POLICY ON STANDARD TERMINOLOGY

1. INTRODUCTION

Terminology related to emergency medicine as defined in this document is applicable to Australasia and is internationally recognisable.

It will apply to all Fellows and trainees of ACEM for both verbal and written communications and the use of terms such as *accident and emergency doctor*, ED doctor, *emergency room* or *casualty* is to be actively discouraged. It is not in the interests of the community for a health care facility without acute inpatient beds and services to use the terms emergency department, emergency, accident, or similar terms when referring to or signposting the service it provides for acute or urgent care.

It is important for clarity and patient safety that terms related to emergency medicine (including those concerning providers of emergency medicine, facilities delivering emergency medicine and common processes in emergency medicine) be standardised.

2. EMERGENCY MEDICINE

Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

2.1 Notes

This is the definition agreed to by the American College of Emergency Physicians, the Australasian College for Emergency Medicine, the British Association for Accident and Emergency Medicine and the Canadian Association of Emergency Physicians contained in the Charter of the International Federation for Emergency Medicine (October 1991) [1]. The National Specialist Qualification Advisory Committee of Australia recognises emergency medicine as a principal specialty, as does the Australian Medical Council and the Medical Council of New Zealand.

3. EMERGENCY PHYSICIAN

An emergency physician is a registered medical practitioner trained and qualified in the specialty of Emergency Medicine. The recognised qualification of an emergency physician in Australasia is the Fellowship of the Australasian College for Emergency Medicine (FACEM).

3.1 Notes

Emergency physician is the preferred term to describe a registered medical practitioner trained and qualified in the speciality of emergency medicine. Other acceptable terms include staff specialist in emergency medicine, specialist in emergency medicine, specialist emergency physician [2] and consultant in emergency medicine.

Junior medical staff are identified by their role in the Department of Emergency Medicine e.g. registrar in emergency medicine, resident in emergency medicine. Junior staff undergoing medical training for Fellowship of ACEM can be further identified by their stage of training e.g. basic trainee in emergency medicine, advanced trainee in emergency medicine.

4. DEPARTMENT OF EMERGENCY MEDICINE

A Department of Emergency Medicine is the pyramidal structure for medical staff within a hospital that is responsible for the provision of medical care, management, teaching and research in emergency medicine.

4.1 Notes

The director of a Department of Emergency Medicine is known as Director of Emergency Medicine.

The Director of Emergency Medicine has overall clinical and administrative responsibility for all patients in the Emergency Department as per ACEM *Statement on Responsibility for Care in the Emergency Department (S18)* [3]. All staff in the department are responsible to the director on operational and clinical matters. This does not preclude policy and ethical responsibility which multidisciplinary team members have to others in the hospital.

5. EMERGENCY DEPARTMENT

An Emergency Department is a dedicated hospital based facility specifically designed and staffed to provide 24 hour emergency care. An Emergency Department cannot operate in isolation and must be part of an integrated health delivery system within a hospital both operationally and structurally. The minimum standards for the four levels of emergency department are defined in ACEM *Statement on the Delineation of Emergency Departments (S12)* [4].

5.1 Notes

Emergency care is provided by a wide range of facilities and providers from remote nurse run clinics, general practices, ambulance services, retrieval services, through to Emergency Departments.

To be designated and signposted as an 'Emergency Department' requires the facility to meet the minimum standards set in S12. Emergency Departments and community based Emergency Care Providers should be part of an Emergency Medicine Network that provides specialist support, advice and training to non-specialist providers of Emergency Care (refer to ACEM *Statement on Rural Emergency Medicine (S27)* [5].

As Set out in *ACEM Statement on the Delineation of EDs (S12)* [4], the minimum standards required to be called an Emergency Department are:

- must operate structurally and functionally within a hospital
- 24 hour dedicated nursing staff with a dedicated Nurse Unit Manager or equivalent
- daily rostered medical staff and 24 hours a day, seven days a week access to medical staff after hours
- dedicated facilities to manage emergency presentations
- co-located dedicated resuscitation area with appropriate equipment to provide advanced paediatric, adult and
- trauma life support prior to transfer to definitive care
- 24 hour access to blood products
- 24 hour access to laboratory and radiology services
- 24 hour access to specialty care or advice

- 24 hour access to retrieval services, as appropriate

- If there are no emergency specialists (Fellows of ACEM (FACEMs)) on staff then the Emergency Department must be part of an Emergency Medicine Network.

There are 4 levels of standards for Emergency Departments, Level 1 (an ED providing an emergency medicine service in a rural hospital) through to Level 4 (an ED providing an emergency medicine service in a tertiary or major referral hospital)

In some established urban emergency medicine networks, there are Emergency Departments that operate during limited hours. These are still considered Emergency Departments if local arrangements direct patients to another Emergency Department of the same or higher level when they are closed.

6. NETWORKS

6.1 Emergency Medicine Networks

An emergency medicine network is comprised of a Level 1 (large, multifunctional tertiary or major referral) or Level 2 (major regional, metropolitan or urban) hospital providing outreach services to non-specialist providers of emergency care in other medical settings.

6.2 Emergency Medicine Training Network

An emergency medicine training network is defined as a group of hospitals that have formally agreed to a coordinated education and training program for emergency medicine trainees. Each hospital within the network must individually satisfy the mandatory criteria for accreditation. For detailed criteria and network requirements, please refer to *ACEM Accreditation Guidelines ACO1* [6].

7. STANDARD TERMINOLOGY FOR EMERGENCY DEPARTMENT PROCESS

7.1 Arrival Time

The first recorded time of contact between the patient and the Emergency Department staff. A recording accuracy to within the nearest minute is appropriate. There should be no delay between the physical arrival in the ED of a patient who is seeking care and their first contact with staff.

7.2 Waiting Time

This is the difference between arrival time and time of initial medical assessment and treatment. A recording accuracy to within the nearest minute is appropriate.

7.3 Time of Medical Assessment and Treatment / Time of Clinical Care Commencement

7.3.1 Time of Medical Assessment and Treatment

Although important assessment and treatment may occur during the triage process, this time represents the start of the care for which the patient presented. A recording accuracy to within the nearest minute is appropriate. Usually it is the time of first contact between the patient and the doctor initially responsible for their care, often recorded as “time seen by doctor”. Where a patient in the ED has contact exclusively with nursing staff acting under the clinical supervision of a doctor, it is the time of first nursing contact, often recorded as “time seen by nurse”. Where a patient is treated according to a documented, problems specific, clinical pathway, protocol, or guideline approved by the Director of Emergency Medicine, it is the earliest time of contact between the patient and staff implementing this protocol. This is often recorded as the earlier of “time seen by nurse” or “time seen by doctor”.

7.3.2 Time of Clinical Care Commencement

Clinical care can be commenced by a doctor, nurse, mental health practitioner or other health professional, when care (or treatment) or investigation/s is provided in line with an established clinical pathway / protocol as defined by the ED [7].

7.4 Assessment and Treatment Time

This is the difference between the time of initial medical assessment and treatment and ready for departure time. A recording accuracy to within the nearest minute is appropriate.

7.5 Inpatient Bed Request Time

This represents the time when a formal request is made to obtain an inpatient bed for a patient requiring admission to hospital. This time is significantly more subjective than arrival time or departure time, but maybe useful in a single hospital setting for comparative purposes. Different hospital systems collect this time in different ways and it may be before or after the Ready for Departure Time.

7.6 Ready for Departure Time

This represents the time when, in the opinion of the treating doctor, no further emergency medicine care is necessary. This time is significantly more subjective than arrival time or departure time, but maybe useful in a single hospital setting for comparative purposes.

7.7 Admission Delay Time

This is the difference between the ready for departure time and the departure time for patients who are admitted to hospital, die in the Emergency Department, or are transferred to another hospital for admission. This time is significantly more subjective than waiting time or assessment and treatment time, but maybe useful in a single hospital setting for comparative purposes.

7.8 Departure Time

This is the time the patient physically leaves the Emergency Department, representing the end of the episode of emergency treatment. This includes patients who are discharged home, transferred to another hospital, die in the Emergency Department, are transferred to another part of the hospital for definitive care, or are admitted to a ward, including an observation ward which may be located in the ED. It does not include patients sent to another area for treatment when return to the Emergency Department is expected, nor does it include patients statistically admitted to beds within the Emergency Department but still receiving care from the same staff. Accuracy to within the nearest minute is appropriate.

7.9 Patient Care Time

This is the difference between the Time of Medical Assessment and Treatment and the Departure time. It represents the time for which the patient receives medical care from Emergency Department staff. A recording accuracy to within the nearest minute is appropriate.

7.10 Total ED Time

This is the difference between the arrival time and departure time. A recording accuracy to within the nearest minute is appropriate.

7.11 Access Block

This refers to the percentage of patients who were admitted or planned for admission but discharged from the emergency department (ED) without reaching an inpatient bed, transferred to another hospital for admission, or died in the ED whose total ED time exceeded 8 hours, during the 6 month time period.

7.12 ED Overcrowding

This refers to the situation where Emergency Department function is impeded primarily because the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure exceeds either the physical or staffing capacity of the Emergency Department.

7.13 TIME BASED TARGETS

The Shorter Stays in Emergency Departments (SSEDs) target and the National Emergency Access refer to time-based targets relating to patient length of stay in the ED, implemented in New Zealand and Australia respectively. Both targets were introduced to improve patient flow with regard to of discharge from the ED or admission to an in-patient unit/ward, leading to improved quality and timeliness of care.

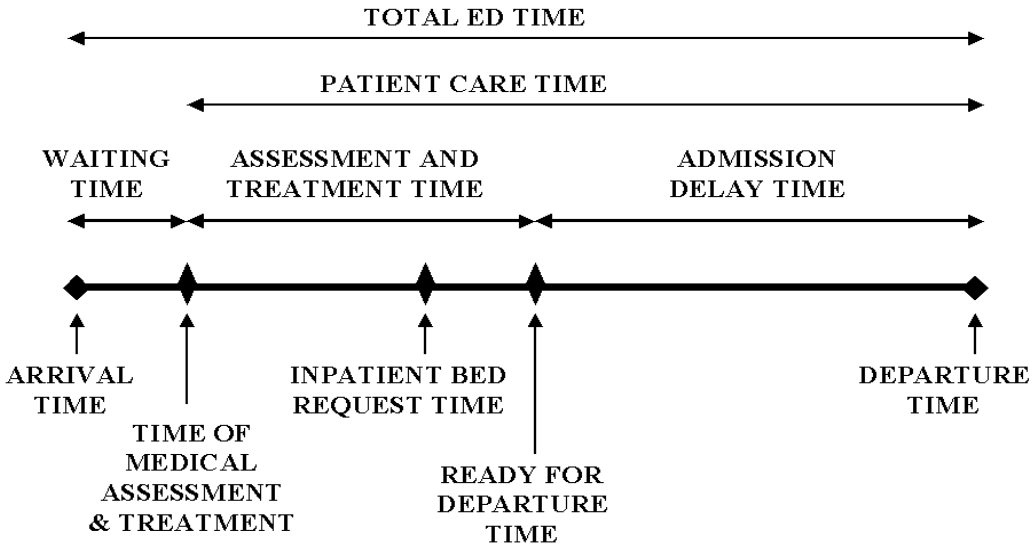
The SSEDs, introduced in 2009, requires district health boards (DHBs) ensure that *"95 per cent of patients will be admitted, discharged or transferred from an ED within six hours"* [8].

The NEAT, introduced in 2012, is an objective of the *National Partnership Agreement on Improving Public Hospital Services,* and has been set at *"**90 per cent** of all patients presenting to a public hospital ED will either physically leave the ED for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours"*[9].

7.14 SHORT STAY UNIT

This refers to a unit designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED. Short stay units have specific admission and discharge criteria and policies. They are physically separated areas from the ED acute assessment area, and are not designed for short term stays longer than 24 hours. Short stay units have a static number of beds with oxygen, suction, patient and ablution facilities. They are not a temporary ED overflow area, or used to keep patients solely awaiting an inpatient bed or awaiting treatment in the ED [10].

8. DIAGRAMMATIC REPRESENTATION



9. REFERENCES

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10. DOCUMENT REVIEW

Timeframe for review: every two (5) years, or earlier if required.

10.1 Responsibilities

Document authorisation: Council of Advocacy, Practice and Partnerships
Document implementation: Council of Advocacy, Practice and Partnerships
Document maintenance: Policy and Research Department

10.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
5.0	TBC	Amendments to Sections 3.1 and 5 Addition of Emergency Medicine Networks (6), Time of Clinical Care Commencement (7.3.2), Time Based Targets (7.13) and SSUs (7.14).