Emergency Care Access Policy

1. Background

The 2009 WA Health Four Hour Rule Program evolved into the National Emergency Access Target (NEAT). Following the expiry of the Commonwealth National Partnership Agreement on Improving Public Hospital Services in 2015, WA Health established the Western Australia Emergency Access Target (WEAT) in January 2016 to continue to drive local improvement in patient access to emergency services.

WEAT requires that 90 per cent of all patients presenting to a public hospital emergency department (ED) are to be seen and admitted, transferred or discharged within four hours.

Peer reviewed evidence since 2006 has consistently highlighted and supported a reduction in morbidity and mortality outcomes from ED patients who leave the ED within four hours of arrival. Evidence shows that there is a greater risk of mortality the longer a patient stays in hospital. Emergency Access Targets were originally established 'in response to evidence that ED overcrowding and prolonged length of stay were associated with increased in-hospital mortality'. (See References.)

2. Policy Statement

This policy is designed to support regions by outlining a number of measures identified as effective in supporting 90 per cent.

Currently there are 14 WA Country Health Service (WACHS) hospitals covered by the WEAT. These hospitals are Albany, Broome, Bunbury, Geraldton, Hedland, Kalgoorlie, Nickol Bay, Busselton, Carnarvon, Derby, Esperance, Kununurra, Narrogin and Northam. While these listed hospitals are the seven official WEAT sites in WACHS, the intention of this policy is to support all WACHS emergency hospitals to achieve an average WEAT performance score of 90 per cent.

Actions when a WACHS WEAT hospital is averaging between 85 – 90 per cent:

2.1 Review the list of measures below to improve WEAT performance

2.2 Once reviewed each facility must develop a local action plan to implement these measures.

Actions when a WACHS WEAT hospital is averaging between 80 – 85 per cent.

2.3 Review the list of measures below to improve WEAT performance

2.4 Once reviewed each region must develop a regional action plan

2.5 Provide a report to the Chief Operating Officer (COO) Operations.

Actions when a WACHS WEAT hospital is averaging less than 80 per cent:

2.6 Review the list of measures below to improve WEAT performance

2.7 Region to develop and implement a recovery plan

2.8 Provide a report to the Chief Operating Officer.

3. List of Measures

The following is a list of measures to assist the regions to comply with an average WEAT performance score of 90 per cent. **These measures may not be applicable to all sites and may need to be tailored to suit local circumstances where applicable.** This list is not exhaustive and regions or facilities may consider additional measures.

Emergency Substitution

- Communication, education and community expectation management re: attending non ED providers when appropriate (e.g. General Practitioners (GPs), pharmacy, phone services and Health Direct. All patients presenting to a WACHS emergency service must undergo full triage assessment before being offered substitution options.

Facilitating Emergency Department Discharge

- Implement or expand same day Hospital In the Home (HITH) service
- Dedicate ED appointments for patients requiring urgent imaging
- Extend on site availability of radiographer hours
- Extend on site availability of pathology for ED
- Facilitate ED access to allied health professions to facilitate discharge
- Facilitate ED access to mental health (MH) liaison team
- Create Fast Track in ED (e.g. by replacing cubicle stretchers with recliner rockers)
- Implement use of management plans for frequent presenters
- Patient transfer staff responsible for moving admitted patients from ED to the ward (e.g. patient care assistants (PCAs) or orderlies) are attached to ED and not the ward
- Consider inpatient admissions for patients who are waiting for transfer to a tertiary service.

Facilitating Admission to Hospital

- Provide direct admission to ward bypassing ED for inter-hospital transfers when clinically appropriate
- ED to direct the transfer of patients to the ward
- Create Infusion lounge, diverting planned procedures away from ED (e.g. by increasing outpatient department capacity)
- Review facility infrastructure to manage demand
- Consider admission to ward while awaiting pathology or imaging results.

Inpatient Flow Management

- Implement a regional patient flow management resource
- Discharge patients before 10am
- Transfer to other regional hospitals
- Hold daily bed management meeting with a bed state representative and when critical, there needs to be a local escalation plan
- Implement an Aged Care Management plan e.g. acute, sub-acute and Patients Awaiting an Aged Care Service (PAACS)
- Implement a MH Care Management plan

- Implement nurse led and junior doctor led discharge following consultant instructions
- Patients awaiting transfer to remote sites are accommodated outside hospital e.g. local hostel
- Predicated date of discharge identified and communicated to patient on admission and patient's family advised by admitting doctor or nurse in charge of the department
- A minimum of two discharge patients seen first on ward round per inpatient team
- Discharge facilitated seven days a week
- Consider 23 hour beds after appropriate procedure in the theatre
- Facilitate access to extended HITH hours e.g. after hours and on weekends
- Discharge scripts done the day prior to discharge
- Discharge summaries commenced on admission and substantially completed prior to discharge
- Review medical practitioner availability to assess and discharge patients e.g. consider the ratio of inpatient salaried doctors compared to contracted medical staff
- Develop information flyers for patients/families regarding transport home on discharge
- Create Short Stay Unit near the ED.

4. Definitions

WEAT	WA Emergency Access Target - Percentage of patients, who are being seen, admitted, transferred or discharged within four hours of initial triage

5. Roles and Responsibilities

The **Regional Director (RD)** is responsible for ensuring that the relevant actions under 2. Policy Statement of this policy are implemented when necessary.

6. Compliance

Compliance with the WACHS Health Service Agreement between the Department of Health (DoH) and WACHS to improve patient access to services and public hospital efficiency, improve system performance and meet the WEAT.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

7. Evaluation

Review of this policy is to be carried out by Medical Services at WACHS central office every three years or earlier if new WEAT targets or policies are published by WA Health.

8. Standards

National Safety and Quality Health Service Standards - 1.1.2, 1.7.1

National Safety and Quality Health Service Standards - 1.5, 1.27

9. Legislation

WACHS must enter into a Service Agreement for the provision of health services as per Section 46 of the *Health Service Act 2016*. The Service Agreement outlines our requirements with meeting WEAT.

10. References

Sullivan C, The National Emergency Access Target (NEAT) and the 4-hour rule: time to review the target. Medical Journal of Australia (MJA) 2016, 204 (9)

Geelhoed G, Emergency department overcrowding, mortality and the 4-hour rule in Western Australia. MJA 2012 196 (2)

Guttmann A, Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada. BMJ 2011; 342:d2983

Kortebein P, Functional Impact of 10 Days of Bed Rest in Healthy Older Adults, Journal of Gerontology 2008 Series A, Vol 63, Issue 10

DB Richardson, Increase in patient mortality at 10 days associated with emergency department overcrowding, MJA 2006, Vol 184 Number 5

Sprivulis PC, The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. MJA 2006; 184 (5)

Richardson DB, The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay MJA 2002 177 (9)

11. Related Forms

Appendix A: Regional Emergency Access Review Tool

12. Related Policy Documents

WACHS Assessment and Management of Interhospital Patient Transfers Policy

13. Related WA Health Policies

MP 0058/17 Admission, Readmission, Discharge and Transfer Policy

MP 0055/17 Performance Management Policy 2017-18 - Health Service Performance Report (HSPR) - Addendum 1

14. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

Clinical Services Planning and Programs Policy Framework

Performance Policy Framework

This document can be made available in alternative formats on request for a person with a disability

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Appendix A: Regional Emergency Care Access Review Tool

Regional Emergency Access Review Tool				
Emergency Substitution	Currently in place? **Yes / No**	**If no**, is it applicable for your site? **Yes / No**	**If no** why?	**If applicable for your site** – Who will implement and by what date?
· Communication, education and community expectation management re: attending non ED providers when appropriate (e.g. General Practitioners (GPs), pharmacy, phone services and Health Direct. All patients presenting to WACHS emergency service must undergo full triage assessment before being offered substitution options				
Facilitating Emergency Department Discharge	Currently in place? **Yes / No**	**If no**, is it applicable for your site? **Yes / No**	**If no** why?	**If applicable for your site** - Who will implement and by what date?
· Implement or expand same day Hospital In the Home (HITH) service				
· Dedicate ED appointments for patients requiring urgent imaging				
· Extend on site availability of radiographer hours				
· Extend on site availability of pathology for ED				
· Facilitate ED access to allied health professions to facilitate discharge				
· Facilitate ED access to mental health (MH) liaison team				
· Create Fast Track in ED (e.g. by replacing cubicle stretchers with recliner rockers)				
· Implement use of management plans for frequent presenters				

Facilitating Emergency Department Discharge - *Continued*	Currently in place? **Yes / No**	**If no**, is it applicable for your site? **Yes / No**	**If no** why?	**If applicable for your site** - Who will implement and by what date?
· Patient transfer staff responsible for moving admitted patients from ED to the ward (e.g. patient care assistants (PCAs) or orderly's) are attached to ED and not the ward				
· Consider inpatient admissions for patients who are waiting for transfer to a tertiary service				
Facilitating Admission to Hospital	Currently in place? **Yes / No**	**If no**, is it applicable for your site? **Yes / No**	**If no** why?	**If applicable for your site** - Who will implement and by what date?
· Provide direct admission to ward bypassing ED for inter hospital transfers when clinically appropriate				
· ED will direct the transfer of patients to the ward				
· Create Infusion lounge, diverting planned procedures away from ED (e.g. by increasing out-patient department capacity)				
· Review facility infrastructure to manage demand				
· Consider admission to ward while awaiting pathology or imaging results				
Inpatient Flow Management	Currently in place? **Yes / No**	**If no**, is it applicable for your site? **Yes / No**	**If no** why?	**If applicable for your site** - Who will implement and by what date?
· Implement a regional patient flow management resource				
· Discharge patients before 10am				
· Transfer to other regional hospitals				
· Hold daily bed management meeting with a bed state representative and when critical there needs to be a local escalation plan				

Inpatient Flow Management - *Continued …*	Currently in place? **Yes / No**	**If no**, is it applicable for your site? **Yes / No**	**If no** why?	**If applicable for your site** - Who will implement and by what date?
· Implement an Aged Care Management plan e.g. acute, sub-acute and Patients Awaiting an Aged Care Service (PAACS)				
· Implement a MH Care Management plan				
· Implement nurse led and junior doctor led discharge following consultants instructions				
· Patients awaiting transfer to remote sites are accommodated outside hospital e.g. local hostel				
· Predicated date of discharge identified and communicated to patient on admission and patients family advised by admitting doctor or nurse in charge of the department				
· A minimum of two discharge patients seen first on ward round per inpatient team				
· Discharge facilitated seven days a week				
· Consider 23 hour beds after appropriate procedure in the theatre				
· Facilitate access to extended HITH hours e.g. after hours and on weekends				
· Discharge scripts done day prior to discharge				
· Discharge summaries commenced on admission and substantially completed prior to discharge				
· Review medical practitioner availability to assess and discharge patients e.g. review the ratio of in-patient salaried doctors compared to contracted medical staff				
· Develop information flyers for patients/families regarding transport home on discharge				
· Create Short Stay Unit near the ED				

Comments