patients with D&V unable to isolate them. No adequate meal/drink provisions, no staff to help patients eat and drink. Development of pressure sores. The list of negatives is endless.
If this is 21st Century nursing, then the NHS has to start dealing with patient care other than patient flow.
11. A patient had a long wait on a trolley. This patient was a friend and a member of staff who had sepsis she died due to a delay in treatment of being unable to off load from an ambulance. I've worked here for 6 years this is the worst I have seen it.
12. This happens on a regular basis. Elderly patients are incontinent with no where to change them. Relatives shout at us nurses and doctors because they are frustrated. There is no dignity or confidentiality as patients are examined on the corridor so other patients and relatives can hear why they are in the department.
13. Difficult situation and is recognised as one of our 'most at risk' areas in the hospital but physically cannot be helped as minimal spaces in department often due to number of patients awaiting beds within hospital that are full. Allocated nurse for corridor during our busiest hours to aim to minimise risk and ensure patients are seen by registered staff and prioritised according to care need.
14. I have seen patients that have been brought in as end of life/palliative having to be put into what is essentially a big empty store room to stop them dying on the corridor in front of other patients.
We allocate nurses to various areas at the start of the shift and this pretty much always includes at least 1 or 2 corridor nurses and healthcare assistants.

Patients and relative regularly complain and kick off about being “left on a corridor” for hours like it’s something we want to do. Ward staff don’t discharge patients so we physically have nowhere to put patients and can’t close the doors, but the lack of beds in somehow A&Es fault. I have personally had to get security on a number of occasions because patients and their relatives have gotten so intimidating and abusive towards myself and other staff about being on a corridor.

15. Nursing on a corridor has become the normal everyday. The majority of the time we have 1 nurse and 1 healthcare trying to nurse up to 18 patients on a corridor everyday. This is clearly unsafe for everyone involved. Dignity, privacy and safety is left at the door. This is not the way an accident and emergency department should be functioning.
16. Patients being assessed in an area outside of resuscitation room - witness cardiac arrests on arriving at hospital. See distressed relatives and also block the passageway to get into resus. Difficult and confidential details are discussed with a curtain for dignity - everyone in the corridor knows who’s behind the curtain and can hear what’s been said.
Patients are toileted in designated cubicles in the corridor, very undignified and embarrassing for them. Always causes distress.
Patients who are clinically unstable are unable to move into an appropriate clinical area due to overcrowding. Delays in administering treatment to time critical patients. Not enough space to monitor safely unwell patients leading to unnecessary delay and harm when they deteriorate.
17. Witnessing a cardiac arrest in a corridor with every other patient & relative watching, with no where to go, is the lowest point of my career.
18. Simple acts of care such as assisting individuals to pass urine become more challenging. Trying to find a temporary cubicle or even the plaster room so they may relieve themselves in privacy. Telling folks to hold on as using a male bottle under the covers in the corridor is not appropriate.
Patients finding themselves in close proximity to situations that make them feel uncomfortable with no scope to make them more secure.
Reminding pressured clinicians they can not consult patients in a busy public space and must ‘find a space’ in order to for them to start helping that individual.
Having really great nursing staff feel like they will be unable to keep an eye on all the patients ‘in the corridor’ or that nauseating feeling that today is day that you wave goodbye to your pin despite your best efforts.
19. All of the above. It is unsafe, undignified and chaotic. Infection control, quality of care, ability to provide basic personal care in a timely fashion are all compromise. Above all safety is compromised, in one particularly shocking example I have been forced to nurse a tracheostomy patient in the corridor for a brief time until I was able to swap them into a cubicle with oxygen and suction.
20. Patients find it hard to alert a member of staff should they need help as there is no call button in the corridor. Have had patients with suspected #NOF wetting themselves on trolleys in corridors in front of other patients as they could not get anybody’s attention to help them use a bedpan.

21. No sleep.

Sometimes cold for patients.

Unsafe. Patients not monitored properly for deterioration many unreported 'near misses' with patients deteriorating and becoming peri arrest which could have been prevented. Gives the public a negative view and lack of trust in the care provided.

22. We do the best we can, we work tirelessly as a trust to provide the best care, it is a challenge. At department level have designated corridor nurses and are given permission to go over our usual nursing numbers to facilitate this. There is often a look of horror from patients and their families when they realise what they have been seeing in the media is affecting their local hospital. It breaks my heart to care for patients this way, but it has become the norm now. As nurses and doctors we are becoming desensitised to the sight of patients lining the corridor.

23. We have had patients having their fracture dislocations reduced in corridors, we have delayed urgent care as there is no space to nurse patients. Patients are routinely sitting by offices, we are using seminar rooms to try to examine patients. There are no toilet facilities for these patients. We have had patients sharing a drip stand in order to get them their treatments. Elderly patients are sitting in wheelchairs instead of on trolleys. People with STEMI are not being assessed in a timely manner. Ambulances are not being released and we recently had a fairly young death where there was a significant delay to the ambulance arriving post arrest.

24. We regularly nurse up to 13 patients on a cold main corridor in ED. One end is in front of the ambulance doors leaving patients cold and kept awake.

Patients with dementia are moved into the corridor, leaving them even more disoriented and scared. This in turn distresses other patients and relatives. It is the most undignified approach to nursing.

25. It should never happen! I have seen patients arrest, fit, fall off trolleys trying to get someone's attention on corridors. Lack of vital equipment compromises patient care and safety on a daily basis! Unfortunately for those of us that work in A&E we are doing as much as we can whilst staff morale is at an all-time low and there is little praise coming our way. We nurse patients in A&E for sometimes 20+hrs and this is now seen as acceptable! It isn't and it's more pressure on an already pushed service. We are not only providing acute and emergency care but we are providing care for medical, surgical, orthopaedic etc patients because we can not get them to the wards. Something needs to change and I hope it does soon. I've worked for 12 years now in A&E and I have never known it to be as broken as it is right now.

Appendix 2

Representative sample of free-text responses to Question 7 on how providing care in these circumstances impacts on staff

1. Staff are leaving.
Crying in shift.
Stressed.
Guilty.
2. Whilst I feel this practice should be avoided when possible.
I feel that it has been organised in a safe way at my hospital and there are strict rules to minimise risk however A collaborative approach with ambulance services, admission avoidance teams and social care/discharge teams needs to be used in order to prevent departmental overcrowding- at times it feels like the hospital feel it is ok for overcrowding in ED- no other department would be expected to run at 150% with no additional staff and it adds unnecessary stress for juniors.
3. The number of patients on the corridor with the volume still coming through the doors is often overwhelming even for our experienced staff. I often come onto shift and see ambulance crews queuing out of the doors attempting to hand over their patients. Trying to keep patients safe on the corridor is becoming increasingly difficult. Due to the acuity and volume, patients are left waiting longer for time critical interventions, personal care and simple things like a blanket, cup of tea or even a cup of water. Getting back around to them to repeat a set of observations is often a struggle at times.
4. Nurses (including very newly qualified nurses) regularly and forcibly deployed from other wards to newly qualified nurses forcibly deployed from other wards to provide emergency care to patients in ED. Knowledge gaps and general safety issues compromise both the patient and nurse and general safety issues compromise both the patient and nurse. Nurses threatened with disciplinaries if they refuse this demand. One nurse who had only been qualified 2 months was forced to choose between running a ward alone or being an ED corridor nurse (despite having no experience in ED).
5. If I find out I'm working in either corridor or similar area I feel nervous and stressed and spend the whole shift worrying that something will get missed or patients will not get the care they need. It is impossible to do a good job in areas such as that and that is a depressing feeling. I regularly go home crying or feeling like I dislike my job. I don't want to feel like this, I want to feel pride in my job and place of work and I honestly don't.
6. Patients are receiving unsafe care. As practitioners we cannot provide the care expected under the code of conduct. When it becomes regular staff become desensitised. Another Mid Staffs scandal is just waiting to happen.
7. Its always a ticking time bomb, if a shift ends without something tragic....I give thanks.
8. Relatives and patients become stressed on the corridor and don't understand why they're there. It's difficult to monitor patients and is undignified. It is stressful when I am trying to nurse on the corridor. It makes me not want to come to work.

9. I have felt vulnerable in these situations as sometimes feel if I leave the area for even 2 minutes that I may have someone put a new patient in the area without my knowledge. Or if my patients have needed personal care I have often had to wheel their trolley to a room that is free (not always available) or not be able to provide the care at all. Dignity is not always maintained. If I need my patient on a heart monitor this is impossible on corridors, etc.
10. I have 25 years experience in ED's and I am now thinking of leaving as I can not keep looking after patients in such conditions this is a decision that I have spent the last year wrestling with as its a career I love and really don't want to leave.
11. Patients everyday are receiving undignified and unsafe care. I, as a nurse, feel ashamed nursing somebody on a corridor and unfortunately there hasn't been a day in at least the past five months where I haven't had to deliver care on the corridor or somewhere else equally as terrible.
12. I dread going to work, because of the pressures placed on the staff. We don't receive any help or any appreciation for working in the conditions, usually just incident reports.
13. It's soul destroying working a 12.5 shift on the corridor and soul destroying for patients and their relatives.
I have been in tears a few times due to working several shifts on there and also thru sheer frustration and exhaustion.
14. It is against my nursing practice to provide undignified care and makes me stressed and sad. I feel unsafe in my practice as I cannot keep on top of basic observations etc as some times in our department there are 20+ patients on the corridor.
15. I fear losing my registration daily because I am providing unsafe poor care I would not wish on anyone purely down to inadequate space, equipment and staffing for the quantity of people.
16. If I am looking after a number of patients in cubicles and I have to walk past corridor patients, I feel unable to look at them for fear of them asking me questions or help. This in turn makes me feel like a bad person, as well as an uncaring nurse.
17. It feels like a factory's conveyor belt...it feels like every person that walks through the doors becomes a number...you lose your identity because everything comes down to beds and numbers, and we are the first port of call and contact with the patients, so all management need to do something about it because our beloved NHS is being set to fail... and it's so unfair and heartbreaking!!! These are people's lives we have in our hands, not products, or numbers on a piece of paper or an mrn on screen!!!!
18. No capacity in department makes it impossible to provide adequate and safe care. Staff are stressed and are 'rushed' to get patients out to make space thus risking unsafe discharges and transfers. Forced to move patients who are still In pain/uncomfortable back out to waiting room to make space for sicker patients. Patients on corridors are facing delays for doctors to assess them as no where to privately examine... if history is taken then patient confidentiality is broken ...this sometimes happens in order to get urgent medications prescribed for patients such as those with suspected sepsis, and then there is the risk that if antibiotics are given on the corridor the patient could potentially have an allergic reaction in an area that is not fit to manage that kind of emergency. Staff are frequently going without breaks as they feel that care is inadequate due to capacity

and thus work through their allocated break time to try to get transfers/discharges done or to get nursing assessments done/treatments for patients in the waiting room. As a nurse in charge there is exceptional stress at trying to identify the patients more needing of assessment room. When limited space becomes available senior management moves ambulance patients/corridor patients 1st without assessing the greater need, ie, if someone in the waiting room who self presented is more unstable. This leads to patients collapsing or worse case scenario having a cardiac arrest in the waiting room. As a nurse coordinator I frequently go without any breaks on a 13hr + shift and often do not have a toilet break due to department pressures and trying to support the other staff members. The stress that all are facing is leading to increased sickness levels amongst nursing and health care staff and almost all the staff I know actively looking for alternative jobs. We are also facing increased violence and aggression from patients and relatives due to their frustration that there is nowhere in department for them to lay down/lack of privacy. Patients on the corridor requiring assistance with hygiene needs... when there is nowhere private to assist them.

19. I have recently been a patient at Hospital... three times over the Christmas period and this was an extremely different experience to the hospital that I work at in North Yorkshire. Hospital actually has a designated sign on the corridor wall placed by the manager explaining why you as a patient have been placed on the corridor, this clearly is usual practice, I found myself with unwell, on the corridor and with no nurse to care for me and when I felt unwell, the sister in charge said 'she wasn't looking after that section, but would let the nurse know'.. no nurse appeared for over an hour to reassess my palpitations, and pins and needles that I was experiencing. Its a very different negative strategy to where I work... where these safety issues have been properly addressed.
20. Working in this environment is so demoralising. Patients are understandably angry but I wish they would understand that I have no control over it and am working with what I have to provide what care I can. I don't think patients and relatives understand the moral injury caused by being forced to provide substandard care and then being yelled at by the people you're trying to help.
21. It makes you feel like a bad nurse not being able to provide care in an individual cubicle and makes you fearful for your PIN number at times.
It's unsafe, undignified and unprofessional and It's embarrassing!
We need better investment in our EDs, larger ED departments all over the country, better public education about who comes to ED (and an overhaul/increase in community services is definitely needed to help relieve ED pressures) and a vastly increased staffing level in ED to ensure safety.
22. With 42 years experience I am leaving as things are no longer nursing.
23. The anxiety for staff in this situation is becoming unmanageable. How long before a nurse has to suffer the ordeal of a referral to the NMC for a problem beyond their control. Not only are staff having anxiety around the patient care but are having to deal with the constant worry of the consequences. Corridor nursing is unsafe for patients and staff.

Appendix 3

Representative sample of responses to Question 8, which asked for details of any initiatives undertaken at respondents' emergency departments to improve patient care this winter

1. Allocated zones for the corridor. 2 privacy and dignity cubicles and 2 hourly rounding with a Dr and corridor co-ordinator nurse. These are triggered by number of patients on the corridor. Over capacity escalation plan updated.
2. Piloted a sepsis resus bed with allocated staff to improve timely interventions. It was successful.
3. Extra staff 2 x nurses and 1 x carer for every shift.
4. Maximum number of patients in each corridor.
5. 1 trained nurse to every three patients.
6. A N/A to provide comfort drinks etc to the patients.
7. Continued datix.
8. Boarding patients on wards to share risk.
9. Taken away two of our majors cubicles and turned them in to quick treatment rooms for ambulatory patients who are sitting in the majors chaired area but who need treatment. For example an IV drip or an ecg. Once it's done they sit back in the waiting area. This stops patients receiving treatment in the waiting area.
10. My trust attempted to pilot a "reverse triage" system in which once patients have been reviewed and awaiting a medical bed are moved back on to the corridor. Then acutely unwell patients are moved to cubicles to be seen.
11. There are now also 2 ambulance service staff members deployed to the corridor each shift to take handover from a number of crews to release them to go back on the road. These ambulance staff members stay on the corridor throughout the shift.
12. Increased nursing and medical templates. Fit to sit and rapid access capacity increased. Given access to appointments at the out of hours GP next door and able to triage patients into them. GP relief in minors. Swast also provided a paramedic or nurse to nurse the queue, which tends to be what we call the corridor!
13. Traffic light system. Colour coded laminates with time of last observations, ews score, is pt nbm, is pt on O2, any treatments given, is pressure area care needed and time of last turn. 1 hour on corridor is green laminate, 2 hours is yellow, 3 hours is red and waiting for a bed on ward is purple.
14. SDEC for frailty.

15. Increased ambulatory care.
16. AmU Consultant in dept for admission avoidance.
17. We run regular high intensity all Trust and partner organisation programs, with an aim to facilitate discharges to maintain capacity. The longest any of these has lasted is 7 days. They make a difference but are not sustainable.
18. The senior nursing staff and medics are incredibly proactive and 'aggressive' in putting patient needs first.
19. We often have senior management and floor managers on the shop floor to coordinate problem solving.
20. We have a designated "queue nurse", patients now "reverse queue" and are put back in the corridor to await a ward bed so new patients can be seen in a cubicle for some privacy to be examined where possible. When we got to 40 patients in the corridor recently the site managers brought the staff from theatres and recovery down to help in majors whilst the CEPOD list wasn't in use overnight.
Nurse to patient ratio 1:6.
Clear escalation plans to senior management.
21. Clear labelling on patient trolleys indicating when obs and meds due.
22. A RN band 6 or 7 allocated to coordinate the queue
 - * 1/2 RNs when possible booked to work in ED with the only purpose of being allocated to queue.
 - * 1 NA allocated to queue.
 - * instead of one big queue, different areas have been designated to have a specific number of patients in case of overcrowding so that looking after patients is more organised and safer.
 - * new revised SOPs have been introduced (reviewed and in constant renovation) for queue in order to ensure safety.
23. Increased discharge planning and MDT use in ED, ED last area to turn into contingency for bed crisis meaning business as usual. Control room and senior staff highlighting early bed issues with good bed management.
24. Senior nurse in ambulance corridor.
25. SOP produced.
26. Risk assessment carried out every 2 hours on ambulance corridor.
27. More reverse boarding.
28. Senior doctor in corridor.
29. Making minors cubicles into majors.
30. Increasing ambulatory care working hours.

31. GP during peak times in ED minors.
32. Increasing nursing and medical staffing template.
33. Safety nurse in ED, senior nurse at the front door.
34. fit to sit on the wards to empty more beds for ED patients.
35. Now 2 nurses to the ambulance line, occasionally there is boarding on the wards which I think one extra pt per ward is far safer than 20 in an ED corridor.
36. Made two areas with curtains, so we can keep swapping patients out that are on the corridor to try and provide care with privacy and dignity.
37. Risk assessment have to done on all patients that go onto the corridor, to ensure they are safe to go out there.
38. They have opened a CDU.
39. They have implemented trust policies that stipulate wards must take a stable + 1 patient to free up emergency department cubicles and enhance flow.
40. Escalation wards.
41. Boarding.
42. Cancelling surgery.
43. By reverse corridor nursing. Additional staff. Fit to sit initiative.
44. Immediate assessment on arrival by ambulance and streaming to appropriate area with early interventions and investigations initiated by nursing staff. Increased capacity with “fit to sit” area to avoid corridor waits if trolley not necessary for care.

The RCN represents nurses and nursing, promotes
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