Australasian College
for Emergency Medicine

Position Statement

Statement on the role delineation of emergency departments and other hospital-based emergency care services

1. Purpose and terminology

This document defines the minimum requirements for four levels of emergency departments (EDs) and two levels of smaller hospital-based emergency care centres.

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Emergency Care Centres		Emergency departments			

The grouping of emergency departments with other hospital-based emergency care services aligns with ACEM Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services.

A division into six levels of service aligns with the published six-level capability frameworks used by Australian and Aotearoa New Zealand jurisdictions for most areas of acute care.

There is no universal term in Australia and Aotearoa New Zealand for the smallest hospital-based emergency care services. This document suggests Emergency Care Centres (ECCs).

2. Introduction

Although only facilities that are operationally and structurally part of a hospital are included in this document, it is acknowledged that emergency care is also provided by a range of facilities and providers. These include general practices, remote nurse-run clinics, pre-hospital and retrieval services and stand-alone urgent care centres.

The six levels delineate the complexity of care that a facility can provide. Higher-level facilities can definitively manage more complex patients.

For many areas of healthcare, the complexity of care that a facility can provide defines the complexity of the patients that will be encountered. This is as public advice, telehealth, and pre-hospital services often appropriately direct complex patients to larger facilities. However, due to the very nature of emergency care, being unplanned and unscheduled, all emergency facilities receive high and low-complexity patients in all age groups with all types of emergencies. A patient with any type of emergency may arrive by private transport irrespective of agreed pre-hospital service flows.

Every ED and ECC is an important entry point to the health system for their community. All patients should receive high-quality care no matter what level of emergency facility they initially attend, recognising that patients may need to be transferred elsewhere in the emergency care network for more specialised or higher level care.

All ECCs and community-based emergency care providers should be part of an Emergency Medicine Network that provides emergency specialist support, advice, and education[1].

A facility must meet the minimum standards set in this document to be designated and signposted[2] as an 'Emergency Department'.

This document is a restructuring of ACEM's previous ED delineation. Emergency facility levels three to six align with previous ED levels one to four, with the accompanying criteria updated.

The framework used to determine the level of an ED is based on:

- Service design
- Service description
- Service requirements
- Workforce
- Support services

2.1 Open and closed emergency facilities

Most ECCs have an **open model** where clinical staff come to the emergency area from the wider hospital or local community when required. Examples of visiting senior decision-makers include general practitioners, rural generalists, general surgeons, and general physicians. Sometimes the senior decision-maker will be an external telehealth provider. In many emergency care centres, nursing staff work in the general hospital and only attend the emergency area when needed.

Level three EDs are a transitional level where nurses and junior doctors are based in the ED, but senior decision-makers specifically attached to the ED are not always available.

All other EDs have a closed collaborative model where clinicians rostered in the ED take primary responsibility for patient management (although they share care by collaborating with external clinicians as appropriate).

More information on ED senior decision-makers can be found in the ACEM Guidelines on Constructing a Sustainable Emergency Department Medical Workforce (G23).

Emergency departments of each level must meet the criteria outlined below. To be accredited for ACEM emergency medicine specialist training, EDs must meet further criteria, as set out in the ACEM Accreditation Requirements (AC549).

[1] S27 Statement on Rural Emergency Care (ACEM, 2023)
[2] P20 Policy on Emergency Department Signage (ACEM, 2023)

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3. Service design

	Level 1*	Level 2*	Level 3*	Level 4	Level 5	Level 6
Designation	Emergency care centre.	Emergency care centre.	Emergency department.	Emergency department.	Emergency department.	Emergency department.
Model of care	Open.	Open.	Transition.	Closed collaborative.	Closed collaborative.	Closed collaborative.
Location	An area of a rural or remote hospital designed to receive scheduled and unplanned and emergency presentations.	An area of a rural or remote hospital designed to receive unplanned and emergency presentations.	An area of a rural or remote hospital designed to receive emergency presentations.	An area of a hospital designed to receive emergency presentations.	An area of a hospital designed to receive emergency presentations.	An area of a hospital designed to receive emergency presentations.
Network role	Designed to manage minor illness and injury, but able to recognise serious illness and initiate appropriate treatment.	Designed to assess common emergency presentations. Can provide definitive care for many patients not requiring immediate imaging or pathology.	Designed to assess all emergency presentations and provide definitive care when resources are available.	Designed to manage all emergency presentations and support smaller emergency facilities in the network.	Designed to manage all emergency presentations and support smaller emergency facilities in the network.	Designed to manage all emergency presentations and support all other emergency facilities in the network.
Interaction with pre-hospital and retrieval services	Can initiate emergency treatment while awaiting pre-hospital and retrieval services.	Can receive ambulances but often bypassed if patients thought to require a higher level of resources.	Receives ambulances but bypassed by patients requiring time-critical management not available onsite.	Receives all ambulances unless bypass required by condition-specific guidelines.	Receives all ambulances unless bypass required by condition-specific guidelines.	Receives all ambulances unless bypass required by condition-specific guidelines.

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Physical design	An outpatient area with simple resuscitation resources (including oxygen, oral airways, bronchodilators, intravenous canulae and fluids, common intravenous antibiotics, adrenaline, and a semiautomatic defibrillator) and simple monitoring equipment (including pulse oximetry and the ability to perform electrocardiograms). Design should allow remote assessment of patients with behavioural emergencies before a decision is made if they can be safely managed.	As for level 1 plus continuous cardiac monitoring, and resources for patients requiring short-term airway protection and assisted ventilation. Design should allow for staff safety if a patient, friend, or family member becomes aggressive.	As for level 2 plus separate resuscitation areas with capabilities for invasive monitoring mechanical ventilation.	As for level 3 with a dedicated short stay unit and area for short term management of patients with behavioural emergencies.	As for level 4 plus areas devoted to improved models of patient flow, such as fast track areas.	As for level 5 plus areas for specific roles if required (e.g. trauma service).

*For Level 1-3. Acknowledging a site's specific circumstances, where onsite services are limited, or cannot be provided, the responsible health service is expected to ensure there is planned and adequate access to these services and supports.

Note that while Levels 1-3 mainly refer to a rural or remote hospitals, there will be smaller EDs in metropolitan locations may meet these delineations.

[3] P11 Policy on Hospital Emergency Department Services for Children (ACEM, 2020)

4. Service Description

	Level 1*	Level 2*	Level 3*	Level 4	Level 5	Level 6
Assessment	Focussed clinical assessment with telehealth support.	Level 1 plus point-of-care-testing.	Level 2 plus onsite pathology and radiology.	Level 3 plus onsite general specialty assessment.	Level 4 plus onsite sub-specialty assessment.	Level 5 plus highest complexity specialty assessment.
Critical care	Stabilisation while awaiting transport, basic life support and semi-automatic defibrillation.	Advanced life support including insertion of laryngeal masks +/- endotracheal intubation, administration of thrombolytics after specialist input.	Initiation of intensive care prior to transport, including non-invasive ventilation, ventilation via ETT, inotropes, and other required interventions.	Level 3 plus onsite intensive care and acute surgery.	Level 4 plus higher-level intensive care and acute sub-specialty surgery.	Level 5 plus highest complexity intensive care and surgery.
Management	Advanced wound care, splinting, and first-line medications (may possibly be prescribed by offsite clinicians, or protocol based).	Level 1 plus: simple emergency procedures and intravenous fluids.	Level 2 plus: procedural sedation in low-risk patients.	Full range of emergency procedures.	Full range of emergency procedures.	Full range of emergency procedures.
Observation	Observation of response to simple treatments.	Short-term observation for stable patients.	Short-term emergency observation.	Level 3 plus emergency short stay unit.	Level 3 plus emergency short stay unit.	Level 3 plus emergency short stay unit.
Local admissions	None.	Stable low-complexity patients with clear diagnoses and management plans.	Patients unlikely to deteriorate and need intensive care or immediate surgery (or with treatment limitations).	All patients when appropriate inpatient resources available.	All patients when appropriate inpatient resources available.	All patients when appropriate inpatient resources available.
Ideal presentations	Minor injury and illness.	Common low-risk presentations requiring minimal investigations.	Any presentation not requiring intensive care or immediate surgery.	Any presentation not requiring time-critical definitive management that cannot be provided onsite.	Any presentation not requiring time-critical definitive management that cannot be provided onsite.	Any presentation unless specialty care (such as paediatrics) not provided at the site.

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5. Service requirements

	Level 1*	Level 2*	Level 3*	Level 4	Level 5	Level 6
Service provision	A clinical information management system which records patient demographics and data for relevant clinical indicators. Pathways for consultation with senior decision makers. Documented policies and procedures (preferably shared with other services of a similar level). An adverse event and risk management program.	As for level 1 plus: Triage should occur on arrival by credentialed clinical staff using the Australasian Triage Scale (ATS)[4-5]	As for level 2 plus: A clinical information management system that aligns with jurisdictional requirements and the National Minimum Data Set There is adequate physical capacity and type of spaces available for management of patients in relation to acuity and access to in-patient and alternative services. Risk management strategies are developed, implemented, and evaluated documented processes to guide clinical management including paediatrics and obstetrics/gynaecology, where appropriate. Documented processes for the management of mental health patients including risk management strategies specific to this group are in place.	As for level 3 plus: Regularly audits performance against the five domains of the ACEM Quality Standards for Emergency Departments and Hospital-based Emergency Care Services. Purpose built resuscitation area for trauma and other life-threatening presentations.	As for level 4 plus: Specialty services on-site for consultation. Provide support to lower-level networked services including advice, education, and quality review. Specific safe area for patients with, or at risk of developing, severe behavioural disturbance and/or patients with challenging behaviours. Extended hours access to allied health services commensurate with casemix and clinical load.	As for level 5 plus: Specialty services on-site such as neurosurgery and cardiothoracic surgery.

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			Formal quality improvement programs, including mortality and morbidity reviews and evaluation of clinical indicators are in place. Quality improvement data is submitted to an independent review process such as ACHS.			
Education and training	An emergency education program for staff. Access to a nurse educator or resources for ongoing educational activities for nursing skills maintenance. Involvement with a regional Emergency Medicine Network through which it can access emergency specialist support, advice, and training.	As for level 1 plus: A program to ensure senior decision makers have current emergency skills and training.	As for level 2 plus aims for involvement (or is involved) in Associateship in Foundational, Intermediate, or Advanced Emergency Medicine Training Programs (or equivalent) and other generalist training programs.	As for level 3 plus aims for accreditation (or is accredited) for ACEM fellowship training and for generalist advanced emergency skills training.	As for level 4 plus: Accredited for ACEM fellowship training.	As for level 5 plus: Involved in development of jurisdiction-wide guidelines for specialty services (such as major trauma).

*For Level 1, Level 2, and Level 3 – acknowledging a site's specific circumstances, where onsite services are limited, or cannot be provided, the responsible health service is expected to ensure there is planned and adequate access to these services and supports.

[4] P06 Policy on the Australasian Triage Scale (ACEM 2023)
[5] G24 Guidelines on the Implementation of the Australian Triage Scale in Emergency Departments (ACEM 2023)

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6. Workforce

	Level 1*	Level 2*	Level 3*	Level 4	Level 5	Level 6
Nursing	Nursing staff attend the emergency area from the hospital when needed. Nurses may have extended skills in emergency care or endorsed limited prescribing.	Nursing staff attend the emergency area from the hospital when needed. Ideally, nurses with extended skills or endorsed limited prescribing are always available.	Nursing staff credentialed in triage and able to use ED equipment located in the ED at all times. Nursing staff have basic emergency care skills as a minimum. A dedicated Nurse Unit Manager or equivalent. Nursing workforce meets nurse:patient ratios and other regulations.	Advanced Skills Clinical Nurses (where applicable), supported by experienced and qualified registered nurses. Team leaders/shift coordinators available at all times. A Nurse Unit Manager or equivalent. A nurse responsible for nurse education. Extended specialist emergency medicine cover (may include on call).	As for level 4 plus: 24-hour specialist emergency medicine cover (may include on call). Extended hours access to selected allied health professionals, such as social worker and/or physiotherapist.	As for level 5. May include subspeciality emergency medicine cover for example toxicology, paediatric EM.
Nurse practitioners, junior doctors, and allied health	No rostered onsite medical staff. Some models of care use onsite rural or emergency nurse practitioners.	No medical staff rostered solely to the ED. Occasionally junior medical staff located in the hospital are available to attend the ED. Some models of care use onsite rural or emergency nurse practitioners.	Medical staff rostered to the ED every day and either in the ED or within 10 minutes call back at night. Medical staff in post graduate year three or below must have senior medical support available onsite within ten minutes.	Medical officers at least Post Graduate Year 4 (PGY4+) should have a 24 hours a day, seven day a week on-site presence and adequate clinical supervisory support.	As for Level 4.	As for Level 5.

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			Medical staff unable to provide critical care require a system of procedural support within ten minutes from senior clinicians or advanced care paramedics. Onsite clerical staff during the day.	Access to social worker(s), clinical pharmacist(s), physiotherapist(s), occupational therapist(s), Indigenous Liaison Worker(s) and Aged Care/ community/specialty nurse resources. Administrative and service support staff should be on-site seven days a week. Emergency nurse or allied health practitioners available.		
Senior decision-makers	Offsite rural generalists or general practitioners provide advice or onsite assistance when available. Senior advice may be provided via telehealth.	Offsite rural generalists or general practitioners provide advice or onsite assistance when available. Senior advice via telehealth can be used for all patients, certain times of day, certain subsets of patients or to cover unexpected gaps in the roster.	Senior decision makers are FACEMs or of advanced standing (such as generalists, general physician, general surgeons, or anaesthetists) under the guidelines provided in G23 Constructing a Sustainable Emergency Department Medical Workforce. Senior-decision makers may be available by telehealth. There should be a Director of the Emergency Department, a	A FACEM as Director, supported by emergency specialist staff (FACEMs), or by generalists with Associateship in Advanced Emergency Medicine (or equivalent) or advanced emergency training and experience should be available at all times. Cover should be commensurate with caseload and G23 Constructing a Sustainable Emergency Department Medical Workforce.	FACEM as Director supported by emergency specialist staff (FACEMs). Cover should be commensurate with caseload and G23 Constructing a Sustainable Emergency Department Medical Workforce.	As for Level 5.

			FACEM or a generalist with an ACEM Associateship in Intermediate Emergency Medicine (or equivalent), who is supported by FACEMs in an Emergency Medicine Network.			

*For Level 1-3. Acknowledging a site's specific circumstances, where onsite services are limited, or cannot be provided, the responsible health service is expected to ensure there is planned and adequate access to these services and supports.

7. Support services

ACEM acknowledges that clinical support service requirements in EDs align with jurisdictional guidelines. ACEM is aware of the following guidelines and notes these are subject to revisions at the discretion of respective health departments:

New South Wales

- NSW Health Guide to the Role Delineation of Clinical Services

Queensland

- Emergency Services CSCF v 3.2 – Department of Health

South Australia

- Clinical Services Capability Framework – Emergency. SA Health
- Clinical Services Capability Framework – Emergency Services – Children. SA Health

Tasmania

- Tasmanian Role Delineation Framework and Clinical Services Profile

Victoria

- Capability framework for Victorian urgent, emergency and trauma care services. Health and Human Services

Western Australia

- WA Health Clinical Services Framework 2014-2024

New Zealand

- Emergency Department Services – Specialist Medical and Surgical Services – Tier Two – Service Specification

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8. Associated documents

Internal

- G15 Guidelines on Emergency Department Design
- G23 Constructing a Sustainable Emergency Department Medical Workforce
- G24 Guideline on Implementation of the Australasian Triage Scale in Emergency Departments
- P02 Policy on Standard Terminology
- P06 Policy on the Australasian Triage Scale
- S11 Statement Hospital Emergency Department Services for Children
- P20 Policy on Emergency Department Signage
- S27 Statement on Rural Emergency Medicine
- ACEM Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services

External

- Australian College of Rural and Remote Medicine. Recommended Minimum Standards for Small Rural Hospital Emergency Departments. Brisbane: Australian College of Rural and Remote Medicine; 2019.
- Victorian Department of Health and Human Services. Urgent care centres: Models of Care Toolkit. Melbourne: Victorian DHHS; 2017.

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Document review

Timeframe for review:	every three years, or earlier if required.
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Revision history

Version	Date	Revisions
V6	Nov 2023	Substantial revision with adoption of a six level model to replace the previous four level classification system.
v6.1	Jun 2025	

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