Emergency Department Clinical Services Plan 2019–2024

Queensland Government

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Interpreter Services Statement

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1 Introduction

This plan outlines emergency department service requirements now and into the future for Metro North Hospital and Health Service hospitals and will be operationalised through various mechanisms.

Emergency Departments (ED) provide timely diagnosis and treatment for time sensitive medical conditions and operate within a broader system including primary health care, ambulatory and the acute inpatient setting. To function effectively, the people and processes within and external to the ED need to work in synergy.

EDs have seen increasing demand with disproportionate growth in resources to manage this demand over the past two decades. This trend is Australia wide.

Metro North Hospital and Health Service (Metro North HHS) is a recognised leader in providing excellent ED health care for patients requiring care ranging from lower acuity to highly specialised services including trauma care. Metro North HHS EDs treated over 292,000 patients in 2017-18 with presentations increasing by 3.2 per cent per annum from 2014-15. Patients are spending a longer time in our EDs, on average 20 minutes longer in 2017-18 (228 minutes) compared to 2014-15. Patients are presenting with conditions that require more time to manage and the broader system is challenged to facilitate transfer of patient care quickly once ED care is complete. The increasing number and complexity of ED presentations is occurring in an environment where the Metro North HHS population continues to grow, age and diversify. To provide sustainable ED services, our system must also evolve to be efficient, responsive to changes in models of care and retain skilled staff.

Whilst EDs must be able to manage all presentations, it is important to ensure that unnecessary presentations are reduced and patients can depart ED in a timely manner. In the primary and community setting, providing responsive programs to support patients in the community should be the premise of patient focused care. This will minimise inappropriate ED presentations and support early discharge at the completion of ED care. Similarly, within the hospital setting, acute inpatient and other teams must work together with the ED to provide timely care to patients in the most appropriate setting. This will allow EDs to maintain capacity for patients in need of urgent diagnosis and intervention.

This Plan primarily focuses on care in the ED. Other services that impact on ED's ability to deliver care, such as primary and community care and hospital services are not a core focus but given their impact on ED flow, are included as additional information for clinical directorates and streams to action. The Plan outlines actions to assist Metro North HHS EDs continue to provide quality, timely and patient centred care to people with an acute illness, their families and carers. The Plan outlines a commitment to our EDs and requires ownership at all levels to ongoing improvements of the system. Metro North HHS has developed this Plan to ensure care is patient-centred, effective, coordinated, accessible, safe, sustainable and efficient.

2 Service environment

Activity

There are five EDs in Metro North HHS serving a population of over 1,000,000 people. The five EDs have varying levels of ED capability and capacity as summarised in Table 1.

Table 1: Metro North HHS ED capability, activity and growth

Hospital	Clinical Services Capability Framework level	Presentations 2017-18	Proportion of adults	Compound annual growth rate (2014-15 to 2017-18)
TPCH	6	91,647	69%	5.7%
RBWH	6	78,954	99%	1.5%
Redcliffe	4	65,476	80%	2.8%
Caboolture	4	53,418	80%	0.6%
Kilcoy	2	2,783	82%	0.4%
TOTAL	**NA**	**292,278**	**82%**	**3.2%**

Note: The annual growth rate for Kilcoy Hospital has been calculated between 2015-16 to 2017-18.

The growth rate in ED presentations across Metro North HHS from 2014-15 was 3.2 per cent per annum resulting in 292,278 presentations in 2017-18.

If there is no change to current models of care, ED presentations are projected to grow to 344,454 by 2021-22 and 402,871 by 2026-27.

Referrals

There are numerous referral sources to the ED and all have an impact on ED demand.

In 2017-18, there were 7212 referrals from general practitioners (GPs) which is a 16.2 per cent per annum increase from 2014-15. Some of these referrals are for conditions that could be more appropriately managed within the community and more likely to have better patient outcomes.

There were 3790 referrals from residential aged care facilities in 2017-18 which is a 24.6 per cent per annum increase from 2014-15. The top three primary diagnoses in 2017-18 included urinary tract infection, pneumonia (unspecified) and minor head injuries. There are conditions being referred that could be managed in the community.

The number of people arriving to an ED via an ambulance in 2017-18 was 102,358 persons. This is a 5.1 per cent increase per annum from 2014-15.

Casemix

In 2017-18, the most common primary diagnosis for adults and children presenting to a Metro North HHS ED was “injury, poisoning, and other consequences of external causes” (82,242 presentations). However, there has been an increasing number of patients presenting for conditions relating to nervousness, restlessness and agitation, unhappiness, demoralisation and apathy, irritability and anger, hostility, physical violence, state of emotional shock and stress, and suicidal ideation. In 2017-18 patients with symptoms and signs involving emotional state increased by 48.2 per cent per annum from 2014-15 (3,175 presentations) and these patients have the fourth largest impact on EDs length of stay[1].

Age groups

Our changing population profile means an increasing number of older people presenting to our EDs. Between 2014-15 and 2017-18, there was a 6.6 per cent per annum increase in older people (65 years and over) presenting to EDs, or an additional 10,706 older persons per annum. The average length of stay in Metro North HHS EDs is increasing and there is a direct relationship between the time spent in ED and age of patients.

In 2017-18, there were 53,259 children that attended a Metro North HHS ED, which is an increase of 3.7 per cent per annum from 2014-15. Children aged 0-14 years constituted 18.2 per cent (53,259) of all presentations.

Admissions

Across Metro North HHS there is an increasing number of patients that are admitted from ED. In 2017-18, 41 per cent of all adult ED presentations and 18 per cent all child ED presentations resulted in an admission, either to a short stay unit or an inpatient ward. This represents a rise of 6.2 per cent per annum in total admissions from 2014-15.

[1] The most total time in ED were for injury, poisoning, and certain other consequences of external causes presentations, followed by Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified followed by Diseases of the circulatory system.

Strategies to address demand and improve patient outcomes

Metro North HHS EDs have initiated or are involved in strategies to reduce demand in the ED and provide better patient outcomes. These programs include:

- **Residential Aged care District Assessment and Referral (RADAR)** a nurse led service facilitating access to hospital based and outreach services for acutely unwell and deteriorating patients. This service assists in preventing ED presentations across Metro North HHS
- **Working Together to Connect Care Program** an enhanced model of care at the RBWH with the aim of providing more inclusive care to a vulnerable group of people who present to the ED multiple times. The program has achieved reductions in ED presentations, savings in occupied bed days, and other benefits including improvements in housing access for this population
- **GP Rapid Access to Clinical Expertise (GRACE)** a model that provides GPs with a single point of access to call regarding management concerns of haemodynamically stable, medical patients. The GRACE service provides direct access to the TPCH Internal Medicine team and helps to reduce avoidable ED presentations
- **Geriatric Emergency Department Intervention (GEDI)** a model adopted at Caboolture Hospital that promotes best outcomes for frail and elderly patients to patients over 75 years of age with a frailty score by providing consistent and reliable care. The model has been successful in reducing hospital length of stay and waiting times.

3 Issues and challenges

Metro North HHS ED staff deliver high quality ED care to patients, despite a number of issues and challenges to overcome. Patients are presenting to EDs with increasing complexity of health issues which require a response that is proactive and adaptive in the ED and beyond. The issues described below span the health system, staff and patients.

System issues

Activity

A significant number of patients remain in the ED more than four hours after presentation across Metro North HHS. As at December 2018, only 67.8 per cent of patients were discharged within four hours. Evidence exists that there is definitive relationship between ED length and increased morbidity and hospital length of stay.

Across Metro North HHS, the main reasons contributing to increased ED LOS include:

- the demand for ED care exceeds staff and physical capacity
- delays to diagnostic imaging and pathology testing and/or results
- inadequate collaboration between inpatient teams and ED to enable timely admission/transfer of care to inpatient wards
- lack of inpatient beds
- lack of agreed pathways for common conditions.

Digital impact

The implementation of iEMR in Metro North has significant risk for ED operations and functioning. Whilst the replacement of EDIS with Firstnet by Cerner will streamline communication between clinicians and allow capability for electronic ordering, the software is not designed to track patient flow which requires a different approach.

Age and socioeconomic status

Age and socioeconomic status are established predictors of ED utilisation and likelihood of admission. There was a 3.2 per cent per annum increase in the demand for ED services between 2014-15 and 2017-18 and the greatest increase was for care of persons aged over 65. Older people have longer ED LOS and higher admission rates.

Models of care

Providing patient centred, culturally appropriate and safe care in a busy ED is sometimes challenging due to the diversity of need and complexity of care. For example, people affected by alcohol or drugs and need greater than four hours to recover, people with complex mental illness and suicidal ideation need close observation, and older people have complex needs and multiple comorbidities to manage.

There are variations in applying standardised care pathways and evidence based care across Metro North HHS. Variations in clinical practice have been shown to increase error rates and adverse events.

Alternative care

We are often challenged to provide connected, coordinated integrated care with primary and community based services to reduce unnecessary referrals, improve models of care and ED capacity, and manage people in the community.

GPs and community based services (including residential aged care) are challenged to manage patients with complex physical, mental and social needs in the community and/or at home who are at risk of a presentation or re-presentation to ED. This is evidenced by the increase in number of GP and residential aged care referrals to the ED between 2014-15 and 2017-18 for avoidable admissions such as urinary tract infections and pneumonia.

Pre-hospital care and information

Our relationship with the Queensland Ambulance Service (QAS) is critical to ensuring patients are directed to the most appropriate facility dependent on their clinical needs and hospital operational capability and capacity. When patients are not brought to the most appropriate facility, there is an increase in the number of unnecessary hospital transfers, ED congestion and delays to treatment.

The current clinical software does not support clinical workflow or reducing variation in care across the facilities. It has has limited utility and interoperability and does not support electronic prescribing, electronic clinical documentation, visibility of workload and patient flow through medical imaging, inpatient bed availability. The system also does not allow timely feedback from patients regarding their experience.

Infrastructure

The number of ED treatment spaces is below recognised benchmarks which challenges ED staff to provide safe, quality and contemporary care. Table 2 provides current activity, built capacity and the number of ED treatment space requirements according to planning guidelines applied at a Metro North HHS level. Currently, Metro North HHS requires an additional 42 treatment spaces and by 2021-22 requires an additional 90 ED treatment spaces if nothing changes.

Table 2: Deficit in ED treatment spaces, Metro North HHS

Metro North HHS	Current ED activity 2017-18	Current built capacity	Projected capacity requirements 2017-18	Current deficit of treatment spaces
Adult treatment spaces (including resuscitation bays)	239,019	135	158	23
Child treatment spaces (including resuscitation bays)	53,259	16	35	19
Total	**292,278**	**151**	**193**	**42**

Note: Queensland Health: Health Service Planning Benchmark Recommendations Paper ED Treatment Spaces and Short Stay Unit Beds November 2010 used to project requirements. For the purposes of this paper, a treatment space includes treatment cubicle, resuscitation cubicle, decontamination room, acute treatment cubicle, subacute treatment cubicle, fast track cubicle, isolation room, consult/treatment room, examination room, multipurpose room, specialty i.e. eye/ear treatment room, psychiatric treatment space, sexual assault room. Excludes short stay observation or emergency medical unit beds, procedure room, plaster room, triage spaces and interview rooms.

All EDs across Metro North HHS have space issues to varying degrees. The physical layout of the ED does not respect the privacy of patients including children and other vulnerable patients who may be exposed to violent and aggressive behaviours. The infrastructure issues include:

- lack of appropriate space for inmates presenting to ED from Woodford prison
- design for children, adults, older people, patients with mental illness or those presenting with drug and alcohol intoxication across Metro North HHS
- the EDs proximity to imaging and support services.

Staff

Providing consistent and standardised care for patients across Metro North HHS EDs is challenging due to a facility focus rather than a whole-of-HHS service. There is also opportunity to improve the sharing and transfer of learnings across Metro North HHS EDs for quality improvement and patient flow purposes.

The workforce models vary between the EDs and extended nursing and allied health roles are not systematically applied. The frequent rotation of junior medical staff through ED presents challenges to embedding practice, requiring significant orientation, training and supervision. Attracting and retaining staff is difficult but particularly for those more regional EDs in the HHS.

Opportunities to use non-clinical time for activities such as research are not always available. In addition, recent staff surveys show a proportion of staff feel overloaded and burned out, and a need for significant focus on staff wellbeing.

Patients

An increasing number of patients are not waiting for treatment or leave after treatment commenced in the ED. The percentage of 'did not wait' or 'left after treatment commenced' was almost double for persons of Aboriginal and/or Torres Strait Islander descent.

Patients are waiting longer to see a doctor and be treated in the ED. The percentage of 'time to be seen by treating clinician' has been increasing over 2014-15 to 2017-18. The Metro North HHS average is 63.8 minutes with the greatest time to be seen by a clinician taking 80.7 minutes and is influenced by many factors including staff resourcing and built capacity.

Other patient-reported concerns include:

- communication from ED staff particularly whilst waiting for care
- confidentiality when giving details of their symptoms in the triage area
- comfort, safety and culturally appropriate amenities in the waiting room
- vulnerable groups unable to get the care and support required in the community
- No alerts are in the system for known patients with an established condition or patients that have recently been an inpatient. These patients are subject to the same process as all other patients which can lead to delays in treatment and suboptimal care for example; patients who are immunosuppressed not happy to wait in the general waiting area where there is increased exposure to pathogens.

4 Review of Current Information

The following provides a summary of key points from the available published information. The emergency medicine colleges in Australia and overseas have well developed guidelines on ED standards of care. The Australian College of Emergency Medicine (ACEM) have a hierarchical structure of 34 standards that are grouped under five domains (clinical, administrative, professional, education and training, and research). The United Kingdom's Royal College of Emergency Medicine (RCEM) has best practice guidelines which recommend: trainee doctors on acute specialty programmes rotating through the ED, senior decision making at the entrance of the hospital and at times of peak activity, the system must have the capacity to deploy extra senior staff.

RCEM standards relating to community care recommend services delivered seven days a week to support urgent and emergency care services and community health care teams to be physically co-located with the ED to bridge the gap between the hospital and primary care, and to support vulnerable patients.

The guidelines emphasise that ED and acute admissions unit has information technology (IT) infrastructure that integrates and safeguards clinical information across urgent and emergency care system.

ACEM and the RCEM provide recommendations on the management of specific conditions in the ED including indicated diagnostic imaging and pathology testing.

Time based targets are an important tool in driving system reforms. Queensland Emergency Access Target (QEAT) is a key performance measure used to monitor patient access to care.

The literature provides strategies to prevent unnecessary hospital admissions for ED including:

- stroke patients being transferred directly to stroke units
- exploring alternative settings other than the ED for elderly patients with multiple comorbidities undergoing investigation by multidisciplinary teams
- patients suffering from falls being assessed first by ambulance falls services.

In the ED, the literature describes numerous models of care, representative of time critical activities that facilitate diagnosis, treatment and disposition. Features of models include adapting to changing patient needs and representing best practice.

Patient outflow obstruction is one of the key factors contributing to ED overcrowding. There are many contributory factors to patient outflow obstruction including high occupancy levels, delays in inpatient admission, older patient age and associated increased length of stay. Interventions aimed to circumvent patient flow obstruction acknowledges that a whole of hospital and system wide approach is required to address patient flow.

Staffing standards and benchmarks all seek to increase productivity, integrate care and provide for a well-qualified and sustainable workforce. Whilst there is literature detailing ideal nurse and medical staffing capabilities, none provide specific staff to patient ratios or evidence of how recommended profiles will improve ED performance.

The ED interfaces with multiple patient cohorts that requires the physical environment to be flexible to adapt to changing patient needs and models of care. Demographic changes including a greater number of elderly patients, increasing number of bariatric patients, the unique needs of children, patient and staff satisfaction require consistency in standards of care.

Patients who present to the ED perceive their injury or condition is serious or life threatening therefore the personal interaction and provision of information is a priority for most patients.

The application of health IT and telehealth in the ED is essential. Health IT adoption in the ED has been associated with significant and persistent reductions in waiting times.

5 Patients, their families and carers needs

The ED is an entry point for many patients arriving to hospital. Managing patient expectations at this point is important to the overall satisfaction with the care received. Most patients who have presented to an ED in Metro North HHS have told us they have had a positive experience and were happy with how they were treated.

Regular communication from staff is valued by patients and a breakdown can lead to patients exiting before treatment commenced, public mistrust and poor health outcomes. Patients and their carers have told us what matters to them when they are in ED is being kept informed of what may happen to them, when it will happen as this helps alleviate anxiety for them, their families and carers. Patients want to feel confident that when staff change during a shift change, their information is completely handed over.

Patients, families and carers want to feel safe and be treated with kindness and respect. If their own medication is taken away from them, they want to understand why. If they are given something to eat, they want to feel confident that the food will not adversely impact on their clinical condition such as diabetes.

Patients want their conversation with the clinicians to be confidential to minimise feelings of vulnerability. Patients under an active management plan for a known condition want to be treated in a consistent manner irrespective of different staff or different locations.

Patients want access to a comfortable and safe waiting room that is age and culturally appropriate inclusive of amenities.

Patients, their family and carers want a clear plain English explanation regarding next steps at the completion of their care in the ED. Carers want to be considered as part of the care team for the patient.

> *Emergency staff great, just communication on wait time lacking, but apology for wait appreciated.*
>
> *The communication in the ED could be better. I know they were busy, but, they left me in a room down there and no-one knew where I was. I didn't know if I could get up, I was just kind of left. That was less than impressive.*
>
> *In the waiting room, there was another family for whom the doctor had to give details of their family member's procedures. There was no privacy for this conversation.*
>
> *Staff are great and very helpful.*
>
> *Staff do a brilliant job.*

6 Staff needs

Metro North HHS ED staff want to be supported by management to do the best job they can in delivering care to patients that meets the expectations of patients, their families and carers.

EDs are high pressure work environments and to help ED staff do their job, they need a supportive team, appropriate infrastructure, equipment and technology that enables them to effectively interact with patients, families and their carers.

ED leadership want to be supported to provide opportunities for the staff to improve their clinical skills, as well as create a workplace well-being culture with a focus on coaching staff on their strengths and emotional intelligence.

What matters to ED staff is that the broader system in Metro North HHS (ED, inpatients, community health services) works together to ensure patients flow in, through and out of the ED in a manner that meets patient needs and supports ED staff wellbeing. ED staff want performance around patient flow to be shared and owned across Metro North HHS.

7 The future for ED services

Over the next five years Metro North HHS will continue to draw on the strengths of our system to provide an environment in which patients can expect care that is respectful and evidence-based, and staff feel confident that the system and processes enabling service provision will respond appropriately. The following principles have been developed to guide future ED care.

Principles

It is expected that implementation of the Plan will facilitate a seamless patient journey across the system and enable EDs across Metro North HHS to enhance:

- **person-centred care**—emergency care is designed and delivered in ways that are responsive to individual patient needs, especially vulnerable patient groups, and reflects contemporary evidenced-based systems and practices that optimise patient outcomes
- **staff wellbeing**—the health and wellbeing of the ED staff is supported by management to provide safe, quality care to patients in a supportive working environment
- **improved access**—patients have clearly defined pathways to appropriate care in a network of emergency services and within clinically acceptable timeframes
- **effective coordinated care**—ED care is delivered within a whole of system framework to support timely management and of patient flow through the ED and smooth transitions to other services in the hospital and/or home
- **safe and sustainable care**—the ED is resourced to meet patient demand to enable provision of care that is safe and sustainable for patients and staff
- **efficient care**—emergency models of care provide timely response to care including safe, timely and supported discharge to reduce demand for hospital care when it is not the best care option for the patient
- **training and development**—a culture of training is embedded into everyday practice which fosters teamwork and collaboration
- **research**—ED staff are encouraged and supported to participate or initiate research.

At all levels, there is recognition that improvements in quality of care do not occur by chance, but from actions of staff equipped with the skills needed to enact changes in care, directly and through support by management. Metro North HHS is committed to delivering on the following goals for ED services.

Patient, family and carers

- Patients will be knowledgeable, confident and supported to navigate the health system for care appropriate to their clinical needs
- Patients will be screened and assessed in the community and referred to definitive care via clearly defined and efficient referral pathways
- Specific pathways are available for vulnerable patient groups with complex and/or chronic care needs such as frail older persons, people with mental illness or behavioural disorders, and children. People who frequently attend an ED for non-urgent care will be actively linked with suitable alternative services
- Patients presenting to any ED in Metro North HHS will experience a similar physical environment, processes, staff identity and care to support easy wayfinding, alleviate stress and improve the overall experience
- Patients, their families or carers who present to a Metro North HHS ED are provided the same high levels of health care, and treated with respect and dignity taking into consideration the cultural, spiritual, social and emotional needs and preferences of individuals. Patients and families are empowered to participate in decision-making about their care through patient-centred systems of care and compassionate attitudes and actions of staff
- Patients have a high degree of satisfaction with the ED care they receive and can provide feedback through established mechanisms e.g. CaRE survey.

Staff

- Our staff feel valued and part of a team who work collaboratively across the service system to provide timely access to high quality, compassionate care
- ED staff have resilience to deliver quality care
- Staff have the capacity and capability to provide high quality care for the general population and the specialised needs of children, older persons, and people with mental illness, for the volume of patients that present
- Staff are supported by processes that facilitate discharge to home in preference to admission for appropriate patients
- Executive support staff in education and training and research opportunities
- There is a culture of continuous quality improvement embedded in ED care
- There will be collective ownership of the patient across all settings and greater awareness of a patient's entire journey
- Health care providers across the system are aware of and support transfer of patients to appropriate service providers in the community
- Staff who work in the community sector are valued for delivering comprehensive generalist care to patients who have health problems that can be prevented, managed or treated in the community.

System

- Executives and clinical leaders drive a system approach to delivering the right care, in the right environment, in a timely way, for all patients
- A culture is developed such that all clinical and support services work together to overcome barriers relating to patient flow that prevent or delay patient access to the care they require. There is culture of trust where people across the services communicate openly to facilitate streamlined patient journeys
- All Metro North HHS hospitals have capacity protocols that are triggered when predefined occupancy levels are reached to maintain patient flow and access to ED care
- Predicted surges in acute care demand across the service system will be monitored and proactive plans are in place to collaboratively manage this surge by balancing competing demands for all health system resources
- Existing and successful models of care are implemented, where indicated
- Agreed ED performance metrics are in place that consider the contribution of all health system components to patient flow, service quality, and patient outcomes. The data is collected and reported consistently in real time to enable the identification of opportunities for service improvement across the service system
- All Metro North HHS EDs provide a consistently high standard of emergency care that meets or exceeds standards
- ED triage systems optimise patient flow and outcomes by streaming all patients to definitive care within the ED or to suitable care in other settings
- ED design reflects innovative, evidence-based models of care, including consideration of the needs of vulnerable groups
- Patients whose emergency care is complete and who are awaiting discharge are accommodated in areas outside the ED with appropriate care. Patient discharge is supported by real time management plans and/or recommendations to ensure transfer and continuity of care
- Patient Access Coordination Hub (PACH), patient flow units, EDs, inpatient teams, and patient support services work together to minimise delays in intra and inter-hospital transfers
- Referrals from ED to outpatient and community health services are easily coordinated and are responsive to the patients and their families' needs
- Working together, Metro North HHS and care partners (e.g. QAS, GPs, residential aged care facilities, non-government organisations) provide timely, connected care across primary, acute and community care settings to meet the emergency care needs of the community
- Metro North HHS residents and referrers have greater awareness and access to urgent care services in the community
- Successful implementation of community based initiatives results in EDs managing the right patient cohort and extends the lifespan of current infrastructure.

8 Action Plan

This section provides the action plan for Metro North HHS wide initiatives. Actions are presented in three sections as follows:

- Section 8.1 contains actions which are within the control and/or influence of ED staff
- Section 8.2 contains actions that require the leadership of the Executive Director Emergency Medicine and Access Coordination Stream (EMAC) and collective ownership by Clinical Directorates and Clinical Streams
- Section 8.3 contains actions where responsibility is owned by the broader acute and community health services
- Section 8.4 contains areas identified during the planning process relating to flow across the system. These areas should be considered by Executive Director of hospitals in their planning activities

Actions are prioritised into high priority (HP) and intermediate priority (IP). TBE refers to groups that are To Be Established.

8.1 Emergency Department service delivery actions

The intent of these actions is to provide an agreed approach to managing increasing demand and aspires to achieve consistency of care for the patients that present to Metro North HHS EDs. Included in the plan are actions relating to ED care in *Metro North Mental Health Plan Services Plan 2018-23*, the jointly developed Brisbane North PHN and Metro North HHS *A five year health care plan for older people who live in Brisbane North 2017-22*, *Metro North HHS Children's Health Services Plan 2016-2021* and *facility plans*.

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
Standardised pathways			
1 HP	Implement clinical pathways and/or a system that limit investigations for specific conditions as per ACEM evidence based recommendations. This includes establishing a framework to eliminate low value clinical practices: • insertion of IV cannula where not clinically indicated. • urine testing where not clinically indicated. • computed tomography (CT) imaging of kidneys, ureters and bladder (KUB) in otherwise healthy emergency department patients, age ‹50 years, with a known history of kidney stones, presenting with symptoms and signs consistent with uncomplicated renal colic. • coagulation studies in emergency department patients unless there is a clearly defined specific clinical indication, such as for monitoring of anticoagulants, in patients with suspected severe liver disease, coagulopathy, or in the assessment of snakebite envenomation. • blood cultures in patients who are not systemically septic, have a clear source of infection and in whom a direct specimen for culture (e.g. urine, wound swab, sputum, cerebrospinal fluid, or joint aspirate) is possible. • imaging of the cervical spine in trauma patients, unless indicated by a validated clinical decision rule. • CT head scans and CT neck in patients with a head injury, unless indicated by a validated clinical decision rule. **Monitor compliance.**	ED Emergency Medicine & Access Coordination Stream (EDEMAC) ED Leadership Team Value based team until embedded in electronic solutions	Y
2 HP	Identify at least five clinical pathways to be standardised across EDs and measure compliance.	EDEMAC ED Leadership Team Relevant Clinical Streams	N
Staff Education and Wellbeing			
3 HP	Improve education and wellbeing through: • develop common education programs for ED clinicians and those who support them. Ensure sharing of resources for these programs • develop and implement programs to advance clinical skills and resilience of ED staff to attain best practice patient care.		N
4 IP	Provide opportunities additional to the Metro North HHS annual staff survey, for ED staff to provide feedback regarding their workplace.	ED Leadership Team	N
5 IP	Implement an agreed process to review staff feedback from planned forums.	ED Leadership Team	N

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
6 IP	Ensure staff have access to appropriate training and education opportunities in accordance with relevant College's training requirements and research opportunities aligned to Metro North HHS Research Strategy 2017-2022	EDEMAC ED Leadership Team	Y
7 IP	Develop a networked ED training program prioritising junior doctors and identified clinical areas e.g. paediatric and adult resuscitation.	EDEMAC	N
Service improvement and quality			
8 HP	Review evidence-based ED models of care and improvement programs to expedite patient flow across Metro North HHS. Current models of care and programs across Metro North HHS EDs for consideration include: • Model with a multidisciplinary team with a focus on patient care, clinical standards and departmental flow. The model includes separate clinical areas for different categories of patients, patients waiting within the clinical area rather than in the waiting room, early senior decision maker review and consultant/registrar inpatient referral (RBWH thermostat model). • Staffing models to specifically provide care for the frail older person including separate physical space (TPCH Older Peoples Assessment Liaison Service). • Innovative model of care (facilitated by new departmental design) focusing on replacing traditional triage and registration with a pivot nurse system, the extensive use of sub-wait areas, a focus on patient clinical space usage while not directly receiving medical care and refinement in patient streaming, including the use of consultant-led midtrack system for seeing suitable category 3 patients (Caboolture Hospital). • Process mapping and embedded forums (e.g. daily huddle) to identify issues and foster engagement across the service system to facilitate timely, high quality patient care (Redcliffe Hospital).	EDEMAC ED Leadership Team	N
9 HP	Develop a set of ED design principles that allow EDs to be flexible to changing clinical practice and changing patient cohorts.	EDEMAC Infrastructure	N
10 IP	Identify infrastructure requirements: • Undertake an infrastructure audit. • Apply evidence based models of care. • Plan for projected capacity.	EDEMAC Infrastructure ED Leadership Team ED, Hospitals	N
11 IP	Undertake regular audits against identified quality standards (e.g. selected ACEM standards) and make improvements as required including Australian Government Department of Health Emergency Triage Education Kit (ETEK).	ED Leadership Team Safety and Quality Teams	N
12 IP	Establish a community of practice between the EDs to promote a culture of a learning organisation.	EDEMAC	N
13 IP	Promote a networked approach to ensure patients presenting to any ED in Metro North HHS will have a similar experience.	ED Leadership Team EDEMAC	Y
14 IP	Implement a process to check the existence of a Management Plan (including ACPs under the Mental Health Act) to ensure care is consistent with a person's preferences.	ED Leadership Team	N
15 HP	Document key summary information at the patient bedside to assist with handover and patient inclusiveness.	ED Leadership Team	N

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
16 IP	Investigate patient pagers to ED initial waiting areas to reduce the risk of infection to immunosuppressed patients.	ED Leadership Team MNIT	Y
17 HP	Optimise the impact of iEMR on the operational activities of ED via the following mechanisms: • involvement of executive in the planning for the requirements of implementation • monitor progress via EMAC Stream and feedback to the Metro North strategic implementation group.	EDEMAC ED Leadership Team	N
Care for vulnerable population groups			
Mental Health			
18 HP	Implement an evidence based approach to managing patients with mental health illness/behaviourally disturbed patients: Specific aims: • Identify and implement an alternate model of care in the ED to assist in triage, assessment and disposition of patients with mental health illness at a specific trial site. • Develop the model of care to identify and manage behaviourally disturbed patients presenting with and without mental health issues at the point of triage. • Develop and implement a behaviour/toxicology unit to manage behaviourally disturbed and intoxicated patients at a selected ED to evaluate effectiveness. • Implement eligibility criteria to transfer care to an inpatient ward post ED care.	EDEMAC Clinical Directors, Mental Health ED Leadership Team Mental Health/ behavioural WG (TBE)	Y
19 HP	Designate separate areas for people with mental health issues, behavioural disturbances and/or with intoxication: • Identify appropriate physical areas for assessment, and management of patients as an interim measure. • Future infrastructure planning includes designated areas for assessment and management of patients.	ED Leadership Team Executive Director, Hospitals Infrastructure	Y
20 HP	Standardise processes for the transfer of mental health patients from ED to acute inpatient units.	ED Leadership Team Clinical Directors, Mental Health	N
21 HP	Establish a mental health education program for medical and nursing staff to include: • the capability of ED staff to conduct an agreed mental health assessment to determine the requirement for specialist mental health assessment • ED staff participation in Statewide Suicide Risk Assessment and Management in Emergency Departments (SRAM-ED) training • understanding of care pathways, roles and responsibilities of MNMH and ED staff • the referral process for mental health assessment by the Acute Care Team (where applicable).	ED Leadership Team Clinical Directors, Mental Health EDEMAC	Y
22 IP	• Develop a plan for Mental Health Services to expand the Drug and Alcohol Brief Intervention Team (DABIT) model of care across all EDs.	ED Leadership Team Directors Mental Health – Alcohol and Drug Service	Y

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
23 IP	Strengthen existing relationships with Mental Health Services in joint responses (including QAS and QPS) to people who may be at risk or in crisis.	EDEMAC Clinical Directors, Mental Health	N
24 IP	Strengthen models of care to enable assertive outreach for people with mental illness discharged from EDs and inpatient units including partnering with non-government organisations and community services.	ED Leadership Team Clinical Directors, Mental Health	Y
25 IP	ED staff to obtain the mental health patient's current clinical record (including management plan and alerts) by: • implementing a process for ED staff to obtain the management plan and alerts from Consumer Integrated Mental Health Application (CIMHA) to inform ED care as an interim measure • Integrate EDIS with CIMHA in the future recognising different clinical software systems in use.	ED Leadership Team MNIT	N
26 IP	Establish a process for recording the number of Emergency Examination Authorities (EEAs) (*Public Health Act 2005*) that present to the ED and the proportion of EEAs that are referred for mental health assessment (*Mental Health Act 2016*).	ED Leadership Team Executive Director, Mental Health	N
Older Persons			
27 HP	For Older People: • develop ED specific pathways, models of care or processes for the management of older persons that complement existing care models • evaluate models of care and pathways and processes.	EDEMAC Medicine Stream ED Leadership Team Older People WG (TBE)	N
28 HP	Patients with a Clinical Frailty Score (CFS) between 4-9 without an identified pathway should be assessed and managed through an older person's process.	ED Leadership Team Medicine Stream	N
29 IP	Implement a process to ensure patients over 75 years who are frail, have a CGA undertaken in the following circumstance: • Acute medical illness and/or other decline such as dementia/ increased confusion, decline in social support, decreased mobility).	ED Leadership Team	Y
30 IP	Implement a validated assessment tool for use in the ED that supports the development of an individualised care plan for the older person (aged over 75 years).	ED Leadership Team Medicine Stream	N
31 IP	Implement a discharge team to support frail, vulnerable older persons discharge home.	Executive Directors of Hospitals ED Leadership Team	Y
32 IP	Upskill ED staff to be able to undertake Comprehensive Geriatric Assessment and develop individualised care plans.	ED Leadership Team Medicine Stream	N

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
Paediatrics			
33 HP	For Children: a. develop common agreed protocols and referral pathways for children who are to be transferred from ED to the wards b. ensure best practice models of care for children's emergency services across Metro North HHS c. improve compliance to Queensland Children's Hospital (QCH) protocols and referral pathways for children who require transfer from Metro North HHS emergency departments to QCH d. implement education and training packages for emergency department staff at RBWH, TPCH, Redcliffe and Caboolture to deliver high quality care to children e. implement models of care to improve integration and coordination of services across care settings and across providers targeting children with special needs and/or complex conditions (including chronic disease and mental health conditions) f. develop infrastructure design principles.	Women's and Children's Clinical Stream EDEMAC Children's Emergency WG (TBE)	N
Aboriginal and Torres Strait Islander Persons			
34 HP	Deliver an in-service training program to increase ED staff: • awareness and education about the system and processes underpinning the Indigenous Health Liaison Officer (IHLO) program • capability to provide appropriate care to Aboriginal and Torres Strait Islander patients.	A&TSI Health Unit EDEMAC ED Leadership Team	N
35 IP	Increase capacity of the IHLO program to support culturally appropriate care to Aboriginal and Torres Strait Islander people presenting to Metro North HHS EDs.	Executive Directors of Hospitals A&TSI Health Unit	Y
36 IP	Implement an Indigenous Nurse Navigator position across Metro North HHS to provide clinical liaison, clinical expertise/information and to complement IHLOs and provide patients with support to transition between services.	Executive Directors of Hospitals A&TSI Health Unit	N
Culturally and Linguistically Diverse People			
37 HP	Develop resources to support ED staff providing appropriate care to all patients including those from different cultural backgrounds e.g. considerations such as food outlets, parking, access to interpreters, pamphlets in different languages "a Guide to ED".	EDEMAC Community/ED Interface WG (TBE)	N
38 IP	Develop a mechanism for QAS to identify and notify EDs of interpreter requirement.	ED Leadership Team	N
Responsive diagnostics			
39 IP	Implement digital solutions for real time notification of investigation results.	EDEMAC MNIT	Y
40 IP	Implement point of care testing in all EDs for essential pathology tests e.g. troponin testing, INR, electrolytes and renal function test.	EDEMAC ED Leadership Team	?
41 HP	Develop agreed turnaround timeframe KPIs for investigations that contribute to delays: • medical imaging (ultrasound, CT scan, plain radiology) • identified pathology tests.	ED Leadership Team Director of Medical Imaging Pathology Queensland	N

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
ED interface with inpatient teams			
42 HP	Improve the efficiency of clinical handover between ED, acute and community settings by developing a standardised clinical handover tool (eg, ISBAR) such that the minimum information requirements for progressive assessments and care plans are explicit.	EDEMAC ED Leadership Team COHD Executive Director of Medical Services	N
43 HP	ED and inpatient team including staff specialist and visiting medical officers develop and implement an agreed process for provision of definitive subspeciality advice for in and out of hours for patients that require subspeciality review within 60 minutes of ED request. • communication/escalation process for junior staff from respective departments if unable to obtain advice within the agreed timeframes • agreed tools such as instant messaging such as summary of the request including test results or images by ED staff to expedite decision making by inpatients consultants • test results available to medical officers on their own device • exploration of the role of an identified senior nurse without a patient load in appropriate clinical areas to provide specialist input to patients in ED (similar to the NUM cancer care model at RBWH) • communication between the most senior level medical officer and the on-call specialist for that shift.	Executive Directors of Hospitals	N
44 HP	Develop a facilitated flow pathway for patients presenting to EDs with a recent admission with the same presenting diagnosis and who require readmission.	ED Leadership Team	N
45 HP	Promote the use of huddles to reflect on care management and opportunities to improve patient experiences and service delivery.	ED Leadership Team Executive Director of Medical Services ED, Hospitals	N
Workforce			
46 IP	Develop a ED workforce model that enables identification of optimum staffing level aligned to patient volume and complexity in consideration of other impacting factors such as bed occupancy levels, physical beds and seniority of staff.	EDEMAC ED Leadership Team	Y
47 IP	Define the roles of a primary contact clinician and senior clinical decision maker.	ED Leadership Team	N
48 HP	Increase pharmacist capacity to enable all suitable patients to be reviewed early in their ED journey to inform patient care decisions.	Executive Directors of Hospitals	Y

8.2 Care in the community and care in the right ED

The intent of these actions is to reduce unnecessary presentations to EDs. Actions describe what is required to improve community and primary care awareness and access to services including the availability of information to ensure patients receive the right care, in the right place and in a timely fashion.

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
49 HP	Enhance community understanding of the role of ED and availability of alternative and appropriate services through: • regular review and adjustment of the current joint (Brisbane North PHN, Metro North HHS, QAS) emergency alternatives media campaign including consideration of the priority groups to be targeted • targeting the media campaign to patients presenting to outpatient services and ED utilising existing electronic/media devices available in outpatients and EDs • broadening outlet of campaign and drawing on various mechanisms for delivery i.e. videos and Instagram feeds.	EDEMAC Communications	Y
50 HP	Develop a local catchment service map for each hospital catchment (recognising that for certain conditions at different times of the day the catchment may cross hospital boundaries) to facilitate appropriate transfer of patients in partnership with Brisbane North PHN and QAS.	EDEMAC, Community and Oral Health Directorate (COHD)	N
51 HP	Enable GP access to specialist advice for navigation and clinical coordination of care in a range of clinical areas (e.g. general medicine, respiratory, cardiac, surgery, anxiety) during a GPs usual business hours via a single call centre: • evaluate existing specialist GP advice services within Metro North HHS for effectiveness (i.e. TPCH GP Rapid Access to Clinical Expertise (GRACE) service and Metro North HHS cancer care haematologist specialist advice service). • refine model based on learnings and implement. • evaluate models and refine.	EDEMAC Medicine, surgery and cancer care streams	Y
52 HP	Implement and evaluate initiatives that provide GPs and RACFs with access to clinical advice and alternative care pathways including: • RADAR[2] program • consider broadening the scope of RADAR to retirement villages.	EDEMAC Medicine stream	Y
53 IP	Analyse ED presentations quarterly to identify emerging patient groups that would benefit from targeted responses by alternative strategies to ED utilisation.	EDEMAC	N
54 HP	Develop a process for regular communication between EDs, PACH, QAS and GPs to ensure all stakeholders remain aware of services available in the community.	EDEMAC	N
55 HP	Provide a list of the bulk billing GP practices in ED waiting room with a free phone to provide patients with alternatives to ED care and investigate proven successful programs that link patients to GPs in partnership with Brisbane North PHN.	EDEMAC	N

[2] RADAR – nurse navigator led service in PACH to coordinate RADAR nurses in each of the hospitals. RADAR in PACH provides GPs and RACFs access to clinical advice and alternative care pathways outside of ED.

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
56 HP	Develop a process for regular communication between EDs, PACH, QAS and GPs to ensure all stakeholders remain aware of services available in the community.	EDEMAC	N
57 IP	Develop a software application for Metro North HHS community to have visibility of ED services provided at each hospital and the wait times with a link to the Brisbane North PHN website for information on other available services.	EDEMAC	Y
58 IP	Advocate for the Department of Health to review the Queensland Health MEDAI directive for currency/applicability with evolving ED models of care.	EDEMAC	N
59 HP	Ensure all existing plans are enacted for established trigger responses to defined levels of emergency department workloads and monitor and review the plans effectiveness.	EDEMAC ED Leadership Team	N
60 HP	Implement strategies for the management of the cohort of people with high social needs who are at increased risk of frequent ED presentation considerate of specific hospital catchment requirements through direct referral to community organisations i.e. homeless service, mental health service. Example *Working Together to Connect Care program at the RBWH*.	EDEMAC Executive Director of Hospitals Clinical Directors, Mental Health	Y
61 HP	Develop and implement a system for QAS to access management Plans for all patients who have a high recurrent utilisation of Emergency Departments. Monitor effectiveness of this process monthly.	EDEMAC	N
62 HP	Review management plans of frequent attenders at ED quarterly and develop a sustainable care pathway for these patient groups in partnership with primary care and community providers.	EDEMAC Clinical Streams	N
63 IP	Identify and formalise an agreed list of clinical conditions and criteria for GPs to have direct admitting rights e.g. Cellulitis patients to HITH.	Medicine stream COHD	N
64 IP	Strengthen models of care to enable assertive outreach for people discharged from EDs and inpatient units including partnering with non-government organisations and community services.	ED Leadership Team Clinical Directors, Mental Health	Y

8.3 Post ED care

These actions address the transfer of care following the conclusion of ED assessment and management. The actions aim to improve patient access to inpatient, outpatient and community based care in a timely fashion by strengthening linkages.

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
65 HP	Implement the Referral Assessment and Navigation (RAN) Service to pull patients from MNHHS EDs to appropriate Metro North HHS community health services. Monitor the RAN Service to align with peak ED presentation times and hospital discharges (up to 16 hours). Enhance the functionality of the RAN portal to: • accommodate direct referrals to the most appropriate community service provider using clinical navigators • investigate options to schedule available next day "hot/urgent clinics using the clinical navigators where capacity exists • have a live view of ED presentations to identify those patients suitable for community services (requires agreement on cohort of patients, and how the pull model will function) • provide immediate feedback to referrer on referral progress and estimated time of first community visit/review/assessment • enable ED did not waits and discharge against medical advice (DAMA) patients from Aboriginal and Torres Strait Islander backgrounds to be identified and followed up by RAN.	COHD	Y
66 IP	Develop and regularly update ED staff including new starters (in orientation package) to understand what services are available in the community and how to refer to RAN.	COHD ED leadership team	N
67 HP	Implement a system for the Hospital In The Home (HITH) registrar to actively identify patients in ED suitable for HITH.	COHD HITH – governance ED Leadership Team	N
68 IP	Increase pharmacy capacity including increasing tele-health for complex pharmacy management in HITH in the community.	COHD	Y
69 HP	Review the scope of Diagnosis Related Groups and conditions referred to HITH and respond to increasing complexity through increasing quantum of multidisciplinary (medical registrar and pharmacist) home visits.	Medicine Stream COHD ED Leadership Team	N
70 HP	Provide daily HITH vacancy report to each ED.	COHD	N
71 HP	Streamline and standardise HITH referral process.	COHD	N
72 HP	Provide a discharge management plan if possible to patients electing to leave against medical advice.	ED Leadership Team	
73 HP	Implement agreed pathways for common admitted conditions.	ED Leadership Team Executive Director of Medical and Surgical Services	N
74 HP	Develop and implement a checklist of actions to be completed by ED teams prior to notifying admitting teams of patient's readiness for admission.	ED Leadership Team	N

Priority No.	Actions	Responsibility in Metro North HHS	Resources required Y/N
75 HP	Implement the *Queensland Health Patient Centred Emergency Access Health Service Directive - Guideline for Inpatient Admission Facilitation*, which provides authority for the ED senior decision maker to discharge patients from the ED to wards.	ED Leadership Team	N
76 HP	Investigate preferred models to expedite the flow of patients from ED to inpatient wards. Examples are listed below but are not exclusive. **Model 1:** Expand the scope of existing medical or surgical assessment service (or develop) to an Acute Assessment Service. The following features should be considered: • acceptance of patients who meet identified criteria to be admitted directly from ED. • physician (including surgical PHO) is available to review ED patients from 8am to 10 pm • units should be in close proximity to ED. **Model 2:** Trial at a selected ED to have an inpatient medical team member for (registrar or a senior nurse) in ED between 2pm to 10pm to actively facilitate transfer of care from ED to the ward.	ED Leadership Team Executive Director of Medical Services Executive Directors of Hospitals	Y
77 IP	Develop performance targets for inpatient team acceptance of patients and monitor compliance with agreed targets. Examples may include but are not exclusive: • 70 per cent of patients referred for admission to be reviewed within 30 minutes of referral • 50 per cent of patients transferred to an inpatient unit bed within 90 minutes following review • percentage of patients referred for admission not seen within 30 minutes of referral.	Executive Directors of Hospitals Directors of ED Executive Director of Medical Services	N
78	Develop a process that enables inter-hospital transfers to be facilitated with a single phone call with no right of refusal by the accepting facility.	Executive Directors of Hospitals ED Leadership Team	N

8.4 Flow across the system

The following areas have been identified through the planning process to support timely flow of patients across hospital service settings. Whilst this is not within the remit of the ED Plan, the importance of these concepts was recognised by stakeholders given the impact on overall patient flow. Executive Directors of Hospitals are encouraged to consider these in their planning activities:

- Barriers that prevent prompt transfer of patients from ED to inpatient wards e.g. availability of operational staff, turnover of vacated beds and the validity of bed availability on bed management systems.
- Processes that support proactive discharge activities e.g. daily decision maker led ward round, criteria led discharge, identification of estimated discharge date, pharmacy ward rounds.
- Processes to support timely discharge post decision to discharge from inpatient ward e.g. rostering additional doctors per team.
- Regular upskilling of clinical ward staff to manage more complicated patients e.g. indwelling catheters and nasogastric tubes.
- Review workforce requirements to expand inpatient coverage outside business hours to facilitate timely transfer of care from the ED.
- Review access to discharge support services outside of business hours.
- Increase access to speciality hot/urgent and routine medical clinics to minimise the number of admissions.

What we will measure?

High level measures will focus on the four domains outlined below at a system level.

patient experience

- real time feedback

staff experience

- real time staff wellbeing feedback in parallel to patient experience measures

quality and safety

- Queensland Emergency Department Strategic Advisory Panel quality indicators
- Closing the gap (DAMA and Failure to Attend)
- Never events
  - No patients to stay in ED for longer than 24 hours
  - QAS patient stretcher offload to be never more than an hour

system (value, efficiency)

- Cost per weighted activity unit
- QEAT
- Patient off stretcher time
- Triage category by waiting time

Implementation, monitoring and review

Implementation

Implementation of the Plan will be led by EDEMAC. The actions in the Plan will be prioritised and implemented over a five-year timeframe. Priority will be given to actions that advance quality standards for EDs and actions that can be achieved quickly.

Whilst EDEMAC will provide overall coordination of Metro North HHS wide actions, individual facilities and other relevant directorates will have specific responsibility for progressing some actions. These aspects will be covered in implementation planning which will be led EDEMAC.

Risks to successful implementation

The success of implementation relies on all stakeholders committed to achieving the stated outcomes. The key risks of not achieving the actions include:

- lack of commitment from the broader service system responsible for overall patient flow
- insufficient future resources allocated to deliver on actions
- inability to meet projected health service need across Metro North HHS
- timely exchange of information via digital solutions.

Resource implications

The process of planning has considered resource implications of the actions. Service development will require resourcing over time through organisational budgetary processes.

Monitoring, reporting and review

Implementation including reporting on the Plan's progress will be coordinated annually by EDEMAC. This process will also facilitate the Plan to evolve and remain current.


Royal Brisbane and Women's Hospital
Adult Emergency
Main Entrance
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