Emergency Department overcrowding and access block

Purpose

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

Definitions

Overcrowding

Overcrowding refers to the state of an Emergency Department (ED) that 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 eight hours (Table 1).[2]

Table 1: Definitions of access block

Australasian College of Emergency Medicine[1]	Proportion of patients whose spend greater than 8 hours in the ED from arrival to admission destination.
Australian Council on Healthcare Standards[3]	Time in ED from presentation to admission that exceeds 8 hours.
NSW Health[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’.

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Background

When an ED becomes overcrowded, physical capacity and safe staffing resources are exceeded, impeding the functionality of the ED and delaying care.[5,6,] Overcrowding has a substantial impact on staff workload, which contributes to increased patient distress and the risk of adverse outcomes.

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.[7] 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.

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 places patient safety at an unacceptable level of risk and is associated with adverse patient outcomes. Developing processes and mechanisms that incorporate the efforts of the ED, site inpatient units and the wider health service to overcome this problem is a strategic imperative.

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Position

1. Health services should have escalation processes in place to address emergency department overcrowding, access block and surges in presentation.
2. Health services should ensure safe staffing of the emergency department and maintain safe staffing levels during periods of ramping or increased demand, with consideration to skill mix and patient acuity.
3. Health services should engage with ambulance services to implement strategies where appropriate patients can be diverted to an alternate facility where safe and appropriate to do so.
4. Health services should liaise with ambulance and intra-hospital patient transport service managers to create strategies that expedite patients transfers out of the facility to pre-arranged destinations with minimal delay.
5. Strategies that incorporate a whole of hospital response to access block and ambulance ramping, should be established to expedite the timely transfer of existing inpatients awaiting admission and restore operational safety.
6. Agreements should be in place between the receiving institution and ambulance service to ensure safe patient care with regards to clinical responsibility of patients in the event of ramping.
7. Processes for the assessment, ongoing review and escalation of patients who have arrived at the ED via an ambulance or means other than an ambulance should be in place.
8. Senior ED clinician review must be available if requested by the triage nurse.
9. A safe environment for the patients and staff should be maintained with consideration given to patient privacy.
10. Maintaining a safe environment should include the development of a weather policy, ensuring adequate rest breaks and appropriate personal protective equipment for staff.
11. The triage nurse maintains responsibility for assigning a priority from the Australasian Triage Scale and as such should assess each patient independently.
12. Care should be taken to avoid the resuscitation area becoming subject to access block, capacity in these areas should be maintained by senior staff as a priority.
13. Patients with a time critical condition, for example assigned an ATS category 1 or 2, should not be subjected to ambulance ramping and managed in an appropriate treatment area.
14. Strategies must be in place to address specific patient groups that contribute to department overcrowding as a result of complex needs. For example, the elderly, patients with mental health illness and those requiring isolation.
15. The department should attempt to maintain efficiency in fast track or rapid assessment areas in order to maintain flow of patients who are not requiring admission.
16. At the discretion of the triage nurse, appropriate patients may be offloaded from the ambulance into the waiting room to wait for a treatment space to become available.
17. Basic investigations may be started for patients who are waiting for a treatment space in the emergency department, however this should be within the workflow developed by the health service. The primary role of the triage nurse will remain as reception and triage of new patients, commencement of basic investigations should be undertaken by an additional clinician.

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References

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