College of Emergency Nursing Australasia

Position Statement

Approved: March 2015

Emergency Department Overcrowding and Access Block

Purpose

This position statement outlines the position of CENA in relation to overcrowding and access block in Australian Emergency Departments.

Definitions

Overcrowding

Overcrowding refers to when the functioning of an Emergency Department (ED) is impeded by the number of patients waiting to be seen, undergoing diagnosis and treatment, or awaiting transfer from the ED. A consequence of overcrowding is that safe levels of staffing or the physical space of the department are exceeded.[1]

Access block

Access block is defined by the Australasian College for Emergency Medicine (ACEM) as patients in the emergency department that require inpatient care but are unable to gain access to appropriate hospital beds within a reasonable time frame, that being 8 hours (Table 1).[2]

Table 1: Definitions of Access Block

Australasian College of Emergency Medicine (ACEM)[1]	Proportion of patients whose spend greater than 8 hours in the ED from arrival to admission destination.
Australian Council on Healthcare Standards (ACHS)[3]	Time in ED from presentation to admission that exceeds 8 hours.
NSW Health Definition[4]	Delay of greater than 8 hours from the time of medical assessment to departure to in-hospital bed. Ready for departure time to actual departure time that exceeds 4 hours.

Surge

Surge is a sudden significant increase in the demands placed on an ED given the normal capacity within which the ED can reasonably maintain standards of care and can contribute to overcrowding.

Ramping

Ramping occurs when ambulance services are unable to complete the transfer of patient care due to ED overcrowding within a time frame that is clinically appropriate because of a lack of clinical space in the ED.[2] Ramping delays the departure of ambulance personnel from the receiving institution, which in turn increases ambulance turn around and decreases services for the community. Ramping may also be referred to as off-stretcher time or ambulance turn around time.

Emergency Department Overcrowding and Access Block

Background

Access block significantly contributes to overcrowding in the ED and reflects a systemic lack of capacity within the health system rather than inappropriate patient presentations to the ED.[5] When the ED becomes overcrowded, physical capacity and safe staffing resources are exceeded, impeding the functionality of the ED and delaying care.[6,7] This is distressing for patients and has a substantial impact on staff workload. Exposure to access block has been associated with significantly longer length of stay[8] and increased morbidity[9] and mortality.[10,11] Access block also adversely impacts on staff by increasing work-related stress and reducing job satisfaction.[12] This can influence workforce sustainability.

Inappropriate ED presentations by patients who should have attended a General Practitioner or other primary health service do not cause ED overcrowding or access block. Rather, the combination of an aging population, increasing numbers of ED presentations and reduced inpatient capacity contributes to overcrowding and access block.[12, 13] In Western Australia, the introduction of the Four Hour Rule Program (FHRP) in 2009 was associated with a marked reduction in access block. The key intention of the program was to improve the quality of patient care by admitting, transferring or discharging a predefined proportion of patient presenting to a public hospital ED within four hours.

Targets set within the FHRP were achieved through strategies that implemented queuing theory and improved patient flow, and have coincided in decreased morbidity and mortality.[14] In 2011, these targets were replaced by a nationwide program called the National Emergency Access Target (NEAT).

Access block is not solely an ED issue but is reflective of a systemic lack of capacity across the service. Overcrowding and access block place patient safety at unacceptable risk and are associated with adverse patient outcomes. Sites must have processes and mechanisms in place to incorporate the efforts of the ED, site and wider health service to overcome this problem.

Position

1. Emergency Departments must have escalation processes in place to address overcrowding, access block, and surges in presentation. This needs to be in conjunction with a whole of hospital response.
2. Agreements must be in place between the receiving institution and ambulance service to ensure safe patient care with shared responsibility in the event of ramping. This includes but is not limited to:
    - Safe monitoring and senior medical review of all patients on the ‘ramp’
    - Commencement of assessment and basic investigations by emergency staff
    - Ongoing surveillance for deterioration of ramped patients and escalation of care as appropriate
    - A safe environment for the patient and staff to transit in.
3. Strategies must be in place to address specific patient groups that contribute to department overcrowding as a result of requiring complex assessment. For example, the elderly, patients with mental health illness and those requiring isolation.
4. Strategies that incorporate a whole of hospital response in the presence of access block and ambulance ramping, must be established to expedite the timely transfer of existing inpatients awaiting admission and restore operational safety.
5. Processes for the assessment, ongoing review and escalation of patients who have arrived to the ED via means other than an ambulance must also be in place.

References

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