Emergency Care Institute
NEW SOUTH WALES

National Emergency Access Target

Sally McCarthy
Medical Director
Emergency Care Institute

March 2012

ED Operational Efficiency Workshop

History

- UK Government 2001 Reforming Emergency Care agenda, genesis of the Four Hour target: "*By 2004 no-one will have to wait more than 4 hours in an A&E department from arrival to admission to a bed in the hospital, transfer elsewhere or discharge. The average length of waiting should fall to 75 minutes*"

- UK February 2004, an incentive scheme introduced aimed at reducing waiting times in (A&E) departments

UK 4-Hour Target

"The regime applied to NHS organisations in England from 2001 to 2005 and was unusual because it *rewarded success and penalised failure* in a process of naming and shaming. It replaced a system of perverse incentives that penalised success and rewarded failure—for example, by rewarding hospitals with long waiting lists with extra money to bail them out."

History

- UK Reports ranged from improving patient care and driving positive whole-of-hospital reform, to negative outcomes: gaming of data, diversion of funding incentives, dysfunctional organizational behaviour and compromise in clinical patient outcomes.
- The main reason given for not reaching the target was "*not enough inpatient beds*"

- April 2009: WA 4 hour rule introduced
- July 2009: NZ Shorter stays in ED (6 hour rule)

UK CEM response to UK target changes

June 2010

CEM welcomes changes to the 4-hour target

"The College of Emergency Medicine (CEM) welcomes today's announcement by the Secretary of State that the 4-hour emergency access standard is to be lowered from 98% to 95%.

We believe that this now represents a level that will allow focus on an improved quality of care and clinical safety for our patients

while preserving all the positive benefits that an increased spotlight on emergency care, delivered in our Emergency Departments in recent years, has achieved."

UK lessons learnt

- 4 hour target impact will be limited if:
  - Does not involve
    - Primary care
    - Acute mental health
    - Social services
- Focus on whole area of unscheduled care
  - Collaborative strategy: primary, secondary and community care

  = more efficient system / better for patients

Introduction of NEAT

Where it is clinically appropriate to do so,

after implementation, “anyone presenting to a public hospital emergency department will be

admitted, referred for treatment or discharged within four hours of presentation”

Communique. Council of Australian Governments Meeting 19 and 20 April, Canberra. Available at http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/communique_20_April_2010.pdf

Expert Panel June 2011: Overarching principles

Recommendations broadly intended to:

- Drive whole of system reform
- Improve system capacity
- Promote engagement and leadership
- Minimise risks to patient safety and quality
- Clear and nationally consistent measurement
- Ongoing review

Expert Panel recommendations to COAG

August 2011

- *Principle 1* Targets and the changes required to meet them will require commitment right across the health and hospital system
- *Principle 2* Hospital executives will need to work in partnership with clinicians to achieve sustainable change
- *Principle 3* Clinical engagement and clinical leadership will be essential if the targets are to be met
- *Principle 4* Targets must drive clinical redesign with a whole-of-hospital approach
- *Principle 5* Clinical redesign must ensure patient safety and enhance quality of care
- *Principle 6* Clinical redesign will improve system capacity and delivery of care
- *Principle 7* Definitions need to be clear and consistent across all jurisdictions
- *Principle 8* The performance of jurisdictions is not comparable
- *Principle 9* Progress towards the targets needs to be linked with continual monitoring of safety and quality performance indicators and audit
- *Principle 10* The impact of targets on demand needs to be monitored and early strategies developed to ensure achievements are sustainable
- *Principle 11* Quality of training needs to be maintained

NEAT

"90 per cent of patients presenting to a public hospital emergency department to be either admitted to hospital, referred for treatment, or discharged at the end of treatment within four hours, where it is clinically appropriate to do so".

NEAT: Baseline and Targets

State	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Baseline	61.8%	65.9%	63.8%	71.3%	59.4%	66.0%	55.8%	66.2%
1 Jan 2012 to 31 Dec 2012 (Period 1)	69.0%	72.0%	70.0%	76.0%	67.0%	72.0%	64.0%	69.0%
1 Jan 2013 to 31 Dec 2013 (Period 2)	76.0%	78.0%	77.0%	81.0%	75.0%	78.0%	73.0%	78.0%
1 Jan 2014 to 31 Dec 2014 (Period 3)	83.0%	84.0%	83.0%	85.0%	82.0%	84.0%	81.0%	84.0%
1 Jan 2015 to 31 Dec 2015 (Period 4)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

National Partnership Agreement on Improving Public Hospital Services

Parties agree that the following data, collected under the Performance and Accountability Framework, will be used to measure the impact of the implementation of both NEAT and NEST on the safety and quality of patient care:

- hospital standardised mortality ratio;
- in-hospital mortality rates for selected diagnostic categories;
- unplanned hospital re-admission rates for selected diagnostic categories;
- healthcare associated Staphylococcus aureus bacteraemia;
- healthcare associated Clostridium difficile infection; and
- measures of the patient experience with health services.

National Partnership Agreement: NEAT KPIs

C42. The percentage of ED patients, who either physically leave the ED for admission to hospital, are referred for treatment or are discharged, whose total time in the ED is within four hours, as per Clause C1.

C43. The number, source and percentage of ED attendances which are unplanned re-attendances within 48 hours of previous attendances.

NSW Emergency Departments

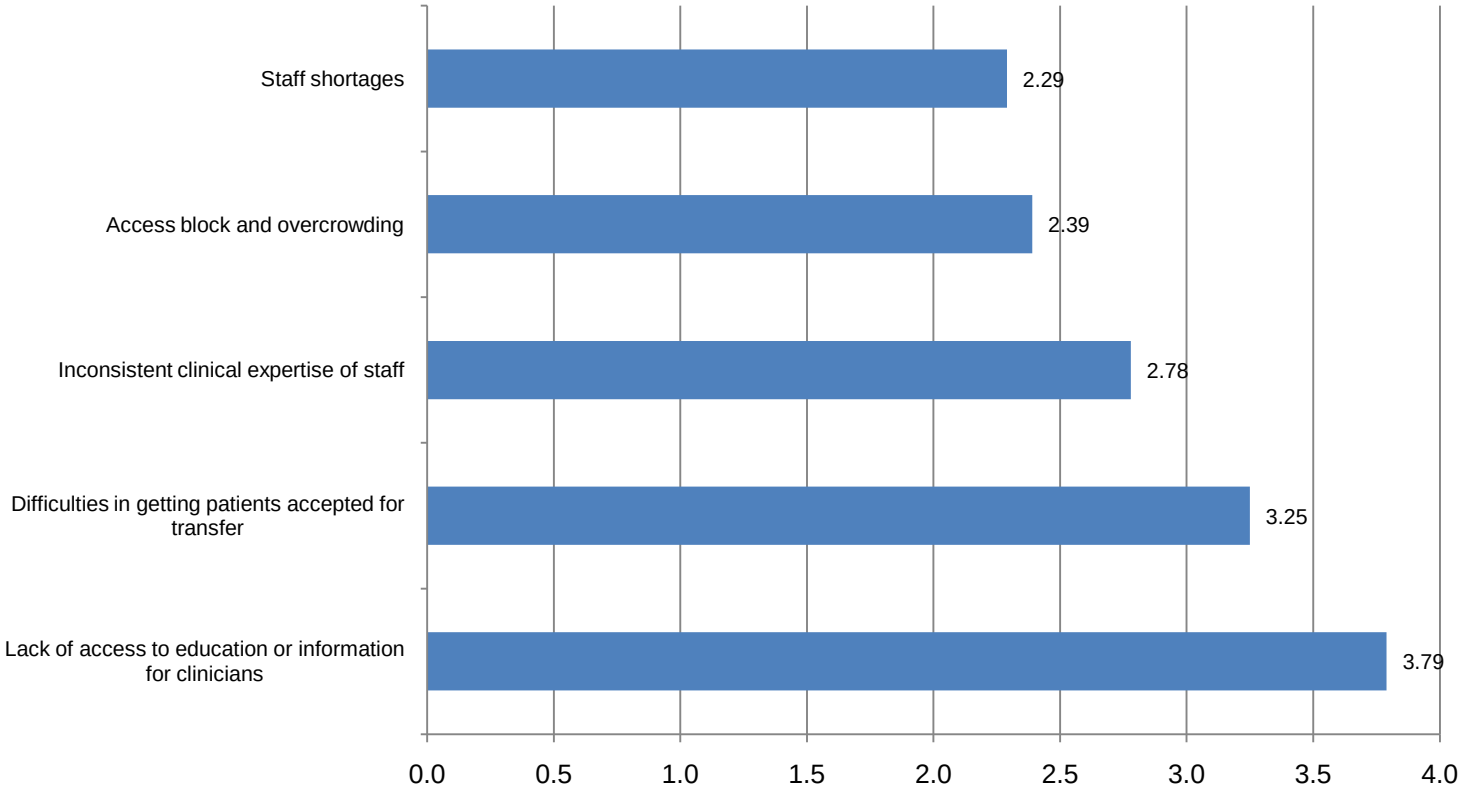
October to December 2011 www.bhi.nsw.gov.au

Currently:

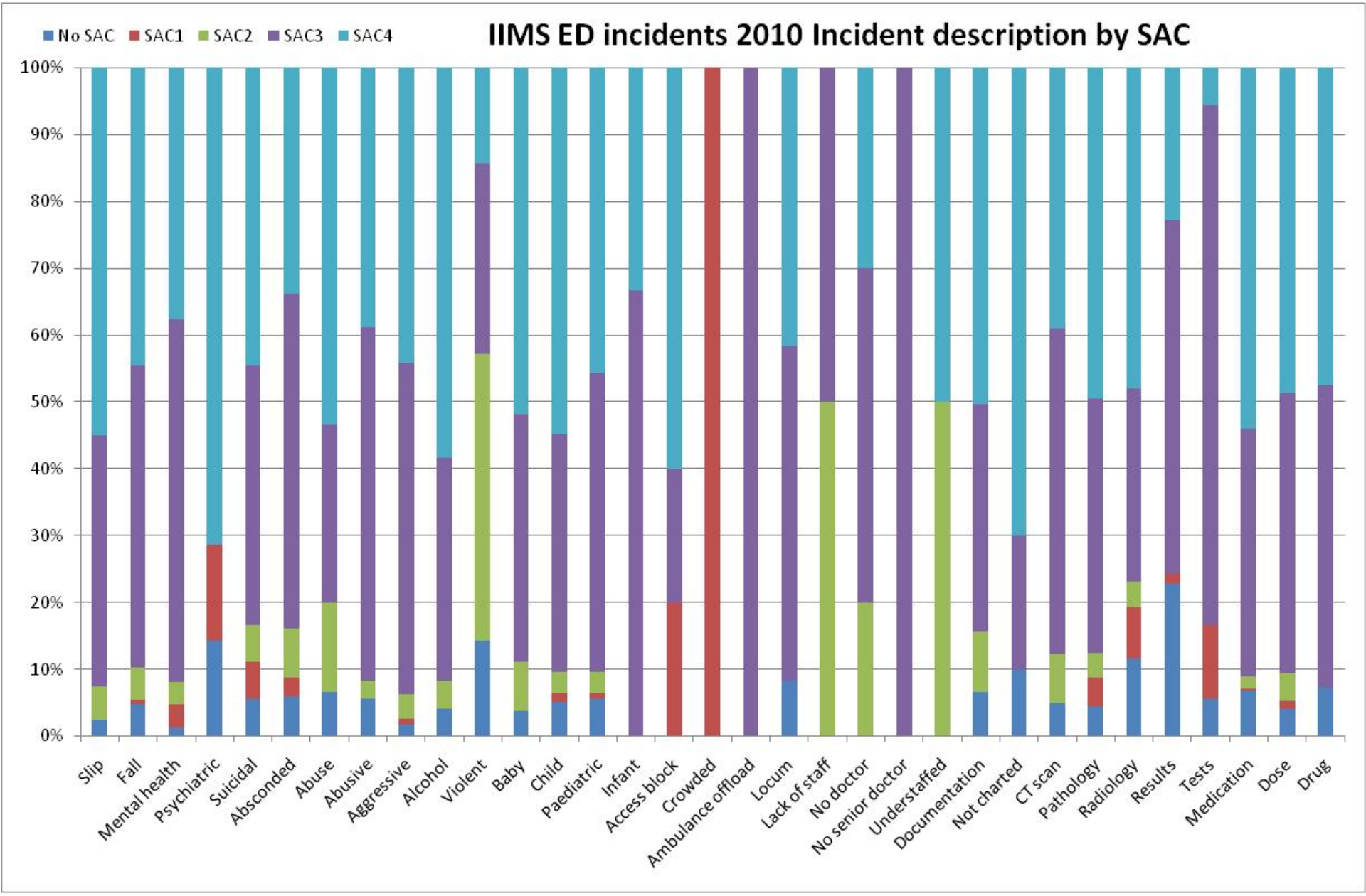
- Admitted patients:
  - 50% leave ED in 6 hours 35 mins; 95% within 19 hours 34 mins
  - **21% leave ED within 4 hours**
- Discharged patients:
  - **69% leave within 4 hours**; 94% by 8 hours

Is access important to ED stakeholders?

Please rate in order of importance the listed challenges below as they apply to your ED. Please indicate by numbering from 1-5 (where 1 is the most important and 5 is the least important)



ECI Stakeholder survey August 2011


IIMS ED incidents 2010 Incident description by SAC
No SAC
SAC1
SAC2
SAC3
SAC4
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Slip
Fall
Mental health
Psychiatric
Suicidal
Absconded
Abuse
Abusive
Aggressive
Alcohol
Violent
Baby
Child
Paediatric
Infant
Access block
Crowded
Ambulance offload
Locum
Lack of staff
No doctor
No senior doctor
Understaffed
Documentation
Not charted
CT scan
Pathology
Radiology
Results
Tests
Medication
Dose
Drug

Emptying the Corridors of Shame: Organizational Lessons From England's 4-Hour Emergency Throughput Target

Weber EJ, Mason S, Carter A, Hew RL Ann Emerg Med. 2011 Feb; 57(2):79-88.e1.

This was a qualitative study of EDs in England, purposively sampled for a range of size and performance on the target. Leadership of EDs at 9 Acute Trusts (hospitals) were interviewed between June and August 2008.

Results

Respondents agreed on the following themes.

(1) Interdependency: Even with extensive ED process re-engineering, **widespread Trust involvement was essential** to meeting the target. Additionally, lack of recognition that it was a “Trust target” contributed to conflicts between staff, concerns for patient safety, and lost opportunity for organizational improvement.

(2) Contrasting change management strategies: ED leadership used collaborative strategies, whereas **change in the rest of the hospital required a top-down approach.**

(3) Burden and benefit for staff: Nursing perceived the greatest burden from the target but also acquired enhanced authority, skills, and roles.

(4) Costs: Although most EDs are now within range of the target, consistent performance while balancing patient safety remains tenuous.

WA results

- "no-one wants to go back"

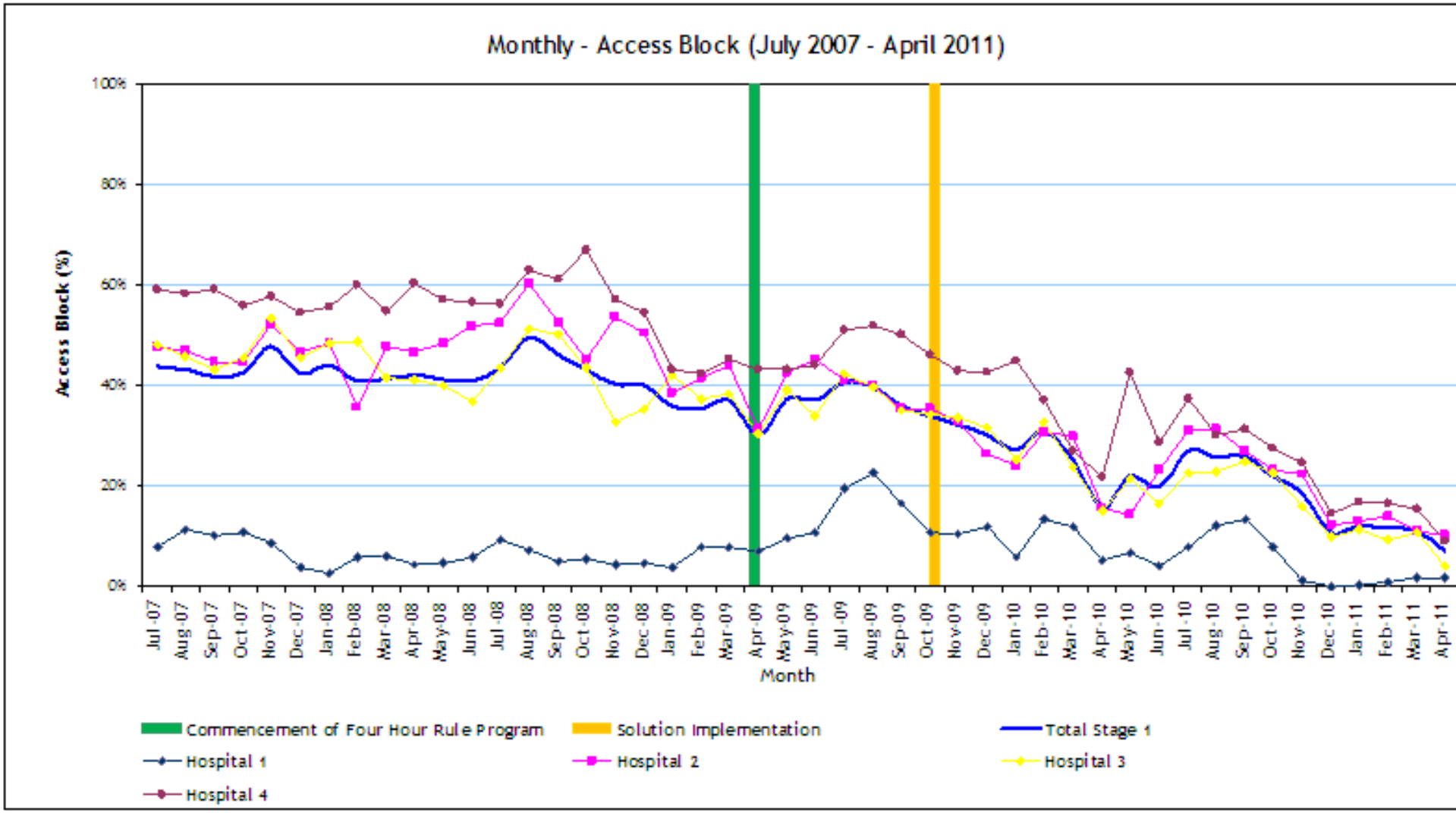
- Stokes review

  Four Hour Rule Program Progress and Issues Review. December 2011. Perth: Department of Health WA. http://www.health.wa.gov.au/publications/documents/FourHourRule_Review_Stokes.pdf

  "The FHRP has seen significant improvement in patient flow across all Stage One Hospitals. The Reviewer consulted with over 315 health workers and no one indicated a desire to return to pre-FHRP processes. However, many areas are struggling with the changes it has brought, and this requires revisiting some key reform concepts.

  Reform of this scale requires significant *sustained executive support and accountability. It is vital the status and governance of the FHRP is part of every* hospital executive committee's core business for change to be achieved and sustained. The findings of the Review indicate that this is not the case consistently across all hospitals." (executive summary page 3)

Access block and the introduction of the Four Hour Rule Program in four Western Australian hospitals



Middlemore NZ

Clinical Head of Emergency Care, Dr Vanessa Thornton, has led the process at Middlemore Hospital.

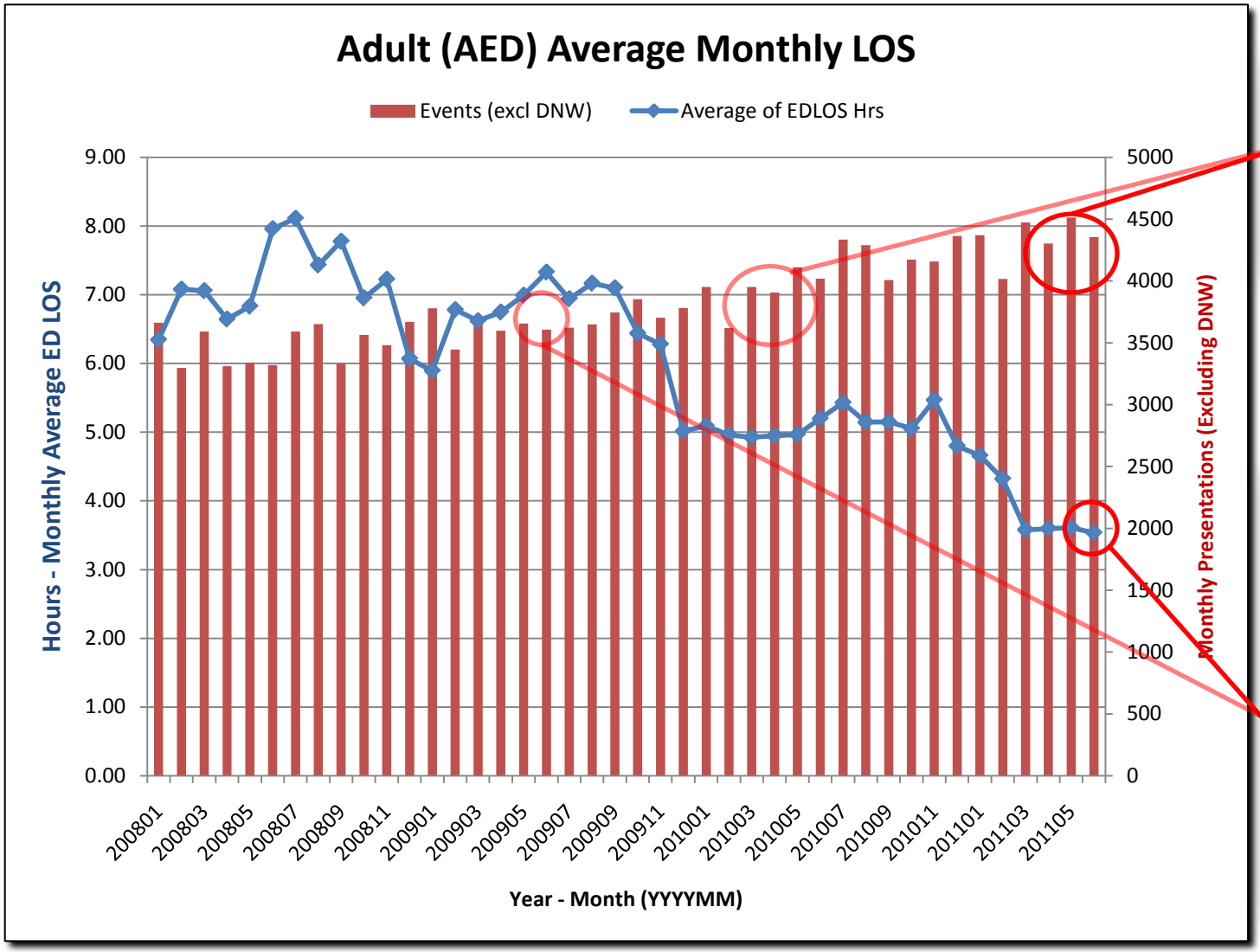
"When you break the steps down, there are a number of contributing factors that can cause delays to a patient's treatment and care. These include duplication, communication problems, outdated systems, wide variation in care, insufficient capacity and bottlenecks in patient flow - slowing the whole patient journey."

Middlemore Hospital NZ

- *Six hours can be ours*

  "**We're fortunate to have a General Manager who has made it his priority to ensure success**. He's had a steering group working to clear roadblocks on the operational side of things, and the results speak for themselves. **We were given the freedom to change the way we work** to make a positive difference for patients. It's really gratifying to know that you're making a difference. It used to the be norm to have patients lined up on trolley beds in corridors, now it's the exception."

Adult ED Presentations and Average Length of Stay



Jan-June 2011 saw a 10.5% increase in presentations compared to Jan-June 2010

ED Length of Stay reduces by 44% in 2 years despite record presentations. June 2011 average LOS 3.6 hours, compared to June 2009, 6.4 hours

Auckland DHB presentation available at http://www.hiirc.org.nz/section/9088/shorter-stays-in-ed/

Activities completed - January to June 2011

Adult activities completed – January to June 2011

- The Medical Bed Manager has been based on Level two till 7 pm. This has reduced the 6 hr breeches in the late afternoon when the department is very busy.
- Implemented ED discharge nurse on weekend.
- Information of the 6 hrs target has been clearly communicated to all ED and APU staff to reiterate that it was the individual staff member's responsibility to achieve the 6 hr target for the patients in their care. The emails were put in all communication books in both departments. This was just part of a series of staff communication to increase staff focus and improve compliance.
- 6 Hr target compliance board were set up in ED to show daily 6 hr compliance. These have been of great interest to the staff.
- The establishment of an ED Short Stay Unit. Room 8 has been designated as the ED short stay unit. The patients in ED who are designated as short stay (SS) will, as always, meet the short stay criteria which are on the ED website. Once a patient is designated SS they move into this room and no acute patients will now be admitted to room 8. The nurse in room 8 will be the Short Stay nurse. This room will remain open at all times.
- Engagement with SMO's, RMO's and nurses on a one on one basis by Clinical Director, Nurse Advisor or Level 2 Clinical Leader .
- Use of the Transition Lounge for discharged ED patients who are waiting on private transportation to take them home, and improved measurement for this patient group with the use of a 'Ready to go' intent in CMS
- Specific communications from the ED Clinical Director to ED SMOs regarding the 6 hour target, with the primary message being that the duty SMO must ensure that within the limits of safe practice, no patients breech the 6 hour target unnecessarily. This means ensuring;
  - a) all appropriate SS patients are quickly identified and designated
  - b) suitable patients are moved rapidly to APU after specialty review
  - c) regular review of all ED patients to ensure care is progressing
  - d) allocation of ED patients waiting to be seen to staff where necessary
  - e) rigorous application of the ED house rules on referral
  - f) follow up with IP specialties who have not reviewed a referral within 1hr
- A 6 hour compliance report sent to the ED senior team daily to allow follow up on days where the compliance has been below benchmark to enable the team look retrospectively for remediable factors
- A change to the electronic ED whiteboard so that the purple colour which designates the patient in ED for 5 hrs has been changed to 4 hrs. This provides more warning that the patients need to have a plan to get out of ED before the 6 hr timeframe is crossed. Implementation date March 4

Auckland DHB presentation available at http://www.hiirc.org.nz/section/9088/shorter-stays-in-ed/

Activities completed - January to June 2011

Adult activities completed – January to June 2011

- Hands on support of AED Flow Charge Nurse to reduce 'roadblocks' to transfer of patients to inpatient wards
- All Nurse Advisors are working with Charge Nurses to provide an action plan to improve ward responses to transfer of patients, handovers and discharge management
- A "Never say No" campaign is underway to focus on timely handover of patient admissions and transfers to ward in General Medicine, Orthopaedics and General Surgery Services. Handover hotline introduced for ward nursing staff.
- Metrics identified and published for wards on their time taken to transfer patients to the ward, with the goal of 100% of patients transferred to the ward within 30 minutes from when the bed is available
- Documentation and rationale to be given by Duty Managers for any patients awaiting bed allocation in AED as of 0600 hours every morning to identify barriers to patients getting inpatient beds overnight
- A daily action plan response tool has been introduced for Nurse Advisors to standardise daily checks and build communication throughout the day
- Instructions that should the Duty Manager have any issues with out of hours staff in terms of refusal to flex where able, closure of beds or keeping beds for patients that it should be escalated for follow up with the Nurse Advisors and Nurse Director
- Duty Managers and Bed Managers continue to review in full regularly the Bed Status at a Glance board for bed requests, particularly when on rounds at night where we know we have some improvement work to be done on times from bed request to acknowledgement.
- Charge Nurses to identify patients that could be outlied to enable smoother out of hours transfer of patients to release acute bed for higher acuity AED patient in specialty wards.
- Communication to Charge Nurses via Nurse Advisors regarding proactive "pulling" of patients to wards once bed allocated
- The Orderly supervisor has made signs to remind all Orderlies to tell the clerks to take the patient off the board as soon as they take the patient out of ED
- Increase engagement of Clinical Directors by CMO and Medical Director through communication and 'call to action'
- Support of General Medicine through diversion of patients to medical subspecialties
- Attendance of Medical Director and CMO at handover meetings
- Support of MRT resource to Level 8 operating rooms to improve access to image intensifiers.
- Proactive Management from Nurse Advisors and Service Managers with more involvement from them in Acute patient flow either at ward level or indeed assisting with patient transfer to wards from AED
- Full time Charge Nurse (improvement specialist role) to focus on reducing delays to Gen Med discharges through hands on support and introduction of discharge co-ordination responsibility within ward nursing team.
- Demand is being matched to resourcing to ensure allocation of orderlies in ED and APU to reduce transfer delays.
- Valuing patient time poster campaign

Auckland DHB presentation available at http://www.hiirc.org.nz/section/9088/shorter-stays-in-ed/

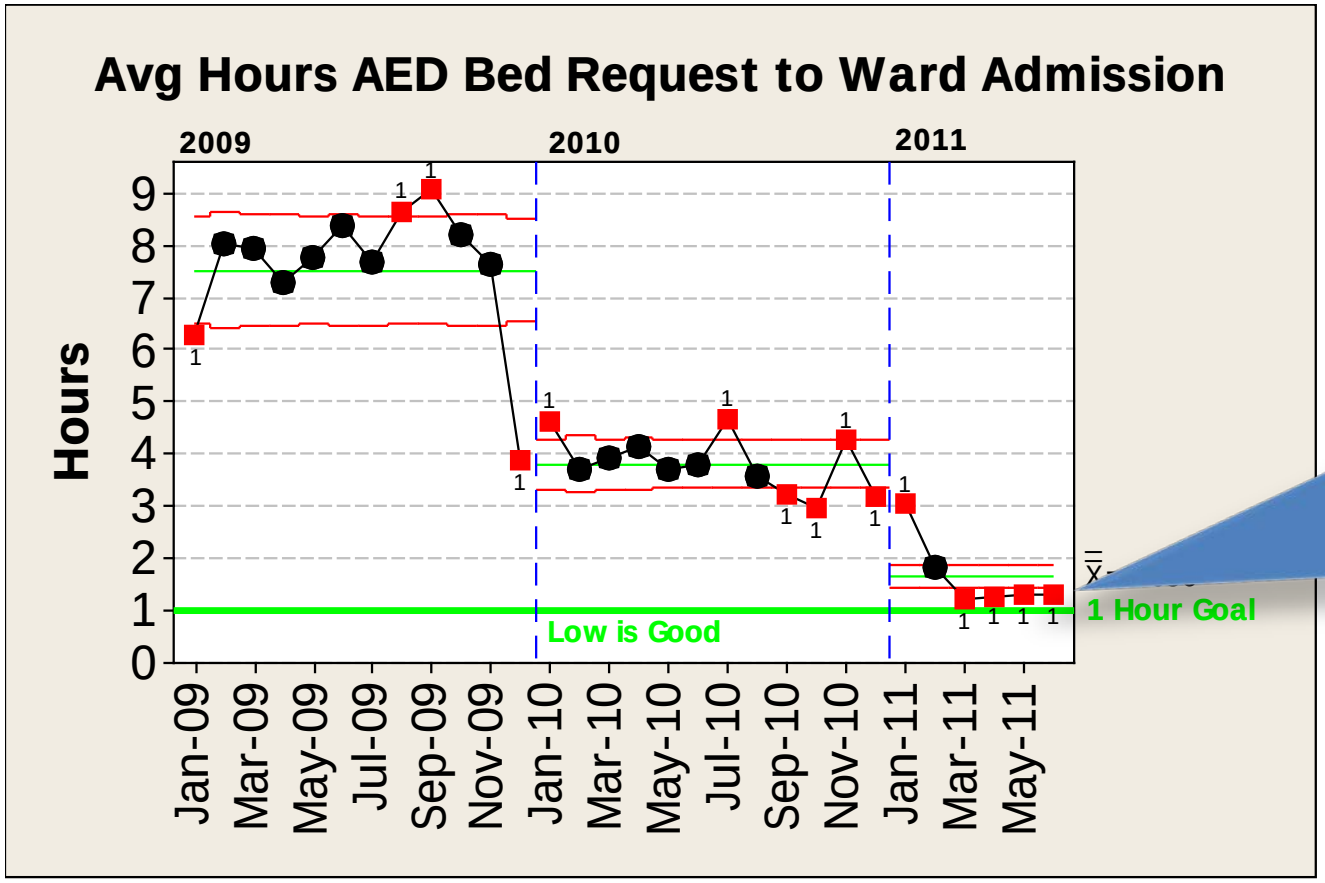
Activities completed - January to June 2011

Adult activities completed – January to June 2011

- Five day rapid improvement event conducted to focus on further solutions for improvement in process from decision to admit to transfer to inpatient ward
- Triggers identified for elective surgery cancellation.
- Improved access to transit care nurse support especially after hours.
- Introduce APU flex beds to reduce bed block for patients requiring short inpatient admission.
- Review winter plan to ensure winter bed model meets expected demand.
- Service Reviews underway across General Surgery and General Medicine in order to increase specialty resource 7 days per week
- Four Nurse Specialists were employed as per the business case. These roles are in addition to the 2 Nurse Practitioners and 1 Clinical Nurse Specialist already employed. New roster will be introduced which will give NS/NP cover from 8 am to midnight 7 days a week.
- Continue work on weekend resourcing to meet variable demand.

Auckland DHB presentation available at http://www.hiirc.org.nz/section/9088/shorter-stays-in-ed/

AED Bed Request to Admission Time



A drop from 7 hours in 2009 to move a patient to the ward from the time of the ED bed request to just over 1 hour for the last four months to June 2011

Auckland DHB presentation available at http://www.hiirc.org.nz/section/9088/shorter-stays-in-ed/

Resources:

http://www.hiirc.org.nz/section/9088/shorter-stays-in-ed/

http://www.ecinsw.com.au/neat

Emergency Care Institute
NEW SOUTH WALES

Emergency Care Institute
NEW SOUTH WALES

Search

Administration & Clinical Support

Allied Health

» Stakeholder questionnaire – what did allied health staff have to say?

» Innovation centre

» NSW 5th Rural Allied Health Conference

Consumers | Doctors | Nurses

Upcoming events

2011 NOVEMBER

MON	TUE	WED	THU	FRI	SAT	SUN
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	1	2	3	4
5	6	7	8	9	10	11

4 OCT Australian and New Zealand Burns Association

5 OCT Paramedical Australia Conference

View all events

What's new

Emergency department visits

The ECI believes it is important to meet and talk to staff working in emergency. This list shows what departments and facilities the team have visted or plan to visit by month. read more

Emergency Care Symposium

On the 4 November 2011, the ECI will be hosting the inaugural NSW Emergency Symposium that will feature the launch of the ECI. The Hon Jillian Skinner (Minister for Health and Medical Research) and Dr Mary Foley (NSW Health Director General) wi ... read more

Useful links

NSW Emergency Care Symposium

4 November 2011

Registrations close on Friday 14 October 2011. Flights for rural atendees paid for by ECI. Don't miss out!

LEARN MORE »

VIEW MAP »

Feedback

Emergency Care Institute
NEW SOUTH WALES

Sally McCarthy
Medical Director
sally.mccarthy@aci.health.nsw.gov.au

Vanessa Evans
Network Manager
vanessa.evans@aci.health.nsw.gov.au

Sophie Baugh
Manager Special Projects
sophie.baugh@aci.health.nsw.gov.au